

Scottish Centre for Employment Research, University of Strathclyde

# Review of Partnership Working in NHS Scotland

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## Executive Summary

1. Partnership working in NHS Scotland has been in operation since 1999 and was positively reviewed in an extensive evaluation in 2012. Since then, however, the landscape of health and social care has changed significantly, with the adoption of health and social care integration, and the development of regional services as part of the National Clinical Strategy. This review aims to provide insight to maximise the impact of partnership working on the delivery of the Scottish Government's Health and Social Care Delivery Plan 2016.
2. The review questions address (a) whether current arrangements deliver on desired objectives at every level; (b) whether current arrangements are sufficient to deliver the pace of change in contemporary health and social care; and (c) whether current arrangements are capable of being adapted to reflect new and emerging structures within an integrated health and social care landscape.
3. From existing evidence, partnership working can span employment relations, organisational governance and workplace innovation, with important interaction effects across these areas that can be crucial to improving the delivery of healthcare services.
4. Research suggests that building effective partnership working is complex and requires resources. Stakeholders require particular capabilities, and strong leadership and commitment at all levels is crucial. Partnership is a dynamic process where challenges must be worked through to ensure that the partnership is able to adapt successfully to change.
5. Partnership is also a form of collaborative governance aimed at formal, consensus-oriented collective decision-making built around a shared view that collaboration is essential to delivering agreed outcomes. Collaborative governance requires investment and capacity-building to support relationships, influence behaviours and manage differences.
6. Partnership arrangements in NHS Scotland connect with a broader Scottish policy agenda that prioritises fair work and inclusive growth, and public service reform and innovation. Fair work is defined as work that offers effective voice, opportunity, security, fulfilment and respect; that balances the rights and responsibilities of employers and employees, and that has the potential to deliver mutual benefit to individuals, organisations and society. Fair work lies at the heart of inclusive growth. There is significant alignment between fair work and partnership working, which are both key to delivering the networked, responsive public services called for by the Scottish Government and its partners.
7. It must be noted that the 'partners' in partnership – normally employers and employees – engage in the process from structurally different positions, given their relative power in the employment relationship. Partnership as a process potentially offers employees a greater say and influence in the running of their organisations that would otherwise be the case. Scottish Government is also a key partner in NHS Scotland's partnership arrangements, bringing both legitimacy, resource and capacity to partnership working.

8. This review is organised around an analytical framework focussing on partnership as an interconnected system of structures, processes and actors. The ongoing challenge is to maintain a reciprocal balance between these, where structures and processes support and influence actors (partners) to deliver the desired outcomes, and actors (partners) can in turn shape structures and processes. Key evaluation criteria for effective partnership centre on its aims and objectives; the nature of partner relations; practices; processes and its outcomes, both process and substantive, for staff, employers and unions.
9. This review spanned multiple methods of data collection at national, regional and local level, including analysis of relevant secondary literature, minutes and documents of partnership and other meetings; non-participant observation of partnership meetings; and semi-structured interviews with 44 representatives of key partners at national and local levels and Chief Officers in HSCPs. The analysis of local partnership comprised a sample of 6 boards, territorial and non-territorial, selected by size and the number of constituent HSCPs. All data was analysed thematically according to the evaluation criteria above.
10. A key question for this review is whether current partnership arrangements in NHS Scotland are fit for purpose. Our evidence clearly demonstrates that partnership in NHS Scotland continues to be extremely robust and functions very effectively. This is no small achievement given the size and complexity of NHS Scotland in an increasingly challenging integrated regional and local landscape. Partners believe overwhelmingly that partnership working delivers on staff engagement and on outcomes for staff, patients and service users. Many examples were cited of high quality service delivery, development and re-design delivered in partnership, with staff-side insight into the needs, aims and values of services making them an important and integral part of solutions to current and future healthcare service challenges.
11. Similar to previous reviews, partnership continues to be widely seen as a highly developed and now mature approach to employment relations, governance and decision-making. Partners report considerable ownership of, and responsibility for, this process of shared governance.
12. The two national partnership structures – SPF and SWAG – are responsible for strategic oversight and workforce policymaking respectively. Area Partnership Forums have both strategic and operational responsibilities at Board level. There were no concerns raised among partners regarding the formal objectives of any of these structures.
13. While previous reviews raised concerns that partnership structures operated more strongly at national than at local levels, this was not replicated here. There are many strong examples of effective local working and relatively fewer cases of weaker or dysfunctional local partnership over time. There is also considerable potential for learning from strong local partnerships that could support weaker or less effective practice.
14. Partners' accounts of the operation of partnership, whilst varied, coalesce around how these structures deliver a process (of shared information, legitimate voices, distributed ability to influence, collective problem solving at the right level and balanced decision making) that produces three important proximate outcomes (decisions that are collectively

endorsed even when one or more partners disagree; benefits - and costs - that are fairly shared; and a shared mind-set for managing change) and two overarching outcomes (staff engagement and high quality health services). Overall, the NHS partnership model is widely viewed by partners as fit for purpose and integral to the successful delivery of the HSCDP.

15. There are, of course ongoing difficulties and challenges in partnership processes. There are concerns that the current role of SPF is insufficiently strategic. Concerns over its format, the (dis)engagement of senior partners and some partner behaviours can be analysed and addressed discretely, but appear connected to uncertainty about its current role in the new integrated landscape, fuelled, partly, by the thorny issue facing partnerships about when engagement starts.
16. There appear to be some weaknesses in the communications, linkages and relationships between partnership structures at different levels. While SWAG appears well connected to local Boards, there is little formal two-way communication between SPF and APFs, and that which does take place appears informal and uneven. This obscures insight on how decisions taken at national level are evaluated, considered and implemented at local level. Similarly, without formalised two-way communication between the Boards collectively and the SPF, and given the limited presence of employers at SPF, its deliberations may take place without robust insights from an employers' perspective.
17. Of perhaps more concern is some partners' views that new bodies are emerging with both strategic and operational responsibilities that might overlap with SPF's role but which are not directly connected to partnership structures and processes. In addition, there are also some concerns over linkages between SPF and RD/PBs (and through these and local boards to IJBs), and between SPF and the NPB, and the possibility that SPF would not always be sighted on operational developments with potential workforce consequences.
18. Turning to people (actors) and roles, partners across all bodies are expected to adhere to a set of guiding principles, values and behavioural standards that are considered necessary to underpin genuine partnership working. The presence of a common language and narrative around the values and behaviours of partnership is striking and a key positive finding of the research. Evidence of discontent with broad partnership values is rare and while no model of partnership working eliminates all issues, challenges and disagreement, there remains a strong emphasis across partners to joint ownership of problems and solutions, mutual responsibility and mutual benefit.
19. Partners expend considerable effort and expertise in partnership working, and partnership could not function successfully without their contributions. Many valuable skills are also acquired and developed through engagement with partnership processes. Intense engagement in the practice of partnership does, however, limit the time available to reflect on what is required of partners, what works well and what can be improved.
20. Many partners raised the need to re-invest in partners' capacity, capability and connectedness beyond the existing induction process in order to improve the quality of

partnership and to signal its continuing importance. This need was seen as particularly acute to support people new to formal partnership roles and to ensure effective succession.

21. Turning to outcomes, it is clear that partnership working in NHS Scotland delivers impressively on employee voice at all levels. Views on whether partnership arrangements had in any way redressed the power differential between employers and employees were mixed, within and across the partner groups. Some partners believed that staff-side were not influential or listened to; others perceived that staff-side were too influential and limited the scope for addressing the need for change in the HSC landscape staff voice; the predominant view, however, was that staff voice was crucial and influential in improving policy content and implementation.
22. Partnership has also delivered mutual benefits to staff and employers. Despite the constraints of austerity, partnership has delivered material benefits and protections to staff. While this increases employers' costs, many partners identified benefits in terms of industrial harmony, greater staff engagement and the likely impact of better pay in recruitment and retention. These benefits have the potential to feed into continuous improvement and better patient outcomes.
23. More broadly on outcomes, there were strong and widely held views that partnership over time has moved from:
  - adversarial to constructive engagement;
  - potential instability and industrial strife to long-term stability and near harmony even in a period of financial austerity;
  - key partners seeing others as a problem to all partners seeing each other as part of the solution;
  - distanced and discrete relationships to close and cross-cutting relationships;
  - posturing and positioning to honest conversations and dialogue;
  - low to high trust relationships;
  - narrow interests to broad collective interests; and
  - 'zero-sum' orientations to 'designing in' mutually beneficial outcomes.
24. Effective partnership working is enabled by a number of critical factors: clarity of purpose; leadership and ownership of partnership; shared values in relation to joint working; the skills and efforts of partners; and engagement in, and commitment to, building consensus. Considerable investment has been made by Scottish Government and by Boards in the past and present to support partnership capacity and capability.
25. The most obvious constraint on effective partnership is that collaborative working and joint decision making are, by their nature, inherently difficult processes. Aligning a complex system across multiple levels of operation exacerbates those difficulties, and better role clarity in relation to SPF may help address this complexity.
26. Effective partnership working also requires that agreement and consistency can be reached within and across partner groups, yet there are inevitable variations in commitment to, and engagement with, partnership across employers, unions and government. Moreover, all

partners can step outside of partnership when it is expeditious to do so. While explicable in terms of the multiple interests that government, employers and unions represent and prioritise, such actions risk undermining commitment to engaging in partnership processes.

27. The table below summarises first, the key enablers of, and second, the challenges and constraints facing, the system of partnership working in NHS Scotland and separately for partnership at national and local level.

	SPF	SWAG	Local Partnership
Enablers	<ul style="list-style-type: none"> <li>• strong commitment to partnership values and to ‘owning’ partnership <ul style="list-style-type: none"> <li>• extensive knowledge and experience of partners</li> </ul> </li> <li>• largely supportive and collaborative relationships among partners</li> <li>• robust commitment to joint decision making and recognition that effective solutions are best designed, delivered and implemented jointly</li> </ul>		
	<ul style="list-style-type: none"> <li>• strong identification with achievements of partnership</li> <li>• shared perception of the legitimacy of tripartite strategic engagement</li> <li>• willingness to change and problem solve</li> <li>• willingness and ability to engage in ‘big thinking’ around partnership’s role in delivering H&amp;SC</li> </ul>	<ul style="list-style-type: none"> <li>• well-defined purpose and operational remit</li> <li>• measurable substantive outputs</li> <li>• good engagement and involvement with other networks</li> <li>• pragmatic approach to conflict resolution and to relative equity partners’</li> <li>• strong connections and communications between national and local partners</li> </ul>	<ul style="list-style-type: none"> <li>• well-defined and shared purpose</li> <li>• operational remit/focus</li> <li>• continuing dialogue despite disagreement</li> <li>• agreement that staff experience drives user outcomes</li> <li>• emphasis on consistent behaviours across Boards</li> <li>• extensive/effective communications</li> <li>• commitment to resolving conflict at its lowest level</li> <li>• commitment to ‘common sense’ and pragmatism</li> </ul>
Constraints and challenges	<ul style="list-style-type: none"> <li>• availability, extent and quality of recent investment in partners’ capabilities and capacity</li> <li>• partners’ use of alternative channels of influence inconsistent with the principles of working in partnership</li> </ul>		
	<ul style="list-style-type: none"> <li>• some lack of clarity over its strategic role</li> <li>• few specific outputs and no real power</li> <li>• lack of visibility</li> <li>• weak external linkages to local partnership and emerging decision-making bodies</li> <li>• process-heavy</li> <li>• absence of key influencers</li> <li>• uneven levels of engagement</li> </ul>	<ul style="list-style-type: none"> <li>• potential overlap with STAC on workforce and terms and conditions issues</li> <li>• some weakness in connections between SWAG and SPF</li> <li>• slow policy delivery</li> <li>• heavy time commitment of partners</li> <li>• challenges in involving the right people in PINs/OfS</li> <li>• tight timescales to deliver OfS policies</li> <li>• areas where agreement cannot be reached quickly or at all</li> </ul>	<ul style="list-style-type: none"> <li>• variable knowledge of, and commitment to, partnership across Board levels</li> <li>• variation in behaviours and practices;</li> <li>• time commitments, particularly in changing established practice</li> <li>• identifying the boundaries between partnership working and managerial decision-making;</li> <li>• pressures on partnership given frontline operational priorities</li> </ul>



28. While partnership arrangements provide a strong representative voice for staff, views differed on whether staff more broadly were aware of, engaged in, and perceived the impact of partnership. There is clear evidence, however, that a majority of staff feel involved in decision-making as reported in the 2017 iMatter survey which compares favourably with survey data for the UK working population as a whole.
29. The second key review question focussed on whether partnership working can cope with an increasing pace of change. HSCDP recognises that the pace of change needs to accelerate across the system at all levels, and this depends on having the right partnership governance and relationships between the workforce, employers and government. Emerging priorities in health and social care around HSC integration, workforce planning, transformational change, digital strategies and Once for Scotland policies will increase demand on partnership processes and capacity. Perhaps further on the horizon, developments like further departure from a 'treatment only' model of health services; the greater involvement of users and patients in HSC decision making; and health and well-being issues within the HSC workforce will also raise challenges for partnership working.
30. Partnership has been described by one NHS partner as 'solid, not fast'. Collective decision making processes can be time consuming, but there is broad consensus among all partners at all levels that these yield both better quality decisions and better acceptance of decisions. These are important outcomes.
31. Achieving these important outcomes at a quicker pace raises issues of capacity, capability and resource. No partners wanted additional meetings of national fora and did not perceive that this would of itself generate a faster response. In relation to SPF, greater clarity and focus on its role and contribution alongside better communication and engagement between meetings was seen as having some potential to increase its effectiveness. Across all levels, having more people with more time to devote to delivering on partnership working, and with the right skills and capability to deliver what is required across the existing partnership structures, is likely to enable more agile working and an enhanced pace of activity, but has significant resource implications for Boards and for unions.
32. The third review question focussed on whether partnership is capable of being adapted to new and emerging H&SC structures. Partners identified both regional delivery/programme boards (RD/PBs) and HSCPs as the relevant new structures within health and social care. RD/PBs have more fully emerged since previous reviews of partnership took place. While perhaps initially slow to engage staff side representatives and so to adopt comparable partnership structures and ways of working, subsequent developments have involved Employee Directors (EDs) along with Workforce Directors/HRD. While this is a positive development, the lack of formal partnership agreements in these structures may imply their relatively greater fragility.
33. Current agreements on partnership do not apply in integrated HSC, and there is considerable scope for variation in approaches in HSCPs. While it is too early to make any robust assessment about the effectiveness of partnership working in this landscape, the models observed in some HSCPs bore striking similarities with the NHS-style approach (i.e. the development of staff-side fora with formal linkages back into NHS board

structures, the use of early involvement and input to strategic and operational decision-making).

34. It is crucial to note, however, that early stage development shapes the operation of new structures. This raises the possibility of more or less positive expectations about how likely it is, and how well, partnership working might emerge in the broader HSC landscape. The optimistic scenario is that partnership working is beginning to emerge in some form in these emerging structures and processes, and will develop further as time progresses, though this may be a slower emergent process of adoption. The more pessimistic scenario is that unless partnership working is well embedded in HSCPs in their early stage, it is less likely to shape these processes as they develop, making it more challenging to adopt effective partnership working in future. Moreover, although some have clearly adopted the NHS partnership model, without any formal arrangement or governance, this may be more vulnerable to change than the more formally established systems within health.
35. There are barriers to the development of NHS partnership working in the integrated landscape, not least that the sector is spread across two employers, with different staff engagement practices and cultures and one of which is not subject to the existing NHS Staff Governance Standards. In addition, there are challenges in extending the influence of SPF on strategy in an integrated H&SC service.
36. There are, however, also important facilitators of partnership working: shared public service ethos; shared use of iMatter as a support for staff engagement at the front-line; and the influence of example and learning at the interface between the NHS and other H&SC actors. It would be naïve to presume how employee relations and staff engagement will develop in the emerging H&SC landscape on the basis of an investigation of NHS partnership working. However, these facilitators could influence the integrated landscape, as could the language and approach of the Fair Work Framework.

#### *Partnership for the future – key recommendations*

37. Much of NHS partnership works extremely well. While this should promote caution in suggesting change to a well-functioning system, continuous improvement can help to maximise the impact of partnership working on the delivery of the HSCDP. It is important to note, though, that in a system of partnership governance, it is for the partnership process to decide and deliver change, and recommendations are offered in that context.
  1. SPF has been the core strategic forum in NHS partnership and our evidence highlights the continuing need for a core strategic forum. Addressing concerns over SPF's lack of purpose and aspects of its functioning should include:
    - clarifying the strategic purpose of SPF relative to other relevant strategic bodies within the NHS, such as the NPB;
    - improving the visibility of SPF and the active promotion of the achievements of partnership;
    - explicitly refreshing SPF membership to reflect its current purpose and encourage more consistent participation;

- encouraging greater reflection on the distinct roles of each partner group;
  - re-establishing an agreement between partners for the earliest possible engagement; and
  - having a robust and mature discussion about where partnership does not apply.
2. There is a need to agree the ‘reach’ of partnership and of the SPF in particular in the new integrated landscape divided by those whose engagement is defined by SGSs and others, and to consider the potential for SPF to take on a more active advocacy approach for partnership working beyond NHS Scotland, potentially using the language of Fair Work. Partnership has developed a mature way of working – the current challenge is to maintain this while developing it and adapting it in very new circumstances.
  3. There is a need to improve connectivity across institutions/levels of partnership by:
    - improving the formal communications between SPF and APFs;
    - establishing a two-way system of communication between SPF and RD/PB and other relevant decision-making bodies, including encouraging the Regional Implementation Leads to attend SPF in rotation; and
    - creating better linkages in the new landscape without simply creating additional process and bureaucracy. The development of a co-ordinated but agile system of joint working will, however, create resource and capacity challenges.
  4. There is a need to improve the functioning of SPF meetings by:
    - reverting primary responsibility for SPF agenda items to staff-side and employer partners;
    - developing an annual working plan and linked objectives;
    - use virtual communications for information sharing between meetings, and organising meetings around outcome focussed thematic discussions with follow-up actions; and
    - ensuring appropriate behaviours by robust chairing, ‘joint policing’ by all partners and a strong reiteration of the expected partner behavioural standards required in a mature national-level fora.
  5. There is a need to reinvest in partnership capacity at national and local levels to avoid attrition of partnership skills, through effective induction, joint training and development.
  6. Partnership working has created an effective system of industrial relations and of staff engagement. The current context, while challenging, could allow for the progression of partnership at all levels beyond staff engagement to the delivery of a more holistic new approach to health and social. Considerable investment in strategic thinking and strategic capabilities will be required to support this progression.

## Part One: Introduction and context

### Introduction

This review was commissioned by The Scottish Government Workforce Practice Unit and Health and Social Care Analysis Division in conjunction with the Scottish Partnership Forum. Its key aim is to provide insight to maximise the impact of partnership working on the delivery of the Health and Social Care Delivery Plan<sup>1</sup> (HSCDP) by reflecting on the adequacy of existing arrangements and their fitness for purpose in the context of the changing health and social care landscape. This requires a robust assessment of:

- whether current arrangements deliver on desired objectives at every level; involve the right people in the right roles; demonstrate the values and behaviours expected within NHS Scotland; and represent best practice in industrial relations;
- whether current arrangements are sufficient to deliver the pace of change in contemporary health and social care; and
- whether current arrangements are capable of being adapted to reflect new and emerging structures within an integrated health and social care landscape.

Partnership arrangements in NHS Scotland have been in operation since 1999 and have been described as “...probably the most ambitious and important contemporary innovation in British public sector industrial relations”<sup>i</sup>. Below we briefly discuss the concept of workplace partnership, and its relevance to broader debates on collaborative governance in public services; review the literature on the impact of partnership in healthcare and the specific context of NHS Scotland; and finally connect to the broader Scottish policy agenda on fair work, inclusive growth and public service innovation and reform.

### Partnership working in context

There is an extensive research base on partnership working as a specific approach to industrial/employment relations that has attracted significant attention from government, policymakers, unions, employers, researchers and other workplace stakeholders since the early 1990s. In the UK the focus has been on organisation-level partnerships. Elsewhere, notably in co-ordinated market economies like Germany, Sweden and Finland<sup>ii</sup>, the focus is on broader social partnership. Both literatures are relevant to Scotland given recent Scottish Government interest in ‘voluntary’ social partnership approaches.

Findlay’s previous work on partnership has highlighted that partnership not only encompasses employment relations but often includes distinct approaches to organisational governance and workplace innovation.<sup>iii</sup> Put simply, more constructive industrial relations and shared decision-making can create the conditions not just for staff engagement and better service delivery but also for more engagement in innovation and change. Our argument is consistent with US research<sup>iv</sup> that it is the ‘interaction effects’ between different employment, work organization and decision-making approaches that deliver staff engagement and improved organisational performance. Understanding these ‘interaction’ effects are crucial to improving service delivery through partnership.

A parallel strand of public services/public administration research also sees workplace partnership as an element of new forms of collaborative governance.<sup>v</sup> Collaborative governance is defined as “a governing arrangement where one or more public agencies directly

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<sup>1</sup> <http://www.gov.scot/Publications/2016/12/4275>

engage non-state stakeholders in a collective decision-making-process that is formal, consensus-oriented, and deliberative”.<sup>vi</sup> A shared approach and collective identity is central to this way of thinking about partnership and collaborative governance – the mission and objectives of the stakeholders must be shared and rooted in ‘reciprocal interdependence’ – that is, the view that collaboration is essential to delivering agreed outcomes.<sup>vii</sup> The benefits of collaborative governance include:

- the sharing and pooling of ideas and other resources to address challenges that cannot be overcome by any one stakeholder;
- the emergence of innovative approaches as a result of the interaction of different stakeholders drawing on their distinctive knowledge and experience; and
- improved ‘buy-in’ and shared ownership at all levels for decisions and initiatives that have been co-produced in consensus rather than imposed from the top-down.<sup>viii</sup>

However, researchers have pointed out that collaborative governance and partnership working requires resources – and the wider the governance network becomes, the greater is the task of boundary spanning by so-called ‘metagovernors’ (people in key partnership roles in the NHS context) to facilitate the alignment of norms, values, and interests, and help convert collaboration into action.<sup>ix</sup> The point here is that metagovernors – whose task is to facilitate and strengthen mutually dependent relations and nurture the constructive management of difference – require the time, resources, skills and influence to work effectively across boundaries and influence partners’ behaviours.<sup>x</sup> In short, collaborative governance and partnership working requires investment and capacity-building.

### *Partnership in healthcare*

Partnerships in healthcare operate beyond Scotland and one of the most notable examples is at Kaiser Permanente (KP), described as the most ambitious labour-management partnership in the history of US employment relations,<sup>xi</sup> covering 86,000 employees in eight US states, represented by more than ten labour unions. The goals of the partnership are to involve unions and employees on decisions to improve the quality of healthcare, provide employment and income security and a good place to work, and to consult and advocate jointly on public policy issues. The KP partnership has delivered important achievements (addressing financial problems; delivering quicker and more effective organisational change; increased leadership support for partnership; growing numbers of employees involved in partnership activities; staffing change without layoffs; improvements in employee attitudes; and reductions in grievances) as well as significant challenges (in moving partnership into an ongoing organisational model; in ensuring that success in national priorities is evenly achieved; in diffusing learning; and in properly evaluating the outcomes of partnership). Some of the relevant lessons from the KP experience for partnership in any context include that: (again) partnership building can be complex and requires resources; there may be a need for stakeholders to develop new capabilities; strong leadership from the top of all stakeholder bodies is needed; and that partnership must always be seen as a work-in-progress – challenges must be worked through to ensure there is no roll back.

Previous reviews of NHS Scotland partnership pre-date recent operational developments around the National Clinical Strategy (NCS)<sup>2</sup> on the formal delivery of regional services and the integration of health and social care (HS&C). Scotland’s H&SC integration agenda has,

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<sup>2</sup> A National Clinical Strategy for Scotland (2016). Edinburgh: The Scottish Government.

since 2016<sup>3</sup>, provided an additional, unique context for any analysis of workplace partnership in NHS Scotland. H&SC integration aims to deliver services better tailored to the needs and outcomes for patients, service users and carers. Integration Joint Boards (IJBs) were launched in April 2016 to oversee smooth transitions between H&SC services with the aim of breaking down barriers to joint working between NHS boards and local authorities.<sup>4</sup>

The 2016 Act requires integration of the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services. Other areas such as children's health and social care services, and criminal justice social work, can also be integrated<sup>5</sup>. Although the legislation makes no reference to an employer-employee 'partnership', there is a requirement that HSCPs include staff-side representatives. Operationally, this means that there are formal links between the NHS partnerships in boards, to IJBs and HSCPs, and then into the new Regional HSCDP Programme Board (RD/PBs)<sup>6</sup> structures through both NHS employers and staff-side representatives.

There are multiple implications for (and demands for the inclusion of) employee participation in IJBs/HSCPs. These bodies are required to focus increasingly on community provision and capacity building and to partner with a range of stakeholders to deliver nationally agreed outcomes. There may also be significant challenges for workforce planning, in relation to terms and conditions, redeployment and role redesign to facilitate inter-disciplinary working, skills upgrading (and the need to address concerns around dilution).<sup>xii</sup> In short, effective workplace partnership will be set new challenges by, and arguably will be crucial to, H&SC integration and delivering on the HSCDP. Yet the governance framework and institutional arrangements for industrial relations and/or partnership vary considerably across IJB stakeholders. Understanding these variations and the degree of, or scope for, alignment around shared approaches is crucial to embedding effective and responsive H&SC integration.

#### *The broader Scottish policy context*

Partnership arrangements in NHS Scotland also connect with a broader Scottish policy agenda that prioritises fair work and inclusive growth, and public service reform and innovation. The Working Together Review (WTR) of Progressive Workplace Policies in Scotland emphasised the importance of building collaborative and productive relationships between employers, employees and unions. As the Review noted, "There is an extensive international literature that identifies and promotes the many benefits to individuals, organisations and societies of collaboration and working together, and the importance of high trust relationships, respect, integrity and the sharing of gains."<sup>xiii</sup> The Review recommendations focussed on the need to build capacity in industrial relations; support fair employment; create a stakeholder body to act as a focus for constructive employer and union leadership of industrial relations and workplace matters; and develop an evidence based approach to constructive industrial relations. Scottish Government, in accepting the Review Report's recommendations, have signalled that these

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<sup>3</sup> Public Bodies (Joint Working) (Scotland) Act (2014), effective from April 2016

<sup>4</sup> Thirty one IJBs were established across Scotland: jointly funded by local authorities and boards. IJBs commission services through Health & Social Care Partnerships (HSCPs).

<sup>5</sup> Integrated hospital services include accident and emergency services, general medicine, geriatric medicine, rehabilitation medicine, respiratory medicine, psychiatry of learning disability, palliative care, addiction and substance dependency services, and mental health services provided by GPs in hospital. Each IJB is required to develop a strategic commissioning plan outlining how these services will be planned and delivered using integrated budgets.

<sup>6</sup> RD/PBs are not Health Boards but 'collaborative' arrangements between boards based around the HSCDP programme at the Regional level.

issues are important across Scotland's workplaces. The Review highlighted the operation of partnership in NHS Scotland as an important model of constructive employee relations from which wider learning might take place.

Established as a direct outcome of the WTR, the Fair Work Convention (FWC) delivered its Fair Work Framework (FWF) for Scotland in March 2016. This sets out in detail the ambitious aspirations of Scotland to be the best Fair Work nation in the world by 2025 and what fair work means. Fair work is defined as work that offers effective voice, opportunity, security, fulfilment and respect; that balances the rights and responsibilities of employers and employees, and as having the potential to deliver mutual benefit to individuals, organisations and society. Effective voice is seen as crucial to delivering on all other dimensions of fair work. The FWF also points to the important role of the public sector in supporting the delivery of fair work. Taking these last two points together, lessons from partnership in NHS Scotland have significant potential to influence the wider development of fair work in Scotland.

Fair work lies at the core of the Scottish Government's commitment to inclusive growth and to combining increased prosperity with greater equality, opportunity and fairness. Addressing inequalities in health is a core component of tackling wider economic and social inequality. NHS partnership clearly spans both 'producer' concerns (i.e. the importance of fair work for NHS workers) and 'consumer' concerns (i.e. the key role of high quality NHS services in building individual capacity and capability to participate in economic, social and civic life).

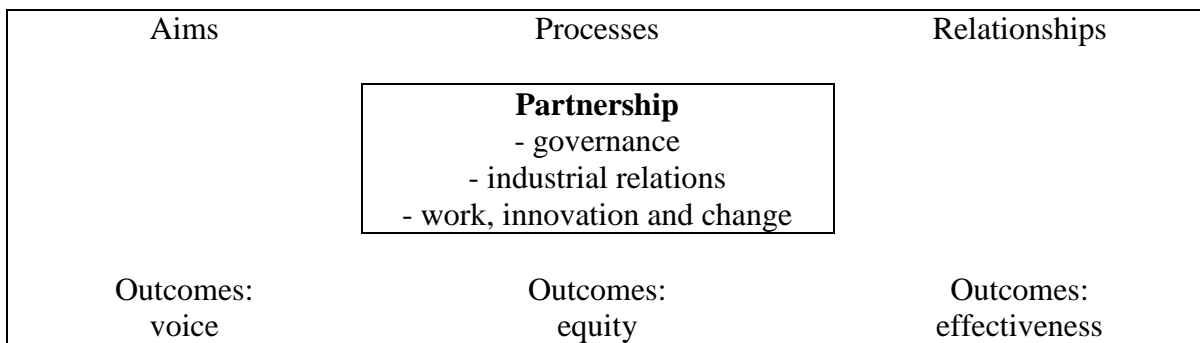
Workplace partnership can also be seen as key to delivering the networked, responsive public services called for by the Scottish Government and its partners. In response to the recommendations from the Christie Report (2011), the Scottish Government has sought to focus on four main areas to drive public service improvement and reform by supporting: a decisive shift towards prevention; greater integration at local level driven by better partnership; workforce development; and a more transparent focus on performance. The Scottish Government and its partners acknowledge the key role of public service workplaces, partnerships and professionals in delivering improved outcomes: leaders and their teams need to work collaboratively across organisational boundaries to ensure that services are shaped around the needs and demands of individuals and communities, and collaboration is crucial to recalibrating services to focus on prevention and early intervention.

Scotland's HSCDP emphasised the need for services and functions to be more efficiently delivered at a national level (e.g. National Workforce Planning, Public Health Improvement) alongside cross cutting system-wide policy initiatives: NCS, digitisation and new technologies in services as part of Realistic Medicine and the Digital Strategy; and the integration of H&SC. The HSCDP recognises that the pace of change needs to accelerate across the system at all levels, and this depends on having the right partnership governance and relationships between the workforce, employers and government. The HSCDP notes that while the NHS in Scotland has been recognised as an exemplar of constructive and co-operative partnership working within the public sector, there is always room for continuous improvement. The evolving health and social care policy and delivery landscape presents fresh and on-going challenges, but also opportunities for adaptation and change.

Effective partnership could help address ongoing challenges in the H&SC policy and delivery landscape. Effective partnership may prove crucial to delivering those outcomes sought around personalisation, innovation and quality in the HSCDP. The importance of collaboration to support innovation has been discussed in our own research on the role of partnership and

mutual gains in underpinning automation, organisational change and upskilling in NHS hospital pharmacy services.<sup>xiv</sup>

The evidence to date points to important benefits of effective partnership in NHS Scotland and elsewhere. However, the literature on collaborative governance in public services – and workplace partnership more specifically – also highlights the challenges around resourcing and supporting these important collaborations. Finally, the H&SC integration agenda and broader drive for innovation and excellence in Scottish public services provides a unique and urgent context for the research that follows. Locating our review of partnership arrangements within the wider policy context and informed by our analysis of existing knowledge, our approach will be framed around the core dimensions contained in the diagram below.



Drawing on the above evidence base, analysing partnership requires a focus on:

- its aims and objectives;
- the nature of partner relations (perceptions of legitimacy, reciprocity, trust and mutual organisational commitment);
- its practices (voice, direct and indirect participation);
- its processes (influencing, problem solving and decision-making channels and structures); and
- and its outcomes, both process (such as better information and communication, improved relationships, perceptions of procedural justice) and substantive (mutual gains between partners that benefit employees, unions and employers including employment security, training, flexibility, development and involvement; more effective voice; confident and committed representatives, improved information flows; stronger performance and more effective change management).<sup>xv</sup>

It is important to note that ‘partners’ in partnership – normally employers and employees – engage in the process from structurally different positions, given their relative power in the employment relationship. Partnership as a process potentially offers employees a greater say and influence in the running of their organisations than may otherwise be the case. For employee partners, therefore, the key outcomes sought from partnership are primarily greater voice and a greater (or more equitable) share in rewards, though many will also be concerned about organisational effectiveness. For employer partners, the desired outcome of greater employee participation is often greater organisational effectiveness; again though, many may also be interested in voice and equity.



## Methods

The research used multiple methods of data collection. The range of information and sources provided system-wide and in-depth coverage of partnership working at national, regional and local levels across H&SC.

**Literature:** We collated a range of literature on the NHS partnership and policy landscape (including national, local, regional and IJB/HSCP governance documentation, iMatter reports and Annual Reports). This allowed us to map out the scope and aims of partnership structures, and the governance processes and relationships at all levels.

**Minutes & Documents:** We accessed and collated minutes from all national partnership bodies (2012-17), regional delivery/programme boards (RD/PBs) (2017-18) and local Boards and HSCPs (over 2018). The national partnership data covered the Scottish Partnership Forum (SPF) and the Scottish Workforce and Governance Committee (SWAG). Documents relating to the Scottish Terms and Conditions Committee (STAC)<sup>7</sup> were also reviewed. This data was collected to gauge and assess the content and scope of these meetings. All national minutes were analysed to identify the partner attendees by their role, provide detail on the number of items presented by topic, by issue and by source. From this data, we were able to identify the content and coverage of discussions and how differing opinions were marshalled by different partners within debates.

**Non-Participant Observation:** We attended eleven meetings across the main national partnership fora, including the Employee Directors Group (EDG), over the period February-October 2018. This gave us a detailed insight into processes, relationships and interactions. All of the meetings were digitally recorded and written notes were also taken.

**Semi-structured Interviews:** These were mainly conducted face-to-face (by telephone when this was not possible) with representatives of all the main partners at national and local levels, plus a small number of Chief Officers in HSCPs<sup>8</sup>. Outwith the main national partner representatives, focus groups were considered as a method of data collection but delays in accessing individual national respondents highlighted the likely difficulties of bringing partners together in this format. Consequently, additional individual interviews replaced the planned focus groups. At the local level we identified a sample of six boards (territorial and non-territorial, and structured by size and the number of their constituent HSCPs) to provide a range of insights into partnership working at local level across Scotland. Where possible we conducted a small number of interviews with a representative from a HSCP. In terms of our sample: while there was reasonable balance across partners in the national group, there was a 2:1 distribution of employers relative to staff-side at the local level.

Individual interviews were carried out with 44 partner representatives. All were digitally recorded, transcribed and analysed thematically according to the schema outlined above. The findings are reported using this structure. All qualitative data sources were interrogated to

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<sup>7</sup> While STAC is the negotiating body for NHS Scotland and notionally reports to national partnership fora, it is not formally part of the partnership arrangements and largely operates independently, with reporting through the separate structures of employers and unions. STAC has a clear and well defined role and remit to negotiate over pay, terms and conditions. While it is imbued with the ethos of partnership working and operates in line with partnership values and behaviours, it maintains more traditional industrial relations arrangements. Because partners largely assessed the effectiveness of STAC as a negotiating body positively, it will not be considered in detail in this report, though some general comments on STAC are addressed in Part 3 of the report.

<sup>8</sup> Including more informal interviews with the iMatter project team and the Chair of the EDG.

deliver key findings. Notably, engaging with all partner groups using different sources allowed for a more robust triangulation of data so that no one partner view dominated the analysis.

For brevity, the term ‘partners’ will be used throughout to refer to interview respondents and participants in meetings observed by the research team. These partners contributed extensive qualitative data, but a significant number asked not to be quoted directly, or even anonymously. Beyond these specific requests, concerns over the potential for quotes to be identified in a small, close knit population resulted in a decision to include no direct quotations. This inevitably means a loss of rich insights from individuals in their own words. All reported views reflect the dominant view expressed by partners, unless specified otherwise. Where there are minority views, these are highlighted in the discussion. In addition, we do not, for the most part, identify the partner group (employer, staff-side and Scottish Government) from which responses arise. Partnership is a collective process and we identify the variety of views within that collective without differentiating between them.

Part Two of this report begins by considering national partnership structures and then goes on to analyse six case studies of local partnership, before discussing emerging RD/PB structures and HSCPs. Part Three offers concluding reflections on partnership, addressing the evaluation questions and the recommendations made by previous reviews, as well as offering recommendations for change.

## Part Two: Findings

### National – Scottish Partnership Forum (SPF)

#### *SPF aims*

Formally the SPF has three core strategic roles: (i) to undertake the strategic oversight of the service and workforce implications of policy decisions; (ii) to influence thinking around national priorities on health and (iii) to champion, oversee and develop partnership and to ensure compliance with its Staff Governance Standards (SGSs)<sup>9</sup>.

Table 1 details the administrative data extracted from the SPF minutes over 2012-2018.

Table 1: SPF Administrative Minute Data 2012-18

<b>Period (2012-18)</b>	<b>SPF</b>
<b>Attendance (%)<sup>10</sup></b>	
Scottish Government	42
Employers	20
Staff-side	34
Other	4
Total	100
<b>Average attendance/ meeting (n)</b>	27
<b>Main Attender Groups</b>	
Scottish Government	<i>Staff/ Directors/ Policy Leads</i>
Employers	<i>Workforce Directors/ HR &amp; Finance</i>
Scottish Government Lead (%) (all items) <sup>11</sup>	84
<b>Main Issues<sup>12</sup></b>	
1	<i>Health &amp; Social Care Integration (14%)</i>
2	<i>Workforce Planning (13%)</i>
3	<i>Finance (12%)</i>
Challenge Rate (%) <sup>13</sup>	4
<b>Main Challenge Issues</b>	<i>Clinical Strategy/ Health &amp; Social Care Integration</i>

Excluding Corporate Governance items

<sup>9</sup> As outlined at <http://www.staffgovernance.scot.nhs.uk/partnership/groups-and-committees/>

<sup>10</sup> These are aggregated figures based on the total numbers of those noted as ‘Present’ and ‘In Attendance’ at the main Committee meetings (i.e. not the Secretariat). The figures exclude those Scottish Government staff who were present to record the Minutes of the meetings but include those Scottish Government staff who were present and in attendance as part of agenda items (e.g. Finance).

<sup>11</sup> This is a likely underestimate of Scottish Government lead and support on the issue agenda. Scottish Government actively invest considerable resources in supporting partnership processes, fora and agenda.

<sup>12</sup> These exclude standard items of Corporate Governance by the Chair (i.e. ‘Welcome and Introduction’ ‘Agree the previous Minutes’, ‘Any Other Business’, ‘Notification of the Next Meeting’, for example).

<sup>13</sup> Although we applied the textual analysis criteria used by Bacon and Samuel (2012), the weakness of textual analysis on Minute data should be highlighted: dependent largely on the ways in which the minutes are recorded by individuals; and that they mask the investments made by all partners in consensus building before meetings. In this sense, ‘challenges’ may refer to noted aspects of ‘concern’ and ‘disagreement’ and should be taken as illustrative of particular aspects of much broader agenda items, where partners wish to highlight formally their ‘concerns’. Statistically, however, similar to Bacon and Samuel (2012), these challenges only amounted to a very small number of cases.

Considering the main issues identified in Table 1, SPF appears to address the range of high-level issues currently affecting the service: H&SC integration; workforce planning; finance; health policy; modernisation topics and items that were reflective on the wider place of 'partnership' in the NHS system. The issues are largely consistent with its formal aims and previous reviews. Similarly, there was a relatively low rate of challenges (i.e. disagreeing): and overwhelming emphasis (using Bacon & Samuel's analytical framework) on largely neutral (e.g. sharing and giving information) alongside co-operative (e.g. consensus and agreement) partnership behaviours. The administrative and the recent observational data were consistent on the types of issues engaged with by SPF.

The qualitative data presents a somewhat different picture of the how SPF's aims are delivered in practice. Some partners voiced concerns over the ability of SPF to direct and shape strategy in an expanded H&SC service, and raised more fundamental questions about the current purpose and status of this 'flagship' partnership forum. Although there is widespread (though not unanimous) acknowledgement and commitment across partners that SPF's role should retain a strategic element, some partners reflected on the tensions between its formal strategic policy roles (influence and oversight) and its current role, in light of concerns over the extent of consultation and a perceived lack of early engagement of SPF in the adoption of the NCS and the HSCDP. These events were widely seen as key moments that have destabilised SPF's strategic role and reduced its influence. There appears, however, to be a relevant backdrop to these 'key moments'. This included a perceived reduction in the knowledge and understanding of partnership and of the SPF role within the wider SG Health Directorate and in public engagement as partners, with fewer NHS partnership events or conferences and more limited opportunities to showcase SPF and partnership. These more immediate tensions appear to have had ongoing ramifications for partner relations and for perceptions of the SPF's current role.

Some points of additional clarification are important here. No partner contested the right of SG to define policy objectives and priorities. The perceived lack of early staff-side involvement in the NCS and the development of the HSCDP challenged the view of staff-side being influential at this strategic level and the role of SPF as the main strategic body in the NHS partnership. What appears to be at the heart of these concerns is the complex question of when partnership starts, alongside the challenges involved in negotiating the multifaceted role of SG as a partner.

The concerns of many partners that SPF has less of a strategic role have been exacerbated by other recent developments. The establishment of the National Programme Board (NPB) to implement the evolving H&SC structures in the RD/PBs appear to some partners to be largely 'out of sight' of NHS partnership processes. Early exclusion of staff-side from the NPB followed by the limited provision of one seat for NHS staff-side representatives has not allayed some of their concerns over where strategic deliberations and decision-making takes place, and any implications for partnership. This has led to a feeling by some that SPF was becoming a more isolated fora, unheard in the emerging H&SC landscape: with a diminished ability to have oversight of and influence on less formal partnership arrangements in the RD/PBs and the HSCPs. Some voiced their fears for the future of the NHS approach to partnership working given their perceived lack of influence on these new landscapes and in National Workforce Planning. It is notable, however, that some SPF partners also acknowledged that, as a collective forum, they held some responsibility for its diminishing strategic role by allowing themselves to become increasingly operational and reactive in their focus rather than being strategic and proactive. SPF deliberations are seen as more fragmented, narrower and less constructive. Some partners at national level also highlighted weak links between SPF and Board-level

partnership. At their core, these concerns point to anxiety about SPF's role and contribution which raise questions about how partnership is understood and invested in at a strategic level.

### *SPF processes*

SPF secretariat support (comprising three partner co-chairs) meets three times each year. The role and contribution of the secretariat was described positively and the recent development of Joint Secretariat Business Meetings to 'better connect' SPF, SWAG and STAC has been well received with the potential to improve information flows and connectivity between these fora.

Attendance at SPF serves two important functions: the ability to make a substantive contribution and presence as a signal of the status of partnership to other internal and external stakeholders. Table 1 (above) and observation highlights that while senior SG and staff-side consistently attend SPF in sufficient numbers, challenges remain around the commitment of employers, particularly Chief Executives and those in large and influential boards. Meetings are no longer regularly chaired by the Director General Health and Social Care and Chief Executive of NHS Scotland, and increasingly infrequent attendance by other operationally important signifiers – e.g. Heads of Clinical Services (Medical and Nursing) – are interpreted as negative reflections of SPF's importance.

There are, of course, alternative explanations for non-attendance. The maturity and success of partnership may have instilled confidence that workforce matters are being addressed appropriately and other aspects of the system - designing and implementing a new H&SC landscape with additional partners in local authorities and beyond – pose significant time and capacity constraints on government and employers.

Two further issues were raised by SPF partners in terms of the composition of SPF: the relatively long tenure of SPF members and the lack of 'new blood' within national level structures. While there have been efforts to address succession issues, others argued that fixed term tenures might encourage a more regular refresh of people in national partnership roles.

SPF meetings take place three times a year, usually for two hours. There is a widespread recognition across all sides of the partnership that this presents limited opportunity for networking and engagement. No partner wanted more or lengthier meetings but many showed a strong interest in having more effective meetings, though with far fewer practical suggestions as to how this could be achieved. SG officials are largely responsible for presenting agenda items, with significantly far fewer items being led by the other partners. This appears to be disproportionately balanced and may raise legitimate questions about the 'co-production' of partnership contributions.

There was near unanimous criticism of the format of SPF meetings: the variable quality of presentations and papers, followed by 'surface' scrutiny and discussions on complex issues of Policy, Finance and Workforce Planning. The majority of partners were clear in their views that the provision of information is a necessary but not sufficient condition for partnership working. In the current climate, this negatively impacts on the capacity and inclination of partners to engage with issues in greater depth: largely provoking 'listening' followed by limited comment. It is evident that the current format is not engaging partners, and is not inviting to attendees, limiting the scope for meaningful discussion and debate. These were described as relatively longstanding issues. While in part these concerns reflect 'housekeeping' issues, arguably they conceal a more challenging problem around perceptions of ownership of, and responsibility for, SPF.

Three meetings a year leaves a large gap between SPF meetings during which, outside of the secretariat members, there appears to be limited collective engagement. Moreover, there is no process or protocol for follow-up after an SPF meeting for other than the SPF secretariat and the posting of minutes, either to local Board Area Partnership Forums (APFs) or to RD/PBs. While formally, SPF is supposed to direct the work of SWAG, in practice SWAG operates largely independently (see below). Some partners argue that there is duplication of effort at SPF and APF levels, that SPF has no authority to delegate some decision-making to local levels in the partnership structure and that this slows the pace of change at a time when change needs to be expedited more quickly.

### *SPF relationships*

All NHS Scotland partners across all partnership bodies are expected to adhere to a set of guiding principles, values and behavioural standards<sup>14</sup> that are considered necessary to underpin genuine partnership working. There was widespread concern over some instances of poor personal behaviours at SPF and, though small in number, they were associated with an ‘unfriendly’ and ‘uncomfortable’ atmosphere at meetings which stifled debate, discussions and contributions. There appear to be no functioning internal mechanisms to address behaviours. While these behaviours were sometimes challenged in relation to the content of the comment or intervention, the nature of the behaviour itself was rarely challenged, pointing to the limits of self-policing of meetings.

Partnership requires particular skills and capabilities. Some partners questioned whether SPF contained the requisite mix of analytical ability, strategic orientation and experience to interrogate, understand and tackle significant policy priorities and challenges, to take a long-term orientation and to be able to bring people with them; and challenged all partners to reflect on whether they have the right people in the right partnership role. These concerns have been exacerbated in recent times by ‘succession’ issues: long tenure, a lack of turnover and concerns over how effectively new partners would replace experienced partners. Some partners, however, found themselves playing a national partnership role without much preparation at the national level other than observation and, occasionally, some shadowing. Research on partnership points to more systematic approaches to supporting the formation of capability, skills and behaviour. While an induction process does exist for national partnership roles, there are concerns that it is not sufficiently systematic in addressing behaviours and skills needs. There appears to be little formal support in these areas beyond induction, for example, continuing professional development support; and relatively few opportunities outside of SPF meetings for new partners to observe and learn from more experienced individuals.

### *SPF outputs and outcomes*

Our framework for assessing the outcomes of partnership focusses on whether and how partnership finds a balance between effective voice for partners, equity and fairness in outcomes, and effectiveness for NHS Scotland – notably (following Budd, 2004<sup>xvi</sup>) on whether one dimension can be improved without unnecessary negative impacts on the others. All levels of partnership in NHS Scotland potentially deliver voice, equity and effectiveness to varying degrees. To illustrate, SWAG designs policy drawing on partner voices in ways that balance organisational effectiveness with fairness for partners, while STAC’s focusses most on delivering equity and fairness of outcomes.

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<sup>14</sup> <http://www.staffgovernance.scot.nhs.uk/partnership/groups-and-committees/>

While SPF's overarching role in championing, overseeing and developing partnership gives it a locus in relation to voice, equity and effectiveness outcomes, its formally strategic role focusses on process across the partnership terrain rather than substantive outcomes. SPF is not tasked, for example, to deliver equity or distributional outcomes as STAC does, and partners struggled to articulate material outcomes from SPF, although some pointed to SPF's role in pushing for payment of the accredited Living Wage in HSCPs and Modern Apprenticeships as examples. Similarly, SPF is not tasked directly to deliver operational policy, as SWAG does, though SPF's deliberations can shape SWAG priorities. SPF's role is ultimately to deliver organisational effectiveness through partnership working that generates engaged staff who, in turn, deliver higher quality services to patients/users. But the SPF role in contributing to the substantive outcomes of the HSCDP is indirect, mediated and shared with other parts of the partnership system.

SPF has a much more explicit and direct role, however, in ensuring effective voice in the system and, on this criteria, many partners see that SPF has been effective. Notwithstanding the widespread concerns over early engagement in policy previously discussed, SPF does provide an opportunity – arguably, the only opportunity – for dialogue at strategic level across key partners in the NHS, and issues of strategic direction and policy are discussed and debated. Measuring the impact of strategic dialogue is, however, difficult. Partners generally believe that they are listened to and heard on many areas of policy delivery, and that they deliver a consensus outcome on a range of issues. While challenging in some instances, SPF produces relationship outcomes among key employer, staff-side and government actors.

There are competing perspectives on the effectiveness of different partner voices. While senior employer partners have formal channels through which to exercise voice outside of partnership structures, it is also recognised by other partners that in some regards, employers have a structurally weaker relationship in relation to the SG, and that while able to exercise voice in an advisory capacity, cannot engage in sanction. This raises challenges for employer partners in their engagement with partnership structures and led to some views that SPF was really a forum for engagement between staff-side and SG, rather than a genuine tripartite body.

Given the inevitable power differential between employers and employees, a significant issue for any evaluation of partnership working is whether such arrangements redress that power differential in any way. Not surprisingly, partners differ in their views on this. Some argued that staff-side voice was not well listened to or influential; that other partners were more influential than staff-side; that staff-side contribution was treated in a token manner to legitimate the process or was side-lined; and that new bodies were emerging in which it was clear that staff-side input was less desired, even if it had subsequently been included. The latter was attributed in part by one partner as a consequence of a renewed focus on (managerial) leadership within NHS Scotland that could be seen as inimical to partnership working.

The predominant view, however, was that staff-side voice was crucial and influential. This was argued for both positive and negative reasons. On the former, staff-side input was seen to improve policy content and implementation, and as necessary to delivering a partnership approach to staff governance that improved both staff and user experience. On the latter, lack of effective voice within partnership may lead to staff-side using voice in an oppositional and less constructive manner. Staff-side partners were viewed by some as exercising a very influential – occasionally too influential – voice within partnership structures, that limited the possibilities to address what these partners saw as necessary change and as opportunities to

align better with the integrated H&SC landscape. In this regard, government were seen by some partners as unwilling to tackle some of these issues with staff-side.

There are more discrete and measureable SPF outcomes. Some, such as near harmony in relation to industrial disputes in NHS Scotland, are shared with the wider partnership system. Others, such as the regular review of Staff Governance and engagement measures, are a clear outcome of SPF. SPF formally provides oversight of the work of SWAG and STAC, though these appear to function largely independently, but the new joint business meetings of both SPF and SWAG secretariats provide an opportunity for influence in both directions.

### *SPF enablers*

Partnership at SPF level is enabled in important ways by the factors below:

- strong commitment to the values and processes of partnership as a form of governance that goes beyond staff representation;
- a strong identification with what partnership structures have delivered since its inception;
- a common perception of the legitimacy of strategic rather than simply operational engagement by employers, staff-side and government;
- the extensive knowledge and experience of partners at SPF relevant to understanding the challenges facing H&SC;
- supportive and collaborative relationships among key players/actors;
- a willingness to make changes to address problems and challenges where appropriate;
- a genuine willingness and ability to engage in ‘big thinking’ around the future of partnership in delivering H&SC; and
- a recognition that effective solutions to existing and new challenges are more likely to be designed, delivered and implemented jointly.

### *SPF constraints and challenges*

Alongside these important enablers of SPF’s work, a number of factors that constrain SPF effectiveness have been discussed in the preceding sections. These are discussed below.

- Lack of clarity over its purpose, power and profile: partners were unsure whether the core purpose of SPF as a strategic body still applied given the widespread view that it no longer operated strategically, and this underpinned disengagement and reactive rather than proactive behaviours. Partners were unclear as to the criteria by which SPF’s role should be assessed. A few partners were more explicit in suggesting that SPF’s influence was limited because it had few specific outputs and no real power, as well as no real connection to emerging decision-making bodies within the NHS. One potentially useful set of views highlighted that if SPF’s power is that of persuasion, it needed to be more visible, to find ways of expressing its authority as the ‘flagship’ of NHS partnership and to set a direction for the rest of the partnership system.
- Some partners’ attributed concerns over SPF’s functioning to insufficiently early engagement in policy developments. The issue of how early in any decision making process partnership begins is a challenge in all partnership arrangements; this challenge is more complex in the NHS partnership arrangements, involving not just employers and staff but also government.
- The process of SPF meetings was also identified as constraining SPF’s effective functioning, and there was almost unanimous agreement that how SPF was conducted needed to be revisited.



- Though identified above as an enabling factor, people were also identified as an important constraint on SPF's effectiveness, in four distinct ways:
  - The absence of key players deprives SPF of insight, leadership and authority;
  - Poor practices and behaviours undermines wider engagement with the forum;
  - Some instances of passivity and pseudo-participation, rather than genuine participation and engagement of partners, limited SPF's effectiveness; and
  - Many partners cited the lack of recent investment in partners' potential and capacity as in sharp contrast to the early days of partnership when training and development conferences supported partners' knowledge and skills development, and partner associates linked national structures with boards to enhance capacities.
- Lack of connectivity or proximity to both established and emerging parts of the H&SC landscape appear problematic and need to be reviewed if SPF is to continue to deliver on its strategic role. These concern formal links with SWAG, and communications with APFs/NPFs. There is no robust way of knowing how national discussions are informed by local boards (and vice-versa), the National Programme Board, RD/PBs and through these to the operation of IJBs. A key challenge for SPF will be to create and sustain better linkages.

## National – Scottish Workforce & Staff Governance Committee (SWAG)

### *SWAG aims*

SWAG's role is to support the development of workforce strategy and to support the Scottish Government Health and Social Care Directorate in the development and implementation of employment policy and practice to ensure that NHS Scotland acts as an exemplar employer. Its remit is to develop employment policy and practice consistent with NHS Staff Governance Standards (which alongside Clinical and Financial Standards constitute the Governance framework for every NHS Board in Scotland). It also monitors policy implementation, ensuring appropriate consistency across employers, the promotion of equality and the elimination of discriminatory practice. SWAG members are governed by the NHS Partnership guiding principles and behavioural standards. SWAG is serviced by a dedicated SG secretariat. Formally, SWAG reports to SPF, though not in practice.

Table 2 details the administrative data extracted from the SPF minutes over 2012-2018.

Table 2: SWAG Administrative Minute Data 2012-18<sup>15</sup>

<b>Period (2012-18)</b>	<b>SWAG</b>
<b>Attendance (%)</b>	
Scottish Government	27
Employers	25
Staff-side	46
Other	2
Total	100
<b>Average attendance/ meeting (n)</b>	26
<b>Main Attender Groups</b>	
Scottish Government	<i>Workforce</i>
Employers	<i>Workforce Directors/ HR &amp; Chief Executives</i>
<b>Scottish Government Lead (%) (all items)</b>	84
<b>Main Issues</b>	
1	<i>Staff Experience/ iMatter (24%)</i>
2	<i>Staff Governance/ PINs (14%)</i>
3	<i>Workforce Development (13%)</i>
Challenge Rate (%)	1
<b>Main Challenge Issue</b>	<i>Staff Experience/ iMatter</i>

Senior-level national partners attend SWAG regularly and partners contribute to discussion. As with SPF, agenda items are largely SG-led. SWAG appears to address the range of workforce issues consistent with its aims: currently, Staff Experience/ iMatter, Staff Governance PINs/‘Once for Scotland’ and Workforce Development alongside other workforce modernisation topics. The issues are largely consistent with previous reviews as reflecting the aims of SWAG. Similarly, there was a relatively low rate of challenges (i.e. disagreeing): and an overwhelming emphasis on largely neutral alongside co-operative partnership behaviours. The administrative and the observational data were consistent in these regards. Challenges mainly featured in discussions around staff experience and whether to use iMatter and the National Staff Survey; or any form of the National Staff Survey in 2016; and the options for staff experience in 2018. These issues were resolved by collective leadership across all partners and by the SG-led policy work and facilitation to reach a consensus.

SWAG is seen unanimously by the national level partners interviewed as having clear aims, a focussed remit, clear terms of reference and a common purpose and no significant areas of contention were raised in relation to SWAG.

<sup>15</sup> The same caveats to the headings and figures outlined in Table 1 apply in Table 2.

### *SWAG processes*

SWAG meets three times per year (reduced from four in January 2015). It is supported by six annual secretariat meetings. SWAG is considered to be proactive in anticipating and identifying what it needs to do, generating its own agenda and work streams. SWAG's agenda is narrower in focus than at SPF. In this context, the reliance on the SG team for agenda items appears to raise no criticism from partners, perhaps because the agenda items are more narrowly operationally focused around very specific issues.

SWAG meetings are described as well-chaired, operationally effective, and task and output focussed. Partners also refer to effective chairing within SWAG so that meetings not only run smoothly and efficiently, but are also focussed on building consensus across the partners. SWAG also engages other networks – Workforce/Human Resource Directors and EDs – beyond the actors who serve on the group. Work packages are delegated to sub-groups containing HRDs co-opted from the HRD network, EDs co-opted from the EDG and staff side representatives. This mode of operation appears to generate significant buy-in and capacity from HRDs and EDs. Links to these networks also keep SWAG well-connected to local Boards.

Formally, SWAG reports to SPF, though it operates largely autonomously, though with an ongoing connection to SPF developed more recently through the joint business meeting of their respective secretariats. One partner, however, suggested that SWAG's relative autonomy might disconnect it from national policies and plans, and impact on the resources that might be levered to deliver on SWAG's remit (e.g. money for transformational change).

Some concerns were raised by partners over duplication between the work of SWAG and SPF, and one suggestion was made that perhaps a merged 'workforce' committee would overcome this potential for duplication. Others, however, noted that SPF provided a distinctive channel in which to address strategic issues that are wider than workforce issues.

### *SWAG relationships*

The view that SWAG provided a strong example of effective partnership working was widely supported. Behaviours were reported as open, friendly and respectful, and strong, constructive, working relationships were reported between SWAG members. Leadership of the group was viewed as genuinely shared, with Chairs representing their constituencies broadly. Participation was considered to be high, and many partners noted that employers engaged constructively with SWAG.

Partnership behaviours were also cited as being evident in relation to the small number of issues on which there have been significant disagreement – most recently in relation to the status of the staff survey and the development of iMatter. Partners reported that differences of opinion were explored and that considerable efforts were made to reach consensus.

### *SWAG outputs and outcomes*

SWAG's role is to use partner voice to deliver good practice employment policies that balance system effectiveness with fairness and equity for staff in ways that are consistent with the Staff Governance requirements on all Health Boards. In delivering on this role, SWAG has clearly identifiable policy outputs that in turn have successfully delivered workplace practice outcomes – KSFs, PIN Policies, Staff Experience insight and OfS approaches – at Board level. SWAG was commonly described by partners as an operational 'engine room' that drives policy and

practice change in relation to the workforce that genuinely shapes impact on staff and on the service.

SWAG has developed 15 operational PINs – employment policies that set national minima SGS but have been enhanced by many local boards. SWAG members and partners more generally recognise these as being of variable quality in their design and construction, and that the potential for local (enhanced) variation could provide some benefits in reflecting distinctive local circumstances. However, they also recognised that Boards could face cost challenges in delivering PINs and that clarifying PINs at local level in the context of allowed variation was time consuming for local and national partners.

Partners describe the recent decision to shift from PIN policies to OfS policies in ways that illustrate how SWAG harnesses partners' voice to produce equitable policies that support operational effectiveness. Following concerns voiced by partners a decision has been taken through SWAG to replace all existing PINs with OfS policies. It was argued that once these are developed, they will effectively produce equality of treatment for all NHS staff in Scotland and, in the process, free up time for EDs and other representatives to focus on the strategic business of their Boards and on staff experience and engagement.

Similar arguments were deployed in relation to changes in NHS Scotland's approach to staff engagement. While the long standing staff survey offered NHS staff a voice to comment on a wide range of relevant subjects, partners' concerns over response rates and its relative passivity as a mechanism for staff voice led to the development of iMatter, a co-produced staff engagement tool based improvements to enhance staff experience. iMatter provides a vehicle to make survey responses more action-oriented and capable of supporting staff-driven change at the local level, linking staff engagement and empowerment to local practice.

SWAG processes ensure that all partners' voices are heard in the development of employment policy. It operates, therefore, as a mechanism for frontline staff and managers to contribute to national level operational decision-making that impacts both groups directly. In translating partners' voices into policy, SWAG faces tensions in reconciling both local and national practice, and staff-side and employer aspirations and priorities.

#### *SWAG enablers*

The key factors identified by partners that facilitated SWAG to function effectively were:

- a well-defined purpose and operational remit;
- a strong commitment to joint decision making on employment policies that impact directly on staff experience and service delivery;
- an operational focus on 'getting things done' and delivering substantive outputs, both directly and through working groups that draw in additional knowledge and distribute the workload beyond national players;
- a pragmatic approach to conflict resolution and to relative equity as underpinning ongoing partnership relations within SWAG;
- partners' extensive knowledge and experience of the national and local implications of employment policies;
- strong collaborative relationships among key partners; and
- strong connections between national and local partners and effective communications from national to local partnership structures through ED and HRD networks.

### *SWAG constraints and challenges*

Partners identified the following constraints and challenges facing SWAG:

- potential duplication with the work of STAC on the border between workforce and terms and conditions issues;
- some weakness in connections between SWAG and SPF (though improved by the establishment of the joint business meetings);
- slow pace in delivering policies;
- heavy time commitment of partners;
- challenges in involving the right people in PINs/OfS;
- tight timescales to deliver OfS policies;
- areas where agreement cannot be reached quickly or at all; and
- partners' use of alternative channels of influence beyond SWAG, inconsistent with the principles of working in partnership.

### *Local/health board level partnership arrangements*

In the national interviews, partners pointed to only one instance of industrial strike action in recent years in NHS Boards (the NHS Tayside Porter's dispute). Although there were references to a few localised board issues over the years, and that the current strength and quality of local partnership could be variable across boards, the predominant opinion expressed was that local partnership was relatively stable. Partnership was viewed as well embedded in the bigger boards in the Central belt and North, and in others where there was a strong sense of mutual ownership of partnership arrangements by partners. In terms of staff governance, many boards were also described as having standards that were over and above the minima (i.e. as PIN+). This picture was largely consistent in our interviews with local partners. It should also be stressed that the national partners (when required) played active roles in attempting to mediate local issues.

### *Local partnership aims*

Local partnership arrangements are framed by national guidance on joint decision making and the establishment of consensus.<sup>16</sup> This sets out the architecture, governance arrangements and processes by which NHS Scotland employers were and still are required to comply. It provides the template for the comprehensive series of formal Health Board-level agreements agreed by the local partners.

The aims of local partnership agreements cover the early involvement of staff in decisions that shape service delivery and development for patients/service users. They cover staff input to strategic organisational objectives, operational functions and workforce practices not covered by collective bargaining. Partnership working is framed by the nationally-derived definition. It is typically defined in terms of harnessing the potential of staff at all levels through involvement in decision-making processes, with staff having access to information and the opportunity to make their views known on organisational changes which may affect them. By extension, investing in staff input is viewed as an investment in the quality of services and in patient care. The emphasis is on partner relationship building and maintaining dialogue even in those areas where partners may disagree. Local agreements mirror the roles and behaviours expected at national levels and are supported by a range of structures and governance arrangements – Staff

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<sup>16</sup> Employee Relations (ER) Model guidance provided in NHSMEL (1999) 59 (ref: Local Partnership Agreements).

Governance Committees and Area (or National in non-territorial boards) Partnership Forums – that ensure early staff input across a range of clinical and non-clinical functions. Other more decentralised bodies operate within Board structures to take the partnership process closer to staff at the operational frontline. These typically ranged across geographical areas and by function, for example, including the main primary care hospital sites. Local partnership attempts to mirror the ED and staff-side roles at Board level in structures and processes throughout the Board to better embed early engagement practices.

All local agreements are open to ongoing update by the partners (within the broad framework set out nationally), usually within locally defined timescales. Our review of local agreements showed some variation across boards in terms of any recent updating of agreements. By their nature, local partnership processes are built around the interactions of NHS employers and staff-side as partners, rather than involving government as a partner directly, and span Board strategic and operational functioning.

No concerns were raised by any local partners with the aims of local partnership working or with the key structures of partnership.

#### *Local partnership processes*

The documentary and interview evidence shows that the partnership structures, processes and governance appear to be relatively mature and well extended throughout the Boards, embedding the architecture of partnership vertically and horizontally. The partnership process appears to be relatively well structured and few concerns were raised over substantive architecture ‘gaps’, beyond identifying some areas where local partnership structures were less developed than others and partners were keen to build up local fora and extend reach to frontline staff.

Area/National Partnership fora (hereafter APFs) at board level are influential local bodies who can exercise real power in relation to proposed changes to services and workforce practices. There was a recognition across partners that while there could be challenges in consensus management in APFs, they were generally seen as relatively positive and effective, covering national issues and discussing local strategic issues on organisational and service change (e.g. primary care facilities, reducing hospital beds and realigning services for patients) alongside sometimes difficult workforce policy and practice issues (e.g. staff redeployment, primary care car parking, electronic rosters). In addition, APFs were seen as forums for engagement with real staff-side engagement and participation in questioning and debate. Management and staff-side accounts of the process of engagement signals a mirroring of expectations and experience at national level – that any discussions and challenges take place in a partnership way, far removed from a confrontational industrial relations approach. There were, of course, some criticism of the operation of local partnership processes, some of which echoed national concerns that partners offered involvement rather than genuine participation and made relatively limited inputs to partnership processes. There were also examples of efforts to address this, for example, by more investment in communications to better inform staff and to support wider participation at the local level.

Where there were problems identified in the interviews, these tended to be more concerned with blockages to proposed changes to established workforce practices rather than with small, medium or large scale service change. Even in these more challenging contexts, most partners reported being able to reach consensus most of the time, and on issues where this was not possible, adhering to the partnership principle of remaining in dialogue.

The interview evidence highlights that partnership processes operate effectively during large-scale service change, for example, developing new primary care facilities, realigning structures to develop regional business units or developing new local partnership arrangements. The partnership process is prominent even in areas within Boards with lower levels of unionisation, strengthening its reach beyond ‘active’ partners. In the local boards that we focused on, all of the partners described partnership as well structurally embedded in the organisation and operational throughout its different tiers and levels. Strong linkages across tiers and levels appears positively associated with wider and deeper organisational ownership of partnership as a process. This was best illustrated in one territorial board where partners pointed to the almost ‘routine’ and ‘habitual’ nature of partnership in everyday working practices and in service change, with defined and articulated processes that provided clear guidance to partners on the practice and boundaries of partnership in decision making.

Boards raise partnership awareness through the use of dedicated Corporate Induction sessions (typically involving a staff-side and/or employer representative) for all new staff and dedicated budgetary resource beyond investing in EDs. Allocation arrangements varied across boards but generally involved investment in a combination of dedicated partnership and facility time to support local capacity. One board operated partnership roles as jobs within the Board alongside dedicated union facility time. All partners saw such investment as ‘good value’, although this weakened when partners were seen to engage in behaviours perceived by others as inconsistent with partnership. There was an acknowledgement however, in one board that the numbers of staff-side representatives were relatively small in comparison to the size of the workforce (and their geographical spread) and that they were planning to review their existing arrangements.

All of the territorial local Boards selected for consideration in this review had partnership representatives on new RD/PBs and integrated H&SC structures: EDs sat on RD/PBs and their partnership networks alongside Workforce Directors; and partnership representative sat on HSCPs (alongside local authority staff-side partnership representatives) as part of the integrated partnership forums established by these new structures, though without voting rights as staff-side. EDs have voting rights in their role as Non-Executive Directors.

As a general rule, partnership processes were often seen by partners as most effective and firmly embedded at corporate and senior levels in Boards. However, there was variation in that pattern, produced through geographic unevenness in partnership reach and varying commitment (strong and weak) to partnership across middle and line management and across occupational groupings and patterns of union representation, including areas of more confrontational management and union stances.

#### *Local partnership relationships*

Reflecting the maturity of the NHS local partnerships, all of the senior local partners typically expressed relatively strong commitments to, and endorsements of, the principles and practice of the partnership approach and process. Partnership was typically expressed as a ‘way of thinking’, ‘behaving’ and interacting based on having open, mature, ‘honest’ non-confrontational relationships between the actors at the senior level; relationships based on mutual trust; and regular references to a shared interest in supporting and improving staff experience and by so doing, delivering better local services for patients.

In practice, for employer partners this meant providing EDs (and designated staff-side representatives) with access to, engagement with, and opportunities to better understand, shape

and influence Board ‘business’ (e.g. in areas like policy and finance) at senior strategic levels. For staff-side, it meant having ‘sight and understanding’ of the strategic and operational issues facing management (at various levels) and an opportunity for input into how the Board operates for staff. The primary partnership relationship was sometimes defined in terms of the working relationship between the Workforce and Employee Directors but there was a wider mutual recognition among most local senior partners of the critical importance of these leadership roles and of:

- having the ‘right’ individuals in senior leadership roles, with appropriate abilities, style and advocacy of partnership;
- conveying the values of NHS partnership and engaging in appropriate behaviours to set the tone, culture and boundaries of partnership in the organisation;
- investing time in building relationships (e.g. between Board Chairs - the Chief Executive and the ED), and exercising particular sensitivity in periods of succession to maintain effective partnership functioning;
- the quality of senior working relationships between partners and their mutual investment in building respectful relationships where they could have ‘difficult conversations’, ‘agree to disagree’ but continue dialogue and ‘stay at the table’; and
- having to manage a sometimes delicate balance between staff experience and patient services, and having an appreciation of the organisational roles played by the other partners.

EDs have complex, often competing and multifaceted national and local NHS partnership roles that, for some, have now been extended into the emerging landscape in RD/PBs structures and HSCPs. Within national and local partnership structures, EDs appear to be playing important and effective roles. At the national level, the partnership support structures provide a direct link into SWAG and support a national ED network (which provides a direct two-way link through which to feed staff-side views into this forum, as well as feed information down the system on issues which EDs may raise in their local APFs and share with the wider local staff-side). There was a recognition by all partners of the desire to get the ‘right’ person in this role: typically someone with experience in local fora and an established trade union reputation, able to work strategically at a senior level, able to represent the views of all staff but strong enough to ‘facilitate’ the competing demands of both management and all of the local staff-side groups while having a ‘common interest’ in what was best for staff and patients. Both employer and staff-side partners could give examples of more and less effective ED behaviours and approaches. For partners, the succession and transition of EDs created uncertainty and there was a recognition that the succession process could be difficult given the demands of the role and the distribution of union local membership and power. In this context, local partners sometimes described the ED role as potentially ‘difficult’ and a ‘poisoned chalice’.

Reflecting upon partners’ perceptions of behaviours at Board level, there was considerably more evidence of positive behaviours consistent with the partnership ethos, rather than systemic and prolonged disagreement, challenge and disruptive behaviours. This was the case even in boards with immediate and significant challenges in the functioning of local partnership. The overwhelming majority of Board level partnership behaviours (over time) were assessed in generally very positive terms. There was a widespread expectation that the quality of the relationship, leadership and values exhibited at the senior levels in boards would set the tone for manager/staff side/employee relationships across the Board.

There was, however, an explicit recognition that although the processes of partnership were relatively strong and embedded in these boards, partners and personalities on all sides could do



significant short-term damage to the partnership ethos and process. Partnership arrangements by their nature contain structural and personal characteristics. The ongoing challenge is to maintain a balance between these, where structures and processes support and influence partners to deliver the desired outcomes, and partners can in turn shape structures and processes to do so. All of this takes place in a demanding context much of which is beyond control of the partners or the partnership arrangements.

Partners acknowledged that there were a number of problem areas in behaviour at local level. These ranged from relatively minor and localised instances of the partners operating out with the behaviours expected within partnership, to more serious and prolonged problems in relationships with consequent implications for the conduct of partnership. Problematic behaviours could be particularly challenging in frontline operational settings, such as in intense, stressful, fast-moving acute settings in primary care where both managers and staff were working long shifts delivering patient care, or in call-centres and control rooms who were 'firefighting' emergency cases. But difficulties can emerge anywhere, and examples were given of team leaders/supervisors making 'small' changes to practices that were 'out of process'. It was generally argued by partners that these disruptions were minor and should be resolved by managers and staff-side at the level they arose, without escalation and the intervention of senior partner representatives in HR and on staff-side.

Where more significant problems existed in these Boards, these concerned:

- managerial and local steward uncertainty about the parameters of partnership working and joint decision making that impacts on the pace of change implementation and increases uncertainty for the workforce. This could arise even in a constructive and engaging partnership climate, sometimes in areas with less experience of partnership processes;
- delays in the prevention of closures to high staff but low-occupancy wards to deliver service realignment;
- persistent problems in some 'pockets' of operations because of poor partner relationships between managers and staff characterised by persistent grievances and the need for ongoing management by HR and staff-side representatives. Persistent problems were taken as an indication that issues were not being managed in a timely fashion, nor were partners learning from them to prevent future issues;
- examples of local management and staff representatives not taking ownership of their own local partnership process, or not investing time in building trusting personal relationships, resulting in too heavy a reliance on HR and EDs to continually 'firefight' and resolve; and
- a lack of appropriate skill-sets and capacities among partners, sometimes arising from weak induction processes or inadequate support for engaging with staff/employers in a fashion consistent with a partnership approach.

The most serious issue, however, was raised in one case study board because of frictions arising from an inter-union dispute and concerns by some local parties about the response to these frictions by both employer and staff side at local levels. This had resulted in one local trade union partner taking the very exceptional step to 'opt out' of local partnership arrangements. This had not only impacted on relationships between members in the APF but was also delaying areas of service change. This review is not designed to address this particular issue, but the circumstances raise a broader general issue about partnership working and in particular the tension in partnership raised earlier about the how structures shape actors (partners) and how actors (partners) impact structures. It is worth noting that in this particular case, the partnership role was – unusually – a job within the Board. Partners did not identify this directly as a cause

of current difficulties, but at least in part the dispute centred on issues around the allocation of partnership roles, which exacerbated existing tensions.

This example highlights issues that are relevant to a broader understanding of partnership, including:

- the significant challenges in maintaining intra-partner unity and consensus;
- the importance of, and challenges within, the ED role, and the need for strong leadership as well as consensus building skills in this role;
- the need to reinforce partnership behaviours on a periodic basis;
- the importance of clear, precise and documented communications on contested issues;
- the limits of two partner rather than multi-partners dialogue on contested issues;
- the testing of partnership in difficult circumstances;
- the need for more explicit channels – formal and informal – to respond to failures to agree within partnership processes;
- the need to see partnership as a dynamic, not static, process that requires ongoing investment of time and effort; and
- the limits of partnership in the absence of supportive partner behaviours.

It is important to note the very exceptional nature of this particular set of circumstances in the context of long-standing and well-functioning partnership arrangements. Of more general importance, however, is the need for partnership structures and processes to be robust irrespective of individual partner characteristics. This is immensely challenging, not least because there are a variety of ‘selection’ processes for partnership roles, some of which lie outside of partnership arrangements, though this latter point strengthens the need for the partnership system – and senior partners – to be capable of maintaining stability where individual relationships are not functioning constructively.

#### *Local partnership outputs and outcomes: voice, equity & effectiveness*

The local Board partners were consistently clear that partnership provided opportunities for voice, and that there was a strong commitment to ensuring that this was heard and reflected in local boards. The Employee Director provided a key voice channel, strongly supported at a senior level. Senior partnership players attached considerable importance to establishing relationships and to supporting partnership behaviours and ethos. In addition, structures such as Staff Governance Committees and APFs ensured ongoing communication and voice.

The opportunities for voice also featured in examples from employer and staff-side partners of wider employee engagement initiatives that involved being visible and listening to staff directly where possible (and the challenge this poses in boards with dispersed workforces). Voice is actively sought through local Board structures (at points of service change), in the previous annual National Survey, and in the measurement of staff experience through iMatter.

There was a recognition of other structural aspects of voice: the role of local partnership in helping to ensure that local managers engage and communicate with staff; and the awareness and feedback from trade union representatives based on their contact with members and their ability to feed staff views through their own structures and to EDs. EDs were keen to stress that these stewards kept them in touch with local issues for staff, enabling their effective functioning as a single point of contact for the wider workforce. While questions over the

representativeness of views were raised by some partners, there was a general acceptance that trade unions were the main (but not the only) means of gauging the views of the workforce.

The issue of voice for non-union members and for staff who are less aware of partnership working arrangements was also recognised by partners. Partners perceived that even for these groups, there would be general awareness of the presence of trade unions in workplaces and in the NHS more generally and of the health, safety and employment protection benefits available to them as employees. In many respects, although NHS staff (or patients and service users) may not know of NHS partnership working, may think of staff-side representatives only as trade union representatives, or may only come across it in times of change or when they seek advice, partners felt staff would know how to make their voice heard or to seek advice when required. The delivery of staff voice through partnership is not, therefore, best measured by the extent of active engagement by staff in partnership processes, a point established in partnership research elsewhere.

For staff-side, partnership was a vehicle to protect the interests of workforces and ensure that staff experience was a factor in decisions. It was very striking how staff-side partners (many long-established employees in the NHS) spoke of the partnership approach as being responsible for transforming the previous culture of NHS boards: how it had help temper otherwise more confrontational management and trade union cultures.

Turning to any equity outcomes of local partnership, staff side partners viewed equity in terms of their enhanced ability to influence staff experience through partnership working. Employers, while acknowledging the benefits of partnership, also identified the constraints they faced in delivering what were seen as equitable outcomes. These constraints were largely financial, caused by the pressures of austerity in the UK and the need to make cuts in local services, while simultaneously delivering the recent pay uplift, setting aside budgets in the new Health and Social Care landscape and healthcare standards in patient care. These appeared to be cross-Board issues. Particular difficulties were cited in delivering a time-unlimited Employment Protection policy and the potential costs of the new OfS staff governance policies, notwithstanding that many believed OfS policies were appropriate for a Scotland-wide NHS workforce. Local staff-side partners also voiced concerns over the potential erosion of 'PIN+' localised standards. For both sides of partnership, moves towards shared services in the new RD/PB structures raised potential challenges at local level that would require careful and sensitive handling.

Focussing on equity of outcomes raises the issue of the local balance of power within Boards. In the Boards with which we engaged, while prospective changes to workforce practices and service realignment and delivery could result in resistance, there were few general concerns raised by partners over power imbalance. This cannot lead to a conclusion, however, that local power imbalances do not exist.

Across many of the interviews, partners (both employer and staff-side) regularly referenced an older industrial relations 'confrontational' approach as a point of contrast with the approach being offered by partnership working and consensus management. In the interviews, there was a strong sense of mutual ownership of partnership by senior partners. There was widespread recognition of the skills and expertise brought by partners, and the crucial role of EDs in particular as strong advocates of the partnership ethos. EDs were often seen as managing workforce issues and change in sometimes very challenging circumstances, but who are able to harness the collective views across trade unions, ensuring voice beyond relative levels of

membership strength. Where ED partners' were seen as an effective component of strong and successful partnership working by employers, this hinged on the value of a single point of contact and their ability to harness staff-side input across a broad range of organisational functions.

Partnership has unequivocally helped deliver stable local industrial relations and all partners clearly advocated and valued the investment in partnership working. Moreover partnership was seen as contributing to system effectiveness in terms of better decision-making at all levels in health boards, with a higher probability of 'getting it right' and avoiding problems. There were a numerous practical examples mentioned by partners around effective partnership input to:

- strategic policy reviews and change;
- organisational service change;
- compliance with Staff Governance Standards;
- redeployment, job redesign, job evaluation and deployment of Modern Apprenticeships;
- health, safety and security on NHS sites;
- absence management and support for return to work;
- resolving local workforce issues at the local level;
- working alongside senior, middle and junior managers implementing change and helping to 'get decisions right' for staff; and
- supporting the wider workforce during organisational change.

#### *Local partnership enablers*

Local partnership was enabled and facilitated by:

- a well-defined and shared purpose;
- an operational remit and focus;
- a strong mature commitment to establishing genuine and trusting partnership working relationships between the local partners at the senior levels;
- a belief in maintaining dialogue despite areas of disagreement;
- a commonly shared interest in the organisation and services for patients/ users and a very strong belief that better staff experience meant better outcomes for patients, families and carers and service users;
- a belief that partnership delivered better decisions for smoother service and organisational change;
- shared values and sense of ownership of partnership;
- efforts to ensure consistent behaviours across the organisation;
- extensive and effective communications;
- a commitment to resolving conflict at its lowest level; and
- a commitment to 'common sense' and to accepting and dealing with the reality that partners may always exhibit ideal partnership behaviours all of the time.

### *Local partnership constraints and challenges*

All local partnerships faced constraints and challenges relating to:

- variable knowledge of, and commitment to, partnership working at different Board levels;
- variation in behaviours and practices;
- the time commitments of partnership, in particular the time required to implement some types of organisational change where these involved established working practices;
- identifying the boundaries of partnership working and managerial decision-making;
- the extent and quality of organisational supports to facilitate better partnership, for example, through induction and training; and
- the pressures on partnership posed by frontline operational delivery priorities.

### *The emerging regional and integrated landscape: implications for partnership*

The emerging four regional RD/PB structures have Minutes available since July 2017. From the Minutes we were able to access (East, North and West), they give a focal structure for the new H&SC landscape. In terms of composition and representation, they are similar to HSCPs. Consequently, they involve a very different set of actors than the national partnership structures: they bring together the different senior clinical (i.e. Directors and Heads of Medical and Nursing services) and non-clinical (i.e. Chief Executives, Directors of Finance and Workforce) of local health boards alongside HSCPs (i.e. Chief Officers), and more recently staff-side partner representatives from the constituent local boards. A criticism from some of the national partners was that these structures were slower to involve staff-side partners and that elements of national staff-side still feel that their involvement is ‘token’. That said, the Minutes show that some local EDs attend and input to discussions with workforce issues, and that formal partnership structures feature in discussions and have been put in place (e.g. as a formal forum in the North and joint meetings between Employee and Workforce Directors in the East and West).

It is still too early to assess the effectiveness of these RD/PB structures in terms of their delivery of partnership processes and outcomes, given that they have only recently submitted their Delivery Plans in the summer of 2018. However, when and where RD/PBs are taking decisions that will inevitably impact on local board employers, the case for wider staff-side engagement becomes more compelling. These issues featured in some of the national and local interviews, with modernisation issues discussed in RD/PBs being subjects that might have been expected to dovetail more explicitly with engagement at SPF. For example, for many national and local employer partners RD/PB structures (joined up with HSCPs) potentially offered a number of service redesign benefits consistent with the National Clinical Strategy (in clinical services in specialist care and surgery, and in regionalised sustainable workforce planning/redesigning new working roles and skills using IT and shared services such as Human Resources and Infection Control), Realistic Medicine (i.e. transforming patient experiences of care through enhanced digital technologies) and managing the integrated H&SC landscape (i.e. local mental health services and GP-led multidisciplinary teams). These are all areas where strategic partnership approaches may deliver beneficial outcomes and be expected in the context of the NHS commitment to partnership working.

Across both national and local partners there were other frequently raised views across partners regarding the RD/PBs. These related to:

- the structural complexity of the new integrated landscape;
- confusion about where decision-making was taking place and whether these structures could, would or should eventually rationalise local boards and be part of future Health Board reform;
- whether the structure in the West was too unwieldy because of the size of Greater Glasgow & Clyde;
- their lack of legal status which may make future regional progress ‘vulnerable’ to tensions relating to individual board accountability (and obvious ‘power’ issues between boards); and
- the issue of implementation leads largely using their own Workforce and Employee Directors to populate RD/PBs.

There was also points of tension on how these RD/PB structures were ‘hidden’ from national NHS partnership structures and for one element of national staff-side, that job evaluation was being conducted ‘out of sight’ of the NHS partnership. At the local level there was a recognition that regionalisation – bringing the potential benefits we outlined above – will generate a lot of challenges for local staff-side in boards.

While there was a strong recognition of the need to integrate H&SC services for patients/ carers, the full range of those strategic and operational issues associated with the integrated landscape – cited , for example, by Audit Scotland (2015<sup>17</sup>, 2016<sup>18</sup>) – were highlighted across national and local partners in relation to:

- developing better strategic and operational links with IJBs;
- some lingering pessimism about the failure of the Joint Futures agenda and its implications for future collaboration across NHS and Local Authorities;
- the increased complexity and confusion of the local health landscape and local governance relationships, budgets and commissioning (purchaser-provider) relationships;
- critiques of the governance processes and their complexity, some lack of accountability, and concerns over whether HSCPs will be sustainable;
- the ‘clash of employer engagement cultures’ between the NHS and COSLA/ SOLACE and within different staff-side branches at the local level;
- the difficulties in having and managing different staff terms and conditions (and line management relationships at the local level);
- concerns that local authorities don’t see the benefits of the NHS approach to, and experience of, partnership;
- a feeling that NHS staff may not experience the same level of engagement in a more ‘Council-centric’ integrated landscape where local democratic accountability has created significant local variation, and related fears about the undermining of Staff Governance Standards in that context; and

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<sup>17</sup> Audit Scotland (2015) Health and social care integration. Edinburgh. Available at: [http://www.audit-scotland.gov.uk/uploads/docs/report/2015/nr\\_151203\\_health\\_socialcare.pdf](http://www.audit-scotland.gov.uk/uploads/docs/report/2015/nr_151203_health_socialcare.pdf)

<sup>18</sup> Audit Scotland (2016) Audit Scotland. (2016). *Changing models of health and social care*. Available at: [http://www.auditscotland.gov.uk/uploads/docs/report/2016/nr\\_160310\\_changing\\_models\\_care.pdf](http://www.auditscotland.gov.uk/uploads/docs/report/2016/nr_160310_changing_models_care.pdf)

- difficulties in communications between local HSCPs (and the impact of local political differences) and a shrinking away from taking ‘tough’ decisions on services, creating risks for health boards and councils.

Partners noted that SPF had attempted to engage COSLA in the NHS partnership structure as observers, but there was a recognition that this approach had failed.

A more positive perspective emerged when we looked at the local Board relationships with HSCPs and in interviews with Chief Officers in HSCPs. In four of the NHS/Local Authority areas considered, HSCPs were still relatively new and developing. In another two, these relationships were more established. In the less developed cases, the NHS partners described some of the challenging issues outlined above and the developmental difficulties experienced by the new HSCPs. In all cases, the employer partners emphasised the need to build and develop consensual relationships between NHS and local authority leaders. One employer partner spoke about differences across the HSCPs and the relative progress made in developing structures made by those who adopted an NHS-type approach to staff engagement, compared to those who did not and subsequently took longer to get to the same point. Another highlighted the relative maturity of the outcomes of their local HSCPs in terms of the quality and understanding of their delivery plans for reducing delayed discharge and that NHS managers were now starting to learn from social care teams in terms of their home support assessments of risk. In addition, some reported that the new GP-contract and the building of multidisciplinary teams was starting to have positive results locally. In one HSCPs area Unison had unified the NHS and Council branch structures, which was seen as positive, and were on the point of formally agreeing a memorandum of understanding for supervisory arrangements between Council and NHS staff. In the other three HSCPs, memoranda had already been established and the Council-based Chief Officers operated on honorary NHS contracts.

All four of the HSCPs we engaged in operated integrated partnership bodies of some sort where staff partnership representatives could influence strategic decisions based on early involvement in organisational change. It was notable that three of the EDs and four of the HSCP Chief Officers we spoke to describe these bodies as having an NHS-type partnership ethos, with early involvement and input to decisions.

This is also largely consistent with reports from some national staff side partners about these local bodies. There was a recognition among some national partners that there were reasons for optimism, and that there was still a need to engage with the new landscape, to be pragmatic, and to reflect on whether the ‘NHS way’ was the only way towards partnership working in H&SC. This might mean less of a focus on higher level governance issues and more on how to solve common problems (for example, reducing delayed discharges or developing sustainable workforce planning models). Some partners ventured that partnership differences on the ground in HSCPs may be more imaginary than real in practice, though the power of a formal agreement on partnership working should not be underestimated. One potentially useful area of debate among some national and local partners concerned the term ‘partnership’, which at one level applies across so many varied contexts as to be unhelpful and, at another, is so closely tied to NHS experience as to potentially be a barrier to adoption elsewhere. Rather than promoting the ‘NHS way’ of staff engagement in the integrated landscape, efforts might be better directed to developing a common language, common values and building relationship. A number of partners pointed more positively to the language of the FWC’s Fair Work Framework as a potentially more neutral language through which to find common ground between stakeholders in the NHS and in local authorities. The Framework’s focus on effective

voice, opportunity, security, fulfilment and respect spans many elements of NHS Staff Governance Standards, and there is strong Scottish Government support for the widespread adoption of the Framework, as well as a commitment from COSLA to engage positively..

The iMatter approach to staff experience may also help promote the values and behaviours that underpin NHS staff governance standards as it is applied more widely in H&SC. At present, iMatter extends to Council staff in 23 of 31 HSCPs, and has generated interest from Councils for non-H&SC staff. Developments like wider adoption of iMatter, a focus on core values and objectives rather than the structures and processes of partnership working, and greater advocacy of the benefits of partnership working may offer practical and effective ways of growing, developing and embedding partnership working across H&SC.

## Part Three: Reflections on partnership in NHS Scotland

### Addressing the evaluation questions

The overarching aim of the research was to examine whether the current partnership arrangements are fit for purpose, particularly in light of the developing integrated H&SC landscape. We have examined the available evidence in terms of the aims and processes of partnership at all levels; the factors that enable or hamper partnership; and the outcomes of partnership in terms of voice, equity and effectiveness. Here we link the research questions and the data framework in three sections: focussing on the current (and pre-existing) arrangements that govern the employees of NHS Scotland (mindful of the recommendations and concerns raised in earlier reviews); considering arrangements across the integrated H&SC landscape; and considering the potential for closer alignment of these two spheres.

#### *Are current partnership arrangements in NHS Scotland fit for purpose?*

From the evidence provided by partners discussed above, much of partnership in NHS Scotland is robust and functions effectively. The many positive benefits of partnership reported in earlier evaluations have been reiterated during this review. This is no small achievement given the increasingly challenging environment of UK government austerity policies, major policy shifts in Scotland to deliver H&SC integration, and wider challenges arising from demographic change, technological developments and the disruptive potential of the UK's decision to leave the European Union.

Partners overwhelmingly answered positively on two of the main questions posed in this evaluation: does partnership working deliver on staff engagement; and does this help to deliver better outcomes for patients and service users? Partnership continues to be seen as a highly developed and mature approach to employment relations and to engaging staff in governance and decision-making at multiple levels, thus delivering on the NHS Staff Governance obligations. While partnership within the NHS in Scotland is multifaceted in its operation, this reflects a complex organisation facing multiple challenges and constraints, and partners report considerable ownership of, and responsibility for, this process of shared governance.

Most partners strongly believe that the services delivered by staff and experienced by patients and service users are enhanced by constructive employee relations that engage staff to deliver higher quality services. While it is challenging to deliver aggregate data to support this (see also similar challenges in Kochan et al)<sup>xvii</sup>, many examples were cited of high quality service delivery, development and re-design delivered in partnership, with staff-side insight into the



needs, aims and values of services making them an essential part of solutions to service challenges.

Taking together the overlapping descriptions of partnership across almost all of the key players interviewed, partnership working has, at its core, a process (of shared information, legitimate voices, distributed ability to influence, collective problem solving at the right level and balanced decision making) that produces three important proximate outcomes (decisions that are collectively endorsed even when one or more partners disagree; benefits – and costs – that are fairly shared; and a shared mind-set for managing change) and two core and related outcomes (staff engagement and high quality health services).

At national levels, Bacon and Samuel's previous review argued for an appropriate relationship between partnership, collective bargaining and workforce planning structures. Recent developments in bargaining in NHS Scotland have firmly addressed the link between partnership working and collective bargaining, notwithstanding that STAC is a negotiating rather than a partnership body. Moreover, the HSCDP has prioritised national workforce planning, and while responsibility for the latter lies with the NPB, workforce planning is now a central concern of SPF.

Previous reviews raised concerns that partnership operated more strongly at national than at local levels. At the current time, partners' concerns over the role of SPF have arguably weakened this aspect of national partnership, while there are many strong examples of effective local working, and in relative terms fewer cases of weaker or dysfunctional local partnership working. There is considerable potential for learning from strong local partnerships that could support weaker or less effective practice.

SPF's current position is problematic, and there is a lack of clarity about its purpose and role which constrains its effectiveness. While SPF's purpose and remit remains formally unchanged, the widespread perception among partners that it has lost its strategic role in practice is of considerable concern, despite disagreement among partners as to how this situation has arisen. Bacon and Samuel urged that partners build agreement and joint commitment to future plans in order to ensure partnership resilience. That some partners perceive a lack of early engagement on some strategic policy directions (albeit contested by other partners) is problematic and appears to have had repercussions for its status. SPF's other difficulties – in relation to its format, the (dis)engagement of senior partners and some behaviours within it – can be analysed and addressed discretely, but appear closely connected to uncertainty about its purpose in the current context.

RD/PBs have more fully emerged since previous reviews of partnership took place. While these were perhaps slow to engage staff-side representatives and so to adopt comparable partnership structures and ways of working, it is clear that process has developed subsequently and that EDs are now involved, along with Workforce Directors/HRD, in RD/PBs. While this is a positive development, the lack of formal partnership agreements in these structures may imply their relatively greater fragility.

Of greater concern than the operation of partnership working at distinct levels are the communications, linkages and relationships between different levels. Notwithstanding the formal reporting relationships between SPF and SWAG, both groups work largely independently of each other, though the recent establishment of the joint business group is perceived to have facilitated better connectivity between the two bodies.

While SWAG appears well connected to local Boards, there is little formal two-way communication between SPF and APFs, and that which does take place appears informal and uneven. This obscures insight on how decisions taken at national level are evaluated, considered and implemented at local level. Neither is there any formalised two-way communication between the Boards collectively and the SPF, and given the limited presence of employers at SPF, its deliberations may take place without robust insights from an employers' perspective.

There are also concerns over the degree of two-way communications between SPF and RD/PBs (and through these and local boards to IJBs), given that none of the territorial Board Chief Executives (including the Regional Implementation Leads) currently attend SPF. This is a gap though which important operational developments with workforce consequences at regional levels might slip. In this context, some partners also criticised the lack of discussion of regional Delivery Plans with individual health boards.

Lastly, there is no formalised two-way communication between SPF and the NPB, and staff-side have only one seat (occupied in rotation by two staff-side partners), yet the NPB is charged with important strategic responsibilities. This may not simply be an issue of improving communication, but a more fundamental issue over where the responsibility for current strategic deliberation currently lies within NHS Scotland, and greater clarity over the relative roles of the NPB and SPF might be helpful. In addition, while the NPB may be in its early stages of development, early stage developments shape future structures and processes.

#### *Does partnership working demonstrate the values and behaviours of NHS Scotland?*

While acknowledging that not all parts of all constituencies – employers, unions and government – are wholly 'bought-in' to partnership working, the presence of a common language and narrative around partnership is striking, as is the strength of feeling that partnership over time has moved from:

- adversarial to constructive engagement;
- potential instability and industrial strife to relative long-term stability in industrial relations, even in a long period of austerity and pressures on public services and pay;
- key partners seeing others as a problem to all partners seeing each other as part of the solution;
- distanced and discrete relationships to close and cross-cutting relationships;
- posturing and positioning to honest conversations and dialogue;
- low to high trust relationships;
- narrow interests to broad collective interests; and
- 'zero-sum' orientations to designing in mutually beneficial outcomes.

There are concerns about behaviours at different levels, but these are small in number and (although they can have significant impacts) they are overwhelmingly eclipsed in most partners' views by more positive partnership behaviours, and there is little evidence of any widespread discontent with broad partnership values. No model of partnership working eliminates problems and disagreement, but there remains a strong emphasis on mutuality and a mature sense of joint ownership of problems and solutions in discussions of partnership in NHS Scotland, with frequent references by partners to mutual respect, mutual responsibility and mutual benefit.

### *Does partnership currently have involve the right people in the right roles?*

Partners expend considerable effort and expertise in partnership working, and partnership could not function otherwise. Many valuable skills are acquired and developed through engagement with partnership processes. All groups, however, identified challenges in finding and committing capacity to partnership processes and, because of these heavy commitments, lacked time to reflect on what works well and learning from it. Many partners raised concerns over succession issues, and the need to re-invest in capacity and capability, both for its substantive benefits and because such investment to support people and relationships would signal the importance attached to developing capacity and expertise, though this was acknowledged to be more difficult in tighter financial circumstances. There was support for joint training and for more opportunities for partners' to spend time together, for example by reinstating the partnership conference to focus on reviewing activities, relationship building, establishing priorities and personal development.

### *What factors facilitate or hamper effective partnership arrangements?*

We have outlined a range of factors that facilitate or enable effective partnership working: clarity of purpose; leadership and ownership of partnership; shared values in relation to joint working; the skills and efforts of partners; and the general investment in and commitment to building consensus to ensure that the process is maintained. Considerable investment has been made by Scottish Government in the past and present to support partnership capacity and capability. Similarly, at local level, Boards invest considerable time (management and staff) in partnership, providing facilities time for extensive engagement in local and national partnership structures.

The most obvious constraint on effective partnership is that collaborative working and joint decision-making are, by their nature, difficult processes. Aligning a complex system across multiple levels of operation exacerbates those difficulties. Partnership working is multifaceted because NHS Scotland is a complex organisation. Addressing complexity is not, however, helped by a lack of clarity about purpose and roles, as previously discussed in relation to SPF. No concerns were raised, however, about unnecessarily bureaucratic procedures that constrain the effectiveness of partnership.

Partnership processes are hampered by two additional significant factors. The first factor is the challenges in ensuring agreement and consistency within partner groupings: for the Scottish Government, what is perceived by some partners as the lower levels of interest in partnership working by health officials outside of those directly involved in workforce matters; for employers, the challenges of more limited commitment to partnership below senior management levels; and variations within and across unions' commitment to partnership working. The second factor is the temptation to step out of partnership when it is expeditious to do so, either by unions directly lobbying politicians, or by employers relying on direct connections to Scottish Government, or by Scottish Government adopting political decisions that reject agreed partnership positions. These examples reflect, particularly in relation to unions and to Scottish Governments, the complexities of their roles and the multiple interests that they represent and prioritise, which in both cases increases some of the challenges involved in partnership working at an organisational level.

### *What outcomes are delivered by partnership working?*

Partnership is widely assessed on the outcomes it delivers. We have argued above that partnership working in NHS Scotland delivers very impressively on employee voice at all levels. It has also delivered mutual benefits to staff and employers. Notwithstanding the

constraints of austerity, partnership has delivered material benefit to staff, particularly in the last pay round, with higher relative pay in NHS Scotland than in England, and in terms of longer standing protections against detriment in redeployment. While this is costly for employers facing tighter health budgets and rising demands for services, there is a recognition that there are also benefits in terms of industrial harmony, greater staff engagement and the likely impact of better pay in recruitment and retention.

#### *Do staff own partnership?*

Clark and Clark's review<sup>xviii</sup> questioned whether partnership provided frontline workers with 'direct and substantial voice in the operation of their workplace'. We have argued above that partnership provides a strong representative voice for staff. Partners had widely varying views on whether staff directly engaged in partnership, or on the extent to which they were aware of it and how it affected them. Some staff-side partners argued that their 'active' members would know about partnership and attribute benefits to it; others argued that partnership did not reach down to front-line staff except in the context of major issues such as organisational change.

As discussed above in relation to SWAG, however, the development of iMatter has the potential to provide a more direct relationship between staff engagement and front-line activities. While 57% of staff reported feeling involved in decisions relating to their organisation in 2017, one of the lowest scores in the survey, this score is still significantly impressive by comparison with the UK working population as a whole where surveys suggest only around one quarter feel they have an influence over decision making at work.<sup>xix</sup> The current ongoing review of iMatter will examine its further potential to enhance staff experience, aligned to the Staff Governance Standards.

#### *Can partnership cope with an increasing pace of change?*

HSCDP recognises that the pace of change needs to accelerate across the system at all levels, and this depends on having the right partnership governance and relationships between the workforce, employers and government.

The ambition of the HSCDP has introduced a range of new requirements including in relation to H&SC integration, workforce planning, transformational change and digital strategies. At the same time, the move to OfS policies brings with it a significant challenge and workload for partnership processes. There are concerns that these issues will not only stretch the capacity of partnership to deliver an expanded set of outcomes, but that it will also challenge partnership processes through impacts on jobs, roles, career paths and systems and through new requirements for workforce development.

Beyond these issues that are currently engaging partners, there are also issues further on the horizon that will challenge partnership: further departure from a 'treatment only' model of health services; the greater involvement of users and patients in H&SC decision making; and health and well-being issues within the H&SC workforce.

Partnership has been described by one NHS partner as 'solid, not fast'. Collective decision-making processes can be time consuming, but can yield both better quality decisions and better acceptance of decisions. These are important outcomes. Achieving these important outcomes at a quicker pace raises issues of capacity, capability and resource. No partners wanted additional meetings of national fora and did not perceive that this would of itself generate a faster response. In relation to SPF, greater clarity and focus on its role and contribution alongside better communication and engagement between meetings was seen as having some

potential to increase its effectiveness. Across all levels, having more people with more time to devote to delivering on partnership working, and with the right skills and capability to deliver what is required across the existing partnership structures, is likely to enable more agile working and an enhanced pace of activity, but has significant resource implications for Boards and for unions.

#### *Is partnership capable of being adapted to the new H&SC structures?*

Current agreements on partnership do not apply in integrated H&SC although the models used in the HSCPs we looked at bore striking similarities with the NHS-style approach (i.e. the development of staff-side fora with formal linkages back into NHS board structures, the use of early involvement and input to strategic and operational decision-making). We suspect however, there are a variety of approaches in this sector and although some have clearly adopted the NHS partnership model, without any formal arrangement, this is of course vulnerable to change.

At the time of the Clark and Clark (2016) review, an integrated H&SC sector was very much in the early stages of development and implementation. There is much more scope for variation in HSCPs and it is still far too early to make any robust assessment about the effectiveness of partnership working in this landscape. It is crucial to note, however, that early stage development shapes the operation of new structures. This raises the possibility of more optimistic and more pessimistic scenarios about how likely it is, and how well, partnership working might emerge in the broader H&SC landscape. The optimistic scenario is that NHS-style partnership working is beginning to develop in some form in these emerging structures and processes, and will develop further as time progresses. The more pessimistic scenario is that unless partnership working is well embedded in HSCPs in their early stage, it is less likely to shape these processes as they develop, making it more challenging to adopt effective partnership working in future.

Although the partnership actors are located in the integrated landscape, the sector is spread across two employers, notwithstanding that both are likely to share a public service ethos. It is interesting to note however, that in terms of iMatter, this model has been applied to 23 of 32 HSCP-based Council staff without any substantial problems for local authorities and staff in this sector.

While it would be naïve to presume how employee relations and staff engagement will develop in H&SC on the basis of an investigation of NHS partnership working, the interface between the NHS and other H&SC players provides a potential lever of influence, as does the language and approach of the Fair Work Framework.

#### *Partnership for the future – key recommendations*

Below, we set out a number of recommendations. We do so drawing on the insights of the partners we spoke to and on from the wider literature on partnership, but also in the knowledge that in a system of partnership governance, it is for the partnership process to decide and deliver change. We note also that much of NHS partnership works well and urge caution in disrupting a functioning system.

1. SPF has been the core strategic forum in NHS partnership and our evidence highlights the continuing need for a core strategic forum. Addressing concerns over SPF's lack of purpose and aspects of its functioning should include:
  - clarifying the strategic purpose of SPF relative to other relevant strategic bodies within the NHS, such as the NPB;
  - improving the visibility of SPF and the promotion of the achievements of partnership;
  - explicitly refreshing SPF membership to reflect its current purpose and encourage more/more consistent participation;
  - encouraging greater reflection on the distinct roles of each partner group;
  - re-establishing an agreement between partners for the earliest possible engagement; and
  - having a robust and mature discussion about where partnership does not apply.
2. There is a need to agree the 'reach' of partnership and of the SPF in particular in the new integrated landscape divided by those whose engagement is defined by SGSs and others, and to consider the potential for SPF to take on a more active advocacy approach for partnership working beyond NHS Scotland, potentially using the language of Fair Work. Partnership developed a new way of working – the current challenge is to maintain this while developing it and adapting it in very new circumstances.
3. There is a need to improve connectivity across institutions/levels of partnership by:
  - improving the formal communications between SPF and APFs;
  - establishing two-way system of communication between SPF and RD/PB and other relevant decision-making bodies, including encouraging the Regional Implementation Leads to attend SPF in rotation; and
  - creating better linkages in the new landscape without simply creating additional process and bureaucracy. The development of a co-ordinated but agile system of joint working will, however, create resource and capacity challenges.
4. There is a need to improve the functioning of SPF meetings by:
  - reverting primary responsibility for SPF agenda items to staff-side and employer partners;
  - developing an annual working plan and linked objectives;
  - using virtual communications for information sharing between meetings, and organising meetings around outcome focussed thematic discussions with follow-up actions; and
  - ensuring appropriate behaviours by robust chairing, 'joint policing' by all partners and a strong reiteration of the expected partner behavioural standards required in a mature national-level fora.
5. There is a need to reinvest in partnership capacity at national and local levels to avoid attrition of partnership skills: through effective induction, joint training and development.
6. Partnership working has created an effective system of industrial relations and of staff engagement. The current context, while challenging, could allow for the progression of partnership at all levels beyond staff engagement to the delivery of a more holistic new approach to health and social care. Considerable investment in strategic thinking and strategic capabilities will be required to support this progression.

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