

**"Assessing partnership working: Evidence from the National Sexual  
Health Demonstration Project"**

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## **Abstract**

Partnership working has become something of a government imperative for tackling complex public health issues and is now more often the norm than the exception in health education and disease prevention work. The literature however, highlights that partnership working may be explained more by rhetorical appeal rather than any concrete evidence of effectiveness. There is little evidence from the literature examining the functioning, effectiveness or outcomes of partnership for health improvement. Partnership working was used within one such public health initiative (Healthy Respect) as a means of implementing and delivering a complex sexual health intervention programme to young people aged 10-18 years in Lothian. The main aim of Healthy Respect was to create an environment that would lead to long term improvements in the sexual health and wellbeing of young people through a multi-faceted approach which linked to education, information and services.

This PhD study aimed to assess the extent and impact of partnership working in the Healthy Respect project; it aimed to examine the process and outcomes of partnership working for the organisations involved in the programme and to theoretically assess how this may impact on improving young people's sexual health and wellbeing. The study used Healthy Respect's logic model as a framework to examine the theory of how change occurred through partnership working in the project. A mixed method research design was used consisting of two postal surveys and in depth interviews with a sample of providers delivering sexual health education, information and services to young people in Lothian.

Results suggest that Healthy Respect was only partially successful in working in partnership with some of the organisations involved in delivering sexual health education, information and services to young people. Partnerships were formed with approximately half of the providers. Those most engaged and working in partnership with Healthy Respect were from the NHS (including school nurses) and voluntary organisations which offered sexual health services to young people. Sexual health services also occupied a dominant position in the local networks of providers. Many providers linked with these services including secondary schools which offered Sexual Health and Relationship Education (SHARE).

Other organisations most notably those from the Local Authority organisations were less willing to work in partnership with Healthy Respect. Many of the barriers (identified through the qualitative interviews with providers) to working in partnership with Healthy Respect came mostly from the Local Authority organisations and offered an explanation as to why partnerships with these organisations didn't develop as planned. Results did suggest that where partnership work was taking place, this impacted on an organisations ability to deliver sexual health information, education and services to young people. However, partnerships with Healthy Respect were only formed with approximately 46% of the providers targeted, therefore not all organisations and subsequently young people would have benefitted from the Healthy Respect programme.

The Healthy Respect programme was heavily reliant on partnership working to deliver the complex intervention. Yet results suggest that they were only partially effective in working in partnership with the organisations involved which may have led to them having little impact on the sexual health and wellbeing of young people (especially the most vulnerable). Partnerships take a long time to build and require a great deal of time and resources to be invested in them to work. However, the results of the study leave us with the fundamental question of whether all this time and effort should be applied to partnership working and interventions of this type for what could be very little impact on young people's sexual health?

This study has contributed to knowledge in the area of partnership working for health improvement. It defined what partnership was using a range of methods which moved beyond supportive attitudes and was able to examine and measure both the process and outcomes of partnership work in this project, something which few studies have been able to achieve.

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## **Chapter 1: Introduction**

### ***1.1 Introduction***

The focus of this research is on the assessment of partnership working, and its impact on organisational development and service delivery as part of a complex sexual health intervention. This study was nested within a larger evaluation of the Healthy Respect National Sexual Health Demonstration Project. The evaluation was managed by Health Scotland on behalf of the Scottish Government (formerly the Scottish Executive). The evaluation was carried out by a collaboration of researchers from Edinburgh Napier University, the University of Dundee, the Medical Research Council (Social and Public Health Sciences Unit) and the Scottish Centre for Social Research working under the umbrella name External Evaluation Team for Healthy Respect (EETHR). The author of this study was affiliated to the team of researchers from Edinburgh Napier University and was registered to undertake a PhD at Edinburgh Napier University. The external evaluation began in January 2006 and ended in November 2009. The evaluation was split into five parts with the team from Edinburgh Napier University being responsible for assessing the effectiveness of Healthy Respect in achieving integrated and sustainable local delivery.

Healthy Respect set out to create an environment that would lead to long term improvements in the sexual health and wellbeing of young people through a multi-faceted approach which linked to education, information and services. Healthy Respect was heavily reliant on

partnership work taking place between themselves and organisations and between organisations involved in sexual health work with young people.

This PhD study used the Healthy Respect project as an example to assess how partnership working 'worked' in practice and whether it achieved the outcomes predicted of it.

### ***1.2 Setting the scene – Partnership Working***

There is an increasing interest and investment in partnership working as a way of addressing challenging public health issues (El Ansari and Weiss 2006, Israel et al 1998 Lasker and Weiss 2003, Roussos and Fawcett 2000 and Shortell et al 2002). Partnerships have become something of a government imperative for tackling complex policy issues and are now more often the norm than the exception in health education and disease prevention (El Ansari and Weiss 2006).

In the UK, partnership working is a key component of the government's modernisation agenda particularly in the health field and has become central to the Government's approach to tackling complex policy issues (Boydell and Rugkasa 2007, Wildridge et al 2004). The Government imperative for partnership working initiated a significant shift in the model of governance across many public sector organisations, moving away from an emphasis on competition between agencies (markets), to a model of inter-agency collaboration (Lewis 2005). Partly driven by this shift, but also indicating a desire to find better approaches, there was significant growth in public policies that embraced the concept of partnerships, also known as alliances, collaborations and networks.

Health policy has been a part of this broader trend, and there have been numerous discussions on a range of collaborative forms of working. In particular, partnerships have become a key means for governing a range of policy initiatives at the local level (Stewart 2007).

The Audit Commission (2005) reported five main objectives which run through Government policy on partnerships, these are:

- Improving the user experience of services
- Ensuring easy and timely access to services
- Dealing with difficult 'wicked issues' in the delivery of services  
e.g. poverty, harmful drug and alcohol use, and stigma
- Promoting citizen involvement in shaping services
- Making best use of all the available resources

The overall impression from Government policy is the need to 'work together' to tackle the increasing and complex public health issues affecting communities. There has been an implicit assumption from Government policy that partnerships are *a priori* 'a good thing', which will aid attempts by various local organisations to improve public health (Smith et al 2009). This has required the development of policy interventions that are dynamic, have a high level of complexity and are able to embrace diversity in stakeholders, geography and organisation (Sullivan and Skelcher 2002).

As part of the Government's emphasis on stimulating integrated local action, a wide range of area based initiatives requiring local partnerships were established. These included partnerships for neighbourhood

renewal, social exclusion, community safety, and child poverty (Audit Commission 1998). The notion that partnership working was essential to achieving public health outcomes in the UK was never contested. This is evident in the plethora of public health partnerships established during the last decade, including Health Action Zones (HAZs), Healthy Living Centres (HLCs), Health Improvement Programmes (HImPs) and Local Strategic Partnership (LSPs) (Smith et al 2009). In Scotland a similar approach was adopted, the legislative and strategic direction outlined in “Towards a Healthier Scotland (Scottish Executive 1999), “Our National Health: A Plan for Action, a Plan for Change (Scottish Executive 2000) and the “Local Government in Scotland Bill (2002) (Scottish Executive 2002) sought to create a foundation for delivering health improvement. These documents focused on the need to tackle health inequality and improve community health through a coordinated approach.

While there was an increased emphasis on the part of government to work together, partnership working in health promotion and the public health field is not a new phenomenon. The need for new strategies to promote health arose due to the realisation that health was influenced by a combination of social, political, environmental and biological factors (Baron-Epel et al 2003). This along with recognition that the health care system has a partial role in enhancing health in the community and cannot be expected to cope with all the factors that cause ill health, led the World Health Organisation (WHO) to stress the need for organisations to work together to target the wider determinants of health (WHO 1985).

*“Partnerships for health will be required at different levels: international, country, regional and local. They are needed for the formulation of health policy; for increasing people’s perception and understanding of health issues; for developing the potential will for action; for target setting, carrying out policies and programmes and shaping service delivery, increasing the selection of priorities and resource allocation; and for monitoring and evaluation of outcomes” (WHO 1999).*

Attempts to improve health and health inequalities therefore required new ways of working that were dependent on working relationships and practices between all stakeholders involved in public health and health promotion.

Existing theory of improvement through partnerships suggests that they provide a means of pooling the abilities, expertise and resources of numerous stakeholders to positively affect health (Granner and Sharpe 2004). The benefits of partnership working are considered to be numerous and include rationalisation of resources, a reduction in duplication of effort and the provision of a ‘more effective, integrated and supportive service for both users and professionals’ (Bloxham 1997). Tait and Shah (2007) state that partnership working is assumed to result in a more effective provision of services, provide a wider range of services within the community, better meet service users needs and benefit the professionals involved in the partnership. Because of this rich potential, partnerships are frequently chosen for participatory, community-based research and grass roots initiatives to promote health (Goodman et al 1996, Goodman et al 1998, Israel et al 1998, Roussos and Fawcett 2000 and Green et al 2001).

*“The aims of public health will best be achieved by agencies, organisations and individuals working together. Partnerships should be a tool for achieving an outcome and in order to achieve that outcome, there needs to be a shared vision and agreement on what to do, by whom and when” (Department of Health 1999).*

While there is an emphasis on the use of partnership working to deliver health improvement initiatives, the literature reviewed falls short of providing evidence with regards to how partnership arrangements actually work in practice and whether they provide the benefits proposed.

### ***1.3 Healthy Respect the National Health Demonstration Project***

#### **1.3.1 Background to the project**

In recognition of the need to improve health in Scotland the Scottish Executive announced plans within its white paper 'Towards a Healthier Scotland' (1999) to set up four National Health Demonstration projects. These were set up as test beds for innovation to identify how to meet some of the health challenges in the twenty first century and to disseminate learning throughout Scotland (Evaluation of Healthy Respect 2 Interim Report 2008). Funded by the then Scottish Executive Health Department (SEHD), Healthy Respect began in February 2001 and ran for three years (known as Phase 1). Its vision was to help young people in Lothian (where it was based) to develop a positive attitude to their own sexuality and that of others, and a healthy respect for their partners, with the aim of reducing teenage pregnancies and sexually transmitted infections (STIs). In March 2003, the then Scottish Executive announced that Healthy Respect would continue for a longer period of demonstration and Phase 2 was funded from April 2005 to March 2008.

Healthy Respect Phase 2 was informed by a review of the evidence undertaken by Health Scotland (Fraser 2006). This showed that the

sexual health of young people in Scotland was poor compared with that of young people in other European countries.

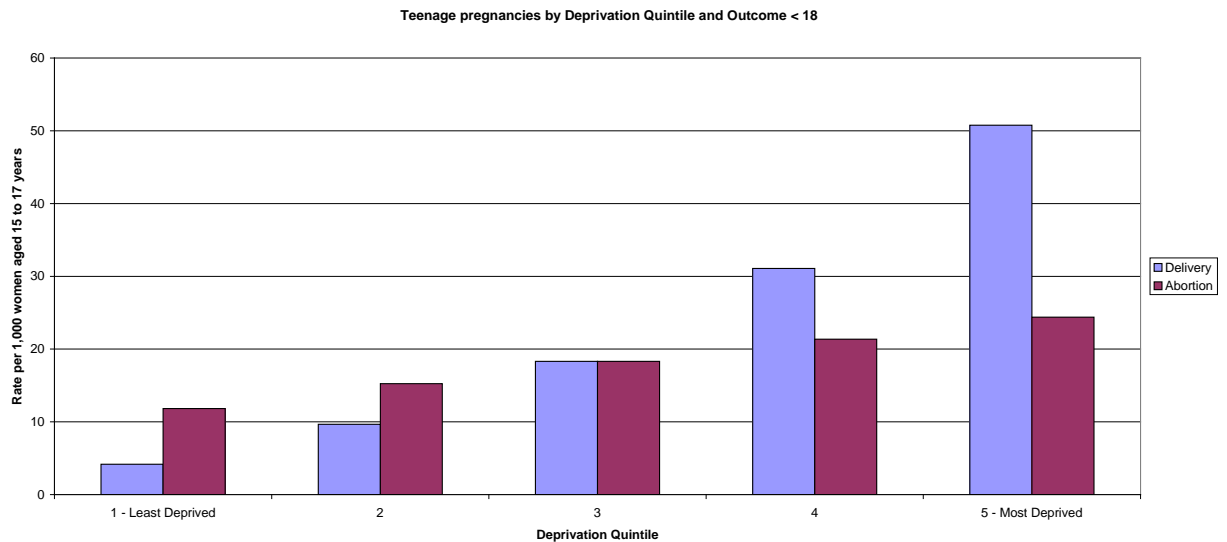
Young people are particularly vulnerable to the adverse consequences of early sexual behaviour and as such are widely recognised to be one of the most important groups for reproductive health interventions (Cowan 2002). Adverse consequences of early sexual behaviour include increased risk of sexually transmitted infections, and the consequences of unplanned and unintended teenage pregnancy (Tripp and Viner 2005). Young people are at an increased risk of STI's as they often fail to use barrier contraception methods (condoms) and are more likely to deny or be unfamiliar with symptoms of infection (Cowan 2002, Tripp and Viner 2005). Adolescents who suspect an infection may be embarrassed or frightened and delay seeking treatment. Once diagnosed, they may fail to complete therapy, especially if symptoms diminish. Due to physiological immaturity teenage girls are more susceptible to infection than adults, as Chlamydia seems to easily infect the immature cervix (Tripp and Viner 2005).

Although teenage pregnancy is often cited as an adverse consequence of early sexual behaviour it is important to recognise that for some young parents it can be viewed as a positive life choice (Tripp and Viner 2005). This suggests that perhaps more emphasis needs to be placed on supporting these young people who choose to become parents in their new role. However for many other young parents who do not choose to make this decision the cost of teenage pregnancy can be high, especially when linked to poverty (Tripp and Viner 2005). With higher



rates of teenage pregnancy than most other Western European countries, reducing unintended teenage pregnancy became a national target for the Scottish Government. Teenage pregnancy is also shown to be linked to deprivation with the rates of teenage pregnancy in deprived areas more than treble those of the least deprived areas (ISD Scotland 2008).

The evidence review undertaken by Health Scotland (Fraser 2006) suggested that economic, social and cultural influences impact on sexual health. Health inequalities are also seen in sexual health: those with lower incomes and socio-economic status have poorer general health, including sexual health, than those who are more affluent (McLeod 2001, Scottish Government 2003, 2005). Lower social class is associated with an earlier start of sexual activity (NHS Centre for Reviews and Dissemination 1997, Henderson and Wight 2002), which in turn is linked to subsequent regret, less protection against conception and STIs and more subsequent sexual partners (Wellings et al 2001, West et al 1993). Higher levels of deprivation are associated with less consistent contraceptive use and a higher risk of teenage pregnancy (Figure 1.2) (Scottish Government 2006).



**Figure 1.1 Teenage pregnancies by deprivation and outcome (under 18 years) (ISD Scotland 2008)**

The risk of teenage pregnancy is increased in association with a number of social, socioeconomic and individual factors. Those who appear to be at particular risk are the daughters of teenage mothers, young people "looked-after" by the local authority or leaving care, school non-attendeess - due to truancy or exclusion - and homeless or runaway teenagers (Acheson Report 1998). According to the Department of Health those groups most vulnerable to sexual health inequality are women, gay men, teenagers, young adults and black and ethnic minority groups (House of Commons Health Committee Third Report: Sexual Health 2003).

### **What might work in addressing Sexual Health?**

An analysis of the main contributing factors associated with the recent decreases in US teenage birth rates concluded that the best strategy for continuing the declines in teenage pregnancy (and STIs) is a multi-faceted approach (Kirby 2001). A multi-faceted approach includes the use of more than one intervention programme, i.e. an approach linking

education and services. This approach is also supported by the Health Scotland review, which examined evidence from other countries that have lower rates of teenage conceptions and STIs (Fraser 2006). Evidence commissioned to support the Scottish national sexual health and relationship strategy (Scottish Executive 2005) also identified the value of a combined approach comprising; sex and relationships education (SRE) supported by parents and professionals across a range of settings; improved access to specialist and generic sexual health services; and systematic marketing of positive sexual health messages (Evaluation of Healthy Respect Phase Two: Interim Report 2008). This along with the knowledge that no-one agency should or could deliver this combined approach on their own suggests the need for these initiatives to be multi-agency i.e. organisations working together in partnership to deliver a comprehensive approach to promote and target health improvement (Backer 2000, Shortell et al 2002).

### **1.3.2 Overview of Healthy Respect**

The programme was classified as multi-faceted in that it intended to link existing providers of sexual health education, information and services. Healthy Respect was a Lothian wide initiative although in the second phase, it concentrated on two localities to demonstrate implementation across a whole local authority (Midlothian) and an area of high deprivation (North West Edinburgh), and had an enhanced focus on tackling health inequalities.

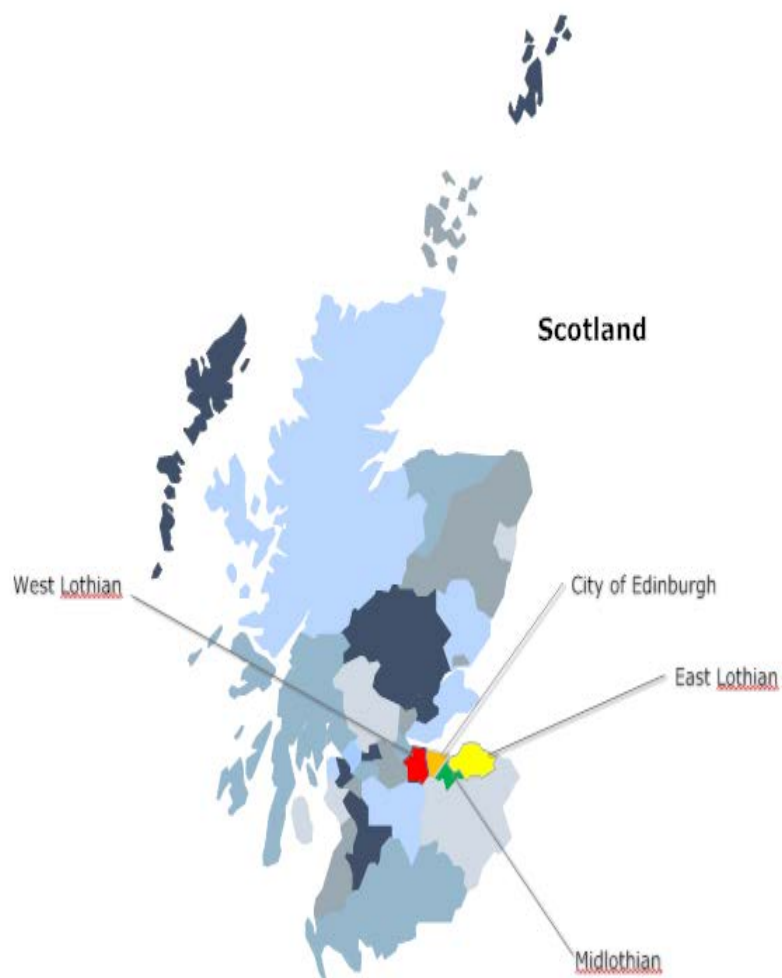
There were two strategic aims:

- To create an environment that would lead to long term improvements in the sexual health and wellbeing of young

people aged 10-18 years in Midlothian and North West Edinburgh through a multi-faceted approach which links to education, information and services.

- To communicate the lessons from Healthy Respect to enable learning and skills to be transferred throughout Scotland (Evaluation of Healthy Respect Phase Two: Interim Report 2008).

The strategic aims of Healthy Respect were also designed to build on the policies outlined in the national strategy on sexual health and wellbeing, Respect and Responsibility (Scottish Executive 2005), and the accompanying evidence base. Healthy Respect operated within the context of the Lothian Sexual Health Strategy (NHS Lothian 2005) and the national framework for health promoting schools, Being Well, Doing Well (Learning and Teaching Scotland 2004) which required all Scottish Schools to become health promoting schools by the end of 2007.



**Figure 1.2 Map of Scotland highlighting the Healthy Respect areas of Edinburgh City, East Lothian, West Lothian and Midlothian**

**Table1.1 Profile of the geographical areas covered by Healthy Respect compared with figures for Scotland (Scottish Neighbourhood Statistics 2009)**

	<b>Scotland</b>	<b>East Lothian</b>	<b>Edinburgh City</b>	<b>Midlothian</b>	<b>West Lothian</b>
Total Population 2007	5144200	94440	468070	79510	167770
Total Population Aged 10-15 years 2007	368311	7651	27009	6157	13338
Total Population Aged 16-19 years 2007	263956	4585	22984	4267	8655
Teenage Pregnancy Aged Under 16 years; Rate per 1000 women aged 13-15 years; 2005-2007	8.1	8.3	8.6	6.8	5.8
Teenage Pregnancy Aged Under 18 years; Rate per 1000 women aged 15-17 years; 2005-2007	42.4	41.3	42.7	41.4	39.7
Percentage economically active people; 2005	79.2	81.1	80.9	83.7	79.9
Looked after by the Local Authority: Percentage of all pupils; 2007	1.28	1.15	1.69	1.25	1.17
S4: Percentage of pupils with 5 awards at SCQF Level 4 and above; 2007	76.1	81	75.5	78.1	77.6

Table 1.1 displays statistics taken from the Scottish Neighbourhood statistics (2009). The statistics give an overview of the population of interest i.e. young people. It examines statistics for the different geographical areas covered by Healthy Respect in comparison with those for Scotland as a whole (SNS 2009). Statistics in each of the areas do not differ much from the Scottish average, although Edinburgh City is slightly above the Scottish average for teenage pregnancy rates in the under 16 and under 18 year age groups. Edinburgh City also has higher rates of young people looked after by the local authority than both the Scottish average and in comparison to the other geographical areas examined.

### **1.3.3 What did the programme consist of?**

There were four main methods used to deliver the Healthy Respect programme:

- Programme delivery to professionals to increase their capacity and capability to provide education, information and services as part of their work with young people and parents.
- Programme delivery to young people
  - Primary Schools
  - Secondary Schools
  - Drop-In Services
  - Other settings (vulnerable young people)
- Programme delivery to parents.
  - Secondary School, Primary School
  - Other settings
- Media and information campaigns
  - Social marketing (The Respect Difference Campaign)
  - Healthy Respect Branding

### **1.3.4 Programme Components - Professionals**

The Healthy Respect team identified a range of professionals considered well placed to deliver education, information or services (or a combination of these) to young people and parents in Lothian. These included teachers, school nurses, youth workers, social workers and staff from within the voluntary sector. Healthy Respect adopted a population-based approach and so set out to engage professionals who could reach large numbers of young people, for example teachers. However, it also wanted to target young people who were at particular

risk of poor sexual health outcomes, and so specifically focused on those professionals working with young people who were looked after and accommodated, excluded from school and attending youth work settings, and who had learning disabilities (Evaluation of Healthy Respect 2 Interim Report 2008).

To support local delivery, Healthy Respect provided a number of programme coordination functions:

- Advocacy and leadership
- Training, professional development and support for those professionals delivering education, information and services (Drop-In's)
- Resources, materials and information

Learning from Healthy Respect (Phase One) suggested that partnership work with professionals and agencies at all levels was necessary. Therefore, Healthy Respect aimed to use knowledge of the evidence base and their experience from Healthy Phase One to increase confidence and expertise for professionals to create a culture within agencies that was more responsive to delivering sexual work with young people (Evaluation of Healthy Respect 2 Interim Report 2008).



### 1.3.5 Programme Components – Young People

#### Education

- **Primary Schools** - The Healthy Respect team delivered training and ongoing professional development to teachers in 18 primary schools in Midlothian to allow them to implement and deliver the Zero Tolerance Respect (ZT Respect) programme within schools. ZT Respect programme for 10 – 12 year olds is a programme delivered as part of the schools' wider Health/Personal Social Development (PSD) programme and focuses on issues of equity and relationships.
- **Secondary Schools** - Sexual Health and Relationship Education (SHARE) training events delivered to teachers, school nurses, youth workers and voluntary sector staff. SHARE is a sexual health education package delivered in S2-S4 in secondary school. Healthy Respect also provided ongoing continuing professional development (CPD) to SHARE trainees delivered twice a year
- **Catholic Schools** - Working in partnership with the Scottish Catholic Education Service (SCES), Healthy Respect commented on all draft materials for use in Catholic schools as part of their relationships and moral education programme. The materials, entitled 'Called to Love', were launched by SCES in November 2007.

#### Sexual Health Services

- **Drop-In Services** – provide young people with sexual health services in local settings. They were designed to be young people friendly, informal and operated by staff who had experience of working with young people, typically school nurses and youth workers. At a minimum, drop-ins provided information and advice on all health issues such as mental health and general wellbeing alongside sexual health. Additionally, some drop-in's offered pregnancy testing, Chlamydia testing and access to free condoms. There were 22 drop-in services by June 2007 and a further three services were being developed at the time of writing.
- **Chlamydia Postal Testing Kit** – the Healthy Respect postal testing kit for Chlamydia was part of the service delivery in Lothian and was made available online.

#### Information

- **Information and products** – that included leaflets on Chlamydia, promotional materials for drop-ins, confidentiality

booklets and rights and responsibilities cards. The 'safe 'n' sorted' handbook on sexual health and relationships and a guide to services, was delivered to all S3 pupils via schools. Copies were also made available through Healthy Respect drop-ins.

- **Healthy Respect Website** – a web resource providing information on sexual health issues, availability of services and guidance on where to get help.

### **1.3.6 Programme components - Parents**

#### **Education**

- Parents' nights were held, either as specific events on Healthy Respect or as part of a wider parents' evening to consult with parents about possible service developments and/or educational programmes in their child's school.
- Home activity resource packs were introduced to 18 primary schools in Midlothian and made available to all secondary schools delivering SHARE in Lothian. This resource, produced by Healthy Respect, provided four SRE homework activities. Its purpose was to engage parents in SRE, and to improve discussion at home about SRE topics, thus helping schools and parents to work in partnership when it came to SRE delivery. Healthy Respect also produced a leaflet, which schools could send to parents to introduce the materials.

#### **Information**

- A specific section of the Healthy Respect website was intended for parents use.
- Consultation on key research findings and pre-testing was undertaken with parents. This led to a social marketing campaign on quality family time (Quality Time Campaign 2006) aimed directly at parents about how they could reduce the possibilities of their child becoming involved in risk taking behaviour at an early age. The campaign included a radio campaign, a specific micro website, newspaper adverts and a compact leaflet delivered to houses with children in Midlothian and North-West Edinburgh.

### **1.3.7 Programme components – Media and Information Campaign**

#### **Social Marketing**

- Three specific high-profile media campaigns were developed using social marketing principles:
  - The Respect Difference Campaign (2005-06) to broaden young people's awareness of the values of respect for themselves and others in relation to building healthy, respectful relationships, and in particular the value of respecting difference in others.
  - The Access to Services campaign (2007) developed to raise awareness among young people of the places that provide information and services on sexual health, relationships and other health matters.

#### **Branding**

- Complementary to the social marketing approach, Healthy Respect adopted a non-profit, partnership brand approach. Branding of the Healthy Respect logo on all resources and information was undertaken.

Healthy Respect (Phase Two) differed from Phase One in that it included work with Primary Schools, the Scottish Catholic Education Service, parents' and had a more focused approach to working with organisations targeting vulnerable young people.

#### **Summary and Rationale**

Partnership work with organisations and professionals involved in delivering sexual health work to young people was clearly an important aspect of this complex sexual health intervention programme. Research on the importance of partnership working in health and the processes this involves is also prominent in government policy and the public health management literature (Clarke et al 2002, Dowling et al 2004).

Yet while there is an increased interest in partnership working as a way of addressing challenging public health and complex policy issues. There is as yet very little evidence assessing the functioning, effectiveness and outcomes of these partnership arrangements for health improvement initiatives.

Simply recommending partnership working as a means of meeting key objectives both masks the complexities and realities of achieving effective partnerships and assumes that partnership working is the best way of achieving such objectives (McLaughlin 2004). If 'what works is what counts' (Secretary of State for Health 1997, Davies et al 2000) then there is a need to evaluate partnership working to provide evidence to establish how and if it works in practice and to say whether it can be associated with providing benefits to those who provide or use services. The Healthy Respect project provided the author with the ideal opportunity to examine partnership working within a complex public health intervention programme. The aim of this study was, to 'Assess the extent and impact of partnership working in the Healthy Respect Project. Three research questions emerged as a means of addressing this aim:

- 1.** What is partnership working:
  - a.** Between the Healthy Respect Team and other organisations who deliver sexual health education, information and services to young people?
  - b.** Between the organisations who deliver sexual health education, information and services to young people?

2. What influenced partnership working between Healthy Respect and the other organisations?
3. What were the outcomes of partnership working between the Healthy Respect Team and the other organisations?

A mixed methods design was used to address the overall aim of the study and the research questions set. The research design and methods are outlined in Chapter 3.

## **1.4 Structure of the Thesis**

**Chapter Two** examines the literature related to the theory, practice and evaluation of partnership working. Firstly, the rationale for partnership working for health improvement is examined. This suggests that partnership work for health improvement is necessary because of the multi factorial nature of factors influencing health and the perceived benefits of partnership work for those involved and the end users. Then the available evidence in relation to the definition, barriers and benefits and issues related to the 'successful' formation and functioning of partnership work are reviewed. The Chapter concludes with an overview of the different methods used for partnership evaluation and a summary of the literature and the rationale for the present study is outlined.

**Chapter Three** outlines the study design and methods, and explains why these methods were used: wave one and two survey of providers and qualitative research. A logic model is included (Appendix A) which was developed by the Healthy Respect Team and allowed the researcher to identify the outcomes that could arise from partnership

working. Logic models are based on the Theory of Change and are used across a wide range of evaluations to make explicit key organisational outcomes and what needs to be done to achieve these outcomes given the available resources and time.

**Chapter Four** reports the results from both surveys, and answers the questions ‘What is partnership working; a) between Healthy Respect and organisations delivering sexual health education, information and services to young people and b) between the different organisations involved in the delivery of sexual health education, information and services to young people?’

**Chapter Five** presents the results from the qualitative interviews and answers the question ‘What influenced partnership working between Healthy Respect and the other organisations?’

**Chapter Six** presents the results from both surveys and answers the questions ‘What are the outcomes of partnership working a) between Healthy Respect and organisations and b) between the different organisations involved in delivering sexual health education, information and services to young people?’

**Chapter Seven** is a critical analysis and interpretation of the findings. The conclusions from the study are the subject of this chapter. The limitations of the study and the contribution to knowledge are discussed and the chapter concludes with a presentation of recommendations for further research and practice.

## **Chapter 2: Literature Review: Partnership Working**

### ***2.1 Introduction***

Chapter 1 highlighted some of the issues surrounding partnership working for health improvement. The literature review examines these issues further and discusses the evidence with regards to factors influencing young people's sexual health. It then goes on to examine these factors within the public health agenda and proposes that the justification for partnership work for health improvement is based largely on theory. The literature review then moves on to examine in more depth the evidence associated with partnership working. The sections of the review comprise; definition of partnership working; types of partnerships; benefits and barriers; partnership formation and functioning and issues affecting the evaluation of partnership work.

### ***2.2 Partnership working for health improvement***

#### **2.2.1 Factors influencing young people's sexual health and behaviour**

Health professionals keen to address the sexual health of young people often adopt current practices without exploring and gaining an insight into the factors that influence teenage sexual behaviour (Wight et al 1998). Whitaker et al (2000) point out that, only by understanding the factors which influence young people's sexual behaviour can we then begin to improve their sexual health. They emphasise that, without this understanding we cannot hope to reach out to young people and help develop the knowledge, skills, and attitudes, which can ensure that they remain safe, healthy and benefit from satisfying relationships.

Both theory and research strongly suggest that factors affecting teenage sexual behaviour are multi-dimensional (Miller and Ahmad 2002, Whitaker et al 2000). These include the society they live in; parent and family relationships; socio-economic factors and factors such as self esteem and educational attainment (Aggleton et al 2000, Burtney 2000, Crouch 2002, Cheesbrough et al 2002, Henderson 2006, Mcleod 2001, Mitchell and Wellings 1998, Social Exclusion Unit 1999). All these factors interplay making the study of this aspect of human behaviour extremely complex.

### **2.2.2 Young Peoples sexual health in today's society**

Society influences our attitudes; the way we communicate with, educate and relate to young people, this, in turn influences their behaviour. Young people are often marginalised by their transitional status in society and are viewed more as children than young people (West 1999). This West (1999) claimed directly attributes to the problems they face in developing their sexual identities and expressing their concerns. In today's society children from an early age are subjected to sexual imagery from the mass media that portray sex as glamorous and desirable. Adults, in their own relationships, are now more open about their sexuality and relationships (Crouch 2002). However, society mainly views young people's sexuality in negative terms. Sex is considered to be part of the adult world which children must be protected from. Once provided with information about sex and sexuality there are fears that young people will run wild, becoming promiscuous (West 1999 and Crouch 2002). The inability of society to be open and positive about young people's sexuality has produced a climate where it is difficult for



adults, whether parents or professionals to be open and honest about sexual matters with children and young people (Whitaker et al 2000, West 2000 and Crouch 2002). Yet in West's study, the young people themselves express the need to talk about sexuality and the need to be treated with respect and openness (West 1999). The greater acceptance of young people's sexuality in the Netherlands (and Sweden) than in the UK may reflect a higher, more independent status for youth as much as a generally more open climate around sexuality (West 1999).

### **2.2.3 Parent/Family Relationships**

Many studies both in Britain and the United States cite the quality of the relationship between parents and adolescents as of vital importance in influencing young people's sexual behaviour. The evidence suggests that parents influence their child's sexual values and skills from an early age. Family and home experiences affect young people's development of gender identity and sexuality. Good parent-child communication about sexuality can help delay young people's first sexual experience and limit poor sexual health outcomes (Jaccard et al 2000). Research also indicates that talking about healthy relationships, including respect, is thought to help children become more self-confident and make appropriate decisions and choices about their personal life (Scottish Executive 2003).

Research indicates that young people say parents are one of their main informants about sex even though most do not openly talk to their parents about these issues. Parents also find it difficult to discuss such matters with their children (Scottish Executive 2003)

Cheesbrough et al (2002) reported that young people, whose parents have no problem when it comes to discussing sexual health issues with them, are more likely to use condoms and contraception than those who have not discussed sexual health matters with their parents or family members. Mitchell and Wellings (1998) agree and state that parent's ability to openly communicate with their children about sexual matters can delay the age of first intercourse and improve the use of contraceptives. Whereas poor parental communication linked to lack of confidence and parenting skills, is strongly associated with poor sexual health (younger age of first intercourse and less condom use) among teenagers (Cheesbrough et al 2002).

Research in the USA suggests that young people brought up in families with egalitarian attitudes to gender roles are more likely to use condoms when they become sexually active. Among American adolescents, safe sexual behaviour is predicted more by teenagers' perceptions of how much their parents care for them, than by the frequency of health warnings or social class (Mechanic, 1990). Further studies have demonstrated that parent's sexual values, in combination with parent/child communication, have an important effect on young people's intercourse experience (Miller and Green 2002, Jaccard et al 2000).

Researchers have suggested that to improve the effectiveness of parents as sex educators, they should be helped to improve their general communication skills (Feldman and Rosenthal 2000). Aggleton and Campbell 2000 suggested that due to the potentially protective role for open communication with parents and parental support for young

people's sexual health, and the difficulties that many parents experience in talking about sex, there is an urgent need for advice and support to help parents communicate more effectively with their children about sensitive topics. In circumstances where parents themselves are unavailable to offer guidance and support, mentoring may provide a useful alternative. Talking about healthy relationships, including respect, may help children become more self-confident and more able to take appropriate decisions and choices about their personal life (Scottish Executive 2003). In light of the research evidence this has led to government policy emphasising the need for partnership work between parents, schools and health services to promote and support a more consistent approach to sex and relationships education to reinforce the key messages (Scottish Executive 2003).

#### **2.2.4 Socio-economic status**

Research has highlighted a social class gradient in teenage pregnancy with greater numbers observed in lower social classes (Burtney 2000, Kane and Wellings 1998, McLeod 2001, Wellings et al 2001 and ISD Scotland 2003). Lower socioeconomic status is also associated with an earlier start of sexual activity which in turn is linked to subsequent regret (Henderson and Wight 2002, Dickson et al 1998, Wight et al 2000, Vanwesenbeeck et al 1999, and West et al 1993). Lower socioeconomic status has also been associated with less protection against conception and STI's, and an increase in sexual partners (Burtney 2000, Vanwesenbeeck et al 1999, and West et al 1993). High levels of teenage pregnancy are associated with high levels of unemployment and exclusion from education (Social Exclusion Unit 1999).

Darroch et al (2001) examined the link between social class and poor sexual health across five countries (Canada, France, Great Britain, Sweden and the United States). They found consistent patterns of relationships between socio-economic disadvantage and adolescent sexual behaviour. The research identified large differences in early childbearing across income and educational attainment levels, with poorer and less educated young women being more likely to have a child during adolescence. They found that differences in initiation of sexual activity across socio-economic subgroups to be small, apart from the United States and Great Britain where they found that poorer teenagers were more likely than better off teenagers to initiate sexual activity before the age of 20 years (Darroch et al 2001). Henderson (2006) in a recent study also found that conception rates were strongly related to socioeconomic factors, whereas the relation between socioeconomic factors and terminations was somewhat weaker.

Similarly, a Life Options Theory asserts that teens who live in communities with a dearth of opportunity for positive future employment, educational advancement, or economic self-sufficiency have little incentive to try to prevent early pregnancy or childbearing (Rubin and East 1999). In fact some young girls may see an economic incentive to being pregnant, as young mothers in the UK receive an array of benefits, from cash to council flats. Therefore, some would argue that the state is actively encouraging young people to become pregnant by offering them economic benefits that they would not otherwise have received if they were not pregnant (Wolfe 2001).

### **2.2.5 Educational Attainment and Self Esteem**

Mitchell and Wellings (1998) claimed that lower academic achievement may also be associated with earlier sexual activity. Whitaker et al (2000) found that, higher levels of self esteem and feelings of hopefulness were associated with young people who do not envisage having sex in the near future. The Social Exclusion Unit propose that low ambition and poor self esteem in girls, which results from low socio-economic status and low academic achievement, should be tackled from an early age (Social Exclusion Unit 1999). They propose that life skills work and community involvement can help to raise self esteem and job prospects (Social Exclusion Unit 1999). They suggest that programmes aimed at pre-school and primary school girls may result in lower rates of teenage pregnancy and better sexual health outcomes later on in their lives (Aggleton et al 2000; Social Exclusion Unit 1999).

Whitaker et al agreed with this. They found that young people who felt more connected to their family, school and the wider community felt less hopeless and were less likely to engage in 'risky' sexual behaviours (Whitaker et al 2000). The importance of members of a community to have their views and needs respected and valued is emphasised by Campbell, this perceived power they claim, promotes health enhancing behaviours (Campbell C 1999). Aggleton and Burtney (2000) reported that boys are frequently overlooked and they feel that there is a need to provide programmes for young men, to increase their self-esteem and confidence. They suggest programmes to increase their awareness and understanding of the way dominant ideologies of masculinity can

increase their sexual health risks, as well as those of their sexual partners (Aggleton and Burtney 2000).

The World Health Organisation (WHO) commissioned a review of literature to determine which risk and protective factors were important for young people's sexual and reproductive health behaviour (WHO 2004). The review highlighted a number of risk and protective factors that should be addressed through programmes and policies:

- Education and schooling; shown to be key factors for not only reducing the risk of early sexual initiation, pregnancy, and early childbearing, but also for increasing the likelihood that young people will wear condoms and contraception when they have sexual intercourse. Programmes and policies that focus on improving school enrolment, retention and performance among adolescents should, therefore be given priority and evaluated for improving sexual and reproductive health outcomes.
- Knowledge and attitudes towards condoms and contraception; is also shown to be important for increasing the likelihood that sexually active adolescents will use them. Sexual health education programmes that aim at improving both knowledge and attitudes about condoms and contraception, as well as improving communication and negotiation skills may have promise based on the findings related to the influence that these factors appear to have.
- Perceived sexual behaviour of friends; adolescents who perceive their friends or peers to be sexually active are significantly more likely to engage in sex themselves and have

multiple sexual partners. Programmes that target peer norms and influences about sex, therefore, hold promise for changing behaviours related to sexual initiation or having multiple sexual partners.

- Partner approval/support for using condoms and contraception (WHO 2004).

It was felt that knowing what these factors were, and how they operate, may not only help target those youth at greatest risk of negative sexual health outcomes, but also help in the design and implementation of more effective sexual health intervention programmes. Although interestingly there was no reference within the report as to the influencing and protective role of parents or the part sexual health service delivery plays in reducing risky behaviour. The report also emphasised that there was not one factor that explained most young people's sexual or reproductive health behaviour and therefore no simple or magic solution was available. It stated that factors putting young people at risk of poor sexual health outcomes were multi-faceted (WHO 2004). Although individual behavioural change is central to improving sexual health, efforts are also needed to address the broader determinants of sexual behaviour, particularly those that relate to the social context (Wellings et al 2001).

### ***2.3 Sexual Health Interventions***

Often sexual health intervention programmes are focussed on one or two causal factors and are managed by a single agency, but given the diversity of known causes, comprehensive programmes are often

justified. Indeed researchers have argued that comprehensive, community wide strategies are likely to have larger and more sustained effects than single-strategy or single-agency approaches (Bernard 1990; Cook and Roehl1993; Hopkins et al 1988), especially when they target known risk factors.

The research evidence argued that there needs to be a variety of programmes each delivering and focussing on the different elements i.e. sexual health education programmes, media campaigns and comprehensive sexual health services all working to a defined goal (the aim of promoting young people's sexual health and wellbeing) (Cheesbrough et al 2002; DiCenso et al 2002; Health Development Agency 2001; Kane and Wellings 1999; Kirby 2001, and 2006; Manlove et al 2002; NHS Centre for Reviews and Dissemination 1997; Oakley 1995; Robin et al 2004; Scher et al 2006; Swann et al 2003).

Certain programmes and characteristics of programmes highlighted within the literature offer some suggestions as to what can be done (although not a blueprint) to promote young people's sexual health (Swann et al 2003):

- Multi agency/Multi factor programmes have consistently shown more positive effects. (Interestingly though there is no agreement in this paper as to what multi-agency/multi-factor means)
- Interventions that tackle the root causes of social dislocation and low aspirations by targeting educational opportunities and aspirations from primary age onwards appear more effective



- Sexual health interventions designed with input from adolescents
- Prevention programmes need to begin from an earlier age, before the onset of sexual activity and before patterns of behaviour are established
- Although programmes should reach all youth, they should be especially certain to reach high risk youth (Swann et al 2003)

In addition to providing a general rationale for partnerships, social science research can be used to shape our thinking about types of interventions (and types of evaluations) that are needed to address young people's sexual health. Structural factors associated with sexual health risk and prevention have been defined as physical, social, cultural, organisational, community, economic, legal or policy aspects of environment that impede or facilitate a person's effort to avoid sexual health risk taking (Cowan 2002). Cowan (2002) believed that traditionally, adolescent reproductive health interventions have not addressed these structural factors which impede their efforts to avoid infection/pregnancy. Thus it may be unrealistic to expect individual behaviour change when the broader societal and cultural context is not supportive of this change. Although Cowan (2002) argued that it would be unreasonable to delay implementing behavioural interventions until complimentary structural adjustments to the wider community can be implemented. It is likely that interventions that combine a behavioural and structural approach will be those most likely to succeed (Cowan 2002). As a result Wellings et al (2001) suggested that the evidence from behavioural interventions show that no general approach to sexual

health promotion will work everywhere and no single component intervention will work anywhere.

#### ***2.4 Partnership working – tackling the multi-dimensional factors affecting sexual health***

Community partnerships in the health promotion and public health policy have become increasingly prominent (Butterfoss et al 2001). One of the first policy documents which changed the way health was perceived, and suggested ways in which it could be improved, was the internationally acclaimed 'A New Perspective on the Health of Canadians' or The Lalonde Report. The Lalonde Report (1974) proposed that individuals must accept responsibility for self preservation, within a broader understanding of human behaviour and biology in response to the social and physical environments. Published in 1974 it was the first international policy to suggest factors other than health care contribute to the health of the population (Crombie et al 2005). The Lalonde Report was followed shortly after by an influential statement from the World Health Organisation (WHO) in 1977. This eventually became known as 'Health for All by the Year 2000' and was launched at the 'Alma Ata' conference in 1978. This conference established that the attainment of health required the action of social and economic sectors as well as the health sector. In this report health promotion was seen as central to enabling people to take control over and improve their health. It called for the examination of health within a systems framework which brings together the fragmented responsibilities of individuals, government, health professions and other organisations involved in producing health

and makes it possible to identify trade-offs in allocating scarce resources (Eilbert 2005).

In recent years, there has been a renewed interest in efforts to improve community health through the formation of different forms of partnerships. (Shortell et al 2002). Evidence has drawn attention to the need to understand and address factors which affect health, but are beyond the control of any one organisation or agency (Gillies 1998). Roussos and Fawcett (2000) state that in public health 'collaborative partnerships' attempt to improve conditions and outcomes related to the health and well being of entire communities. In public health, these collaborative partnerships take many forms, including coalitions of community members and groups, alliances among service agencies, consortia of health care providers from the grassroots and broader advocacy efforts and initiatives. Partnerships and collaborations of various types have become a central strategy for promoting community change (Backer 2000).

Complex public health interventions of which the Healthy Respect project is one, aspires to create change in a service environment with a view to improving the health and well-being of the target population. Berkeley and Springett (2006) suggested the remit for complex intervention is defined by their:

a. Underlying philosophy, expressed in their:

- Usage of the social definition of health (i.e. health seen as physical, social and emotional well-being);
- Work towards achieving equity/reducing health inequalities;

- Ascribing to the idea that the root causes of ill health are located at different levels and, hence, they need to be tackled at all levels by all relevant agents;
  - Systematic thinking/whole systems approach.
- b. Mechanisms used in affecting change such as:
- Inter-sectoral collaboration/partnership working;
  - Community involvement/participation.
- c. Ultimate objective of
- Sustainability/mainstreaming of the initiative (Berkeley and Springett 2006).

While partnership working is currently the mechanism being adopted within Healthy Respect and other public health initiatives, there is little evidence of how it actually works in practice or indeed if it delivers the benefits predicted (improvement in access to services and information, improvement in the quality, coordination and delivery of services and the production of successful outcomes for the organisations involved and the end users). This adds further justification of the need for research which investigates how partnerships actually work in practice and their ability to achieve the outcomes predicted of them.

## ***2.5 Partnership working: A literature review***

### **2.5.1 Partnership definition**

Partnership working can be understood within systems theory as being an open or whole systems approach to service delivery. Stewart (2007) stated that there is an increasing advocacy for a 'whole systems' approach to service delivery to counter the tendency of fragmentation

and disconnectedness which can exist when organisations are 'closed' or not working together. Pratt et al (1998) described whole systems working as "an approach to organisational development that views groups of people coming together around a shared purpose as living systems". Systems are described as closed or open. Closed systems are characterised as being completely autonomous and independent of what is going on around them. Open systems on the other hand exchange materials, energy and information with their environment (Iles et al 2001). The system is open in the sense that there is constant interaction between each organisation or agent and all the other agencies that make up the environment they find themselves in. In the context of partnership working the 'system' must be thought of as the totality of players, including public, private, voluntary and citizens (Stewart 2007).

However, on examining the partnership literature it became increasingly obvious that there was no one agreed definition of partnership working. In fact the area of partnership working has been referred to, understandably, as a "terminological quagmire" (Lloyd, et al 2001). Terms such as collaboration, cooperation, coordination, coalition, network, alliance and partnership are often used interchangeably within the same literature (Huxham 1996, Percy-Smith 2005 and Sloper 2004). Relating to these problems of definition there are those that comment on how different forms of working may occur along a continuum, with isolation and integration as the extreme points (Powell et al 2001). Isolation refers to the absence of joint activity and integration refers to

organisations being ready to form a unitary organisation (Institute of Public Health in Ireland 2007).

Horwath and Morrison 2007 when discussing integration believed that five different levels of endeavour can be identified. At the simplest level, the focus is on communication between individual service providers. The next level refers to staff working together to deliver local services. The highest degree of integration occurs when whole systems collaborate with regard to the planning, commissioning and management of services (Horwath and Morrison 2007). Between the extreme points of both examples there may be some informal inter-agency contact marginal to the goals of the separate organisations; or contact may be more formal and structured but still marginal; or it may develop to a stage where joint working is seen by the agencies as central to mainstream activities and in which a level of trust has developed (Institute of Public Health in Ireland 2007).

However, which ever term is used, it can mean different things to different people under different circumstances (Elston and Fulton 2002, Glendinning 2003). Lowndes (2001) described partnership as a 'variety of arrangements with different purposes, time-scales, structures, operating procedures and members'. While the variety of definitions and descriptions may be confusing Wildridge et al (2004) stated that there are several commonalities between the different definitions offered for partnerships:

- Between organisations, groups, agencies, individuals, disciplines

- Common aim or aims, vision, goals, mission or interests
- Joint rights, resources and responsibilities
- New structure(s) and processes
- Autonomous, independent
- Improve and enhance access to services for users and carer's
- Equality
- Trust (Wildridge et al 2004).

Partnerships vary in purpose, objectives, scope of activities, philosophy, history, membership size and composition, organisational structure, degree of formality, budget, number and function of staff, and many other dimensions (Rosenbaum 2002). Powell et al (2001) categorised partnerships according to which sectors are involved, including public-private, public-public, public-voluntary and public community partnerships. Partnerships can also involve all these parties to make up what is referred to as multi-sectoral partnerships.

Ling (2002) suggested that partnerships work in different ways and variables include; membership; how partners are linked; the scale and boundaries of partnerships; and the organisational context of the partnership. Ling (2002) commented that given these variations, there is no single model of partnership in the UK.

This debate over the definition and type of partnerships also leads to problems with evaluation i.e. how do evaluators know what type of partnership work is being adopted in the project under investigation. Where partnership work has been evaluated it was rarely adequately defined and many of the studies assumed that evidence of supportive

attitudes to working in partnership were themselves a positive outcome and a proxy for success (Smith et al 2009). This has led many commentators to stress the need for those involved in partnership endeavors to make explicit from the beginning of the process, not only what was meant by partnership working in the project, but also what it was set up to achieve. This would then help to assess the extent to which outcomes could be directly attributable to partnership work.

In acknowledging and as a means of overcoming these problems; in this study the author chose not to define partnership work in arbitrary terms but instead preferred to describe what partnership working was in the context of the Healthy Respect project. Partnership working was an important aspect of Healthy Respect and was used as a means of delivering the complex sexual health intervention programme to the young people. In order to do this it relied on professionals and the organisations in which they operated to work together. It used Healthy Respect's logic model and subsequently the 'Theory of Change' to systemically analyse and therefore describe what partnership working was and how it worked in this project. A measure was developed to assess whether partnership work was taking place between organisations. This measure was then used to assess the extent to which partnership working could be associated with the intended outcomes as suggested in the logic model.

### **2.5.2 Drivers for and assumed benefits of partnership working**

Whilst, there may be problems associated with defining partnerships, there are many drivers for and assumed benefits to the adoption of



partnership working. The Audit Commission (1998) stated the 'wicked issues' as being a strong driver – problems that are both complex in themselves and also cross traditional organisational boundaries, so that agencies can only hope to tackle them adequately by working together. Barnes et al (2005) forwarded that health inequality is a prime example of a 'wicked issue'. Other reasons the Audit Commission (1998) gave for partnership working are to:

- Deliver coordinated packages of services to individuals;
- Reduce the impact of organisational fragmentation and minimise the impact of any perverse incentives that result from it;
- To meet a statutory requirement.

Entwhistle (2008) suggested that there are four main rationales or anticipated outcomes of partnership: advantages of scale, scope, supervision and learning. The advantage of scale suggests that partnerships allow public services, like their private counterparts, to maximise the return from scarce resources (Entwhistle 2008, McQuaid 2009). The advantages of scope suggests that partnerships are associated with improvements in the effectiveness and equity of service delivery and progress on the wicked issues that cut across public sector jurisdictions.

The supervision rationale suggests that in theory trusting forms of coordination (of which partnerships are characterised) solve the problem of significant transactional costs associated with principle agent problems i.e. hierarchical and market forms of working, by abolishing the

distinction between principles and agents. By uniting the intention of partners in common goals partnerships promise lower transaction costs, because partners do not, at least in theory, need to be supervised; they can be trusted to do the right thing because everyone is working towards the same goals (Entwhistle 2008). The supervision rationale draws attention to the importance of a series of behavioural characteristics like agreed goals, trust and communication.

The learning rationale posits that by engaging different groups and sectors in enduring and relatively equal consultative arrangements it is possible to make better strategic decisions about service delivery. In this way the new partnerships promise deeper and broader participation than can be realised through the traditional institutions of representative democracy (Entwhistle 2008). It is assumed that partnership working leads to increased organisational development through capacity building; where partnership working offers opportunities for the partners to learn from each other (Entwhistle 2008, Backer 2000). Professional development opportunities arise when colleagues share expertise and learn from each other through discussion of casework and joint interventions (Rudd et al 2004). Atkinson et al (2007) reported that positive impacts on professionals centred mainly on multi-agency activity being rewarding and stimulating, increasing knowledge and understanding of other agencies, and improving relationships and communication between agencies.

Partnership working is therefore thought to produce mutual benefits that range from additional resources, increased credibility, and better

understanding and responsiveness to community needs (Eilbert and Lafronza 2005, Gray 1989, Huxham 1996, Lowndes et al 1998, McQuaid 2009, Naidoo and Wills 1995). Weiss et al (2002) propose that partnerships gain an advantage over single agencies by creating what they refer to as 'partnership synergy'. A partnership creates synergy by combining perspectives, knowledge, and skills of diverse partners in a way that enables the partnership to a) think in new and better ways about how it can achieve its goals; b) plan more comprehensive, integrated programmes; and c) strengthen its relationship to the broader community (Weiss et al 2002). When partners effectively merge their perspectives, knowledge, and skills to create synergy, they create something new and valuable a whole that is greater than the sum of its parts (Weiss et al 2002).

However, what must be noted is that while there may be many assumed benefits to partnership working there is as yet very little research evidence to support these hypotheses (See for example Dowling et al 2004, Tait and Shah 2007, Smith et al 2009).

### **2.5.3 Barriers to partnership working**

Whilst there are many assumed benefits to partnership working, often what is overlooked by those proposing and advocating a partnership approach is the time, effort and resources needed for partnership formation. Partnership work is difficult to do well and making partnerships work effectively is one of the toughest challenges facing organisations. Despite the general agreement that partnerships are a

'good thing', there are many formidable barriers to successful partnership formation and functioning.

Many partnerships are difficult to establish, even harder to sustain, fail to achieve their full objectives, or are partnerships in name only (Provan et al 2005). Some of these problems can be blamed on the lack of adequate financial support to provide an administrative infrastructure for the partnerships or can be attributed to internal causes that are related to the partnership members themselves. For instance most community organisations must respond to their own particular set of constituencies or stakeholders, including funders, regulators and clients (Asthana et al 2002). Therefore these groups do not always believe that cooperation is in their organisation's best interests.

Sometimes central policy may require partnership working, but if the driver for agencies working together is principally Government insistence on them acting thus the internal dynamic for collaboration may be weak (Banks 2002). Culture clashes can also be expected from people who come from different sorts of organisations and need to find ways to work together. Wills and Ellison (2007) in undertaking a study examining challenges facing partnership working noted that it was unrealistic to expect agencies to identify common ground when each of them believe that each have legitimate 'core business' – a degree of agreement about different and discrete roles that has been dubbed 'domain consensus'. And while the legitimacy of each service's 'core business' drew partly on the (perceived) expertise of the staff therein and partly on their statutory responsibilities, this was reinforced by the largely stereotypical views

that participants from each service held of staff in each of the other services. In the main, this reflected widespread misunderstanding about the breadth of each service's activities and the values underpinning their professional and organisational culture (Berkeley and Springett 2006, Wills and Ellison 2007).

Traditionally the major partners in health improvement initiatives are: the Health Service and Social Services/Local Authority. As institutions, they have external similarities (e.g. rules, hierarchies, role structures) but the content of these elements (e.g. how things are done, what rules apply to what) is different (Berkeley and Springett 2006). The long history of difference and sometimes conflict between the two organisations, stemming from differences in culture, background, tradition, 'language', philosophies, priorities, perspectives and attitudes to public accountability have significant adverse effects on their ability to form working relationships (Hiscock and Pearson 1999).

As well as these two traditional bureaucracies, health improvement initiatives may also require the involvement of the voluntary sector and, sometimes the private sector. The organisational cultures and structures of organisations in these sectors vary markedly from those of the statutory organisations as well as between and within themselves. In general, both these sectors are more flexible in their approach and not usually bound by hierarchical order which characterise large statutory institutions. As such, they are often at odds with the rules and regulations which bind the statutory institutions (Berkeley and Springett 2006).

Health improvement initiatives call upon a variety of expertise (e.g. medics, social workers, managers, teachers, academics and community representatives). As a result, potential conflict situations may arise due to 'tribal' territorial thinking and the inward-looking aspect of professionalism (Beattie 1995, Hugman 1995, Springett 2005). Yet the current policy discourse focuses only on the need for partnership working assuming that 'if interagency partnership policies, processes and structures are established, then front line partnerships between a range of traditionally separate professions will fall into place' (Hudson 2002). However, Hudson (2002) argued that reasons which keep professions apart have to do with differences in:

- Professional identity i.e. the body of knowledge which becomes part of individual personal identity;
- Professional status i.e. at what level in the overall hierarchy of professions one's profession lies; and,
- Professional discretion and accountability i.e. discretion and accountability which arise due to one's professional role (Hudson 2002).

When evaluating the Sure Start Project in England for example, the main barriers to partnership working were:

- Time and money; partnership is resource intensive-getting agreement takes a lot of time and effort
- Professional barriers-partners have different languages, different codes and values

- Professional attitudes-to work together; providers need to be driven by the needs of the user-and each will see the user in a different way
- Working to targets and the current management emphasis on personal responsibility. Unless each partner has the same objectives, each will have a different agenda and may have different targets.
- Different planning and budgetary mechanisms and
- Different organisational structures-central, regional and local areas may be different (Barnes et al 2005).

#### **2.5.4 Factors thought to influence successful partnership working**

Previous published literature (Audit Commission 1998, Dowling et al 2004, Sloper 2004, Stewart 2007, Teenage Pregnancy Strategy Evaluation 2005) provides some indication as to what factors are thought to be characteristic of successful partnership working. For partnership work to be successful it is thought that certain things need to happen; starting from a basis of recognised need and/or previous joint achievement can help organisations achieve a shared vision, something regularly cited as key to successful partnership working (Hardy et al 2000, Gray 1989, Huxham 2000). Another commonly cited ingredient is trust. Indeed trust is the key concept raised in all discussions about the attributes of successful partnership work (Stewart 2007). The consensus is that, although it is possible to work jointly with little trust between partners, the most successful partnerships have a strong level of mutual trust (Wildridge et al 2004).

Research suggested that success with implementation and partnership maintenance is associated with good leadership (Rosenbaum 2002). Partnership working might appear to diminish the importance of leadership (because partnership may involve the suppression of strong leadership in the interests of consensus building). However, in practice leadership is as necessary in partnership ventures as in single organisational development. Good leadership would inspire vision, enthusiasm and commitment, and command the trust of other partners (Buonocore 2004, Rosenbaum 2002, Schaefer 2004, Stewart 2007). Leaders need to be able to transform practice cultures to achieve the desired outcomes (Outhwaite 2003, Wagner 2004, Wesorick, 2002). Kerfoot (2001) has gone so far as to suggest that successful leaders will motivate the group to achieve outcomes that exceed the prospects of the endeavour.

Another important factor especially connected to sustainability is that of organisational ethos, does the organisation or partner believe in what the partnership is trying to achieve, is the organisation a willing and enthusiastic partner because it sees the benefits of joint working in relation to client outcome. Sustainability is often described as 'institutionalisation' and refers to the extent to which a new programme becomes embedded or integrated into the normal operations of an organisation (O'Loughlin et al 1998).

The literature suggests that effective communication between partners is also regarded as important for successful partnership working. Several writers stressed the importance of effective communication systems



between agency partners and often within agencies, and between the collaborative project and mainstream services (Hardy et al 2000, Balloch and Taylor 2001). Communication, it is argued, builds awareness, understanding and trust (Balloch and Taylor 2001). To build a partnership it is vital that an organisation:

- has a good understanding of the current state of the communications and relationships between the partners
- plans and structures communication to ensure they are working to build partnership
- work with each other and behave in a way that supports the kind of communication that enables partnership (Hardy et al 2000).

Context of the partnership - the conditions that give rise to a collaborative partnership can also influence its growth and potential effect on community health (Roussos and Fawcett 2000). Some of these conditions include the community history of previous collaboration to address related concerns and whether the partnership forms in reaction to a felt community concern, opportunities for external funding, and/or other occasions. Although these conditions are not mutually exclusive, each may exert different influences on the functioning of a partnership (Roussos and Fawcett 2000).

Another factor often referred to in the literature for successful partnership working is the part that senior management support plays. Brinkerhoff (2002) reported that senior management support contributes

to partnership performance both directly and indirectly. Directly, such support translates into resource commitments (e.g. financial, personnel etc) and often entails flexibility to accommodate partner preferences and constraints, or to maximise partnership performance. Indirectly, the participation and support of senior management symbolises the organisations commitment to the partnership and its success, contributing to trust building among partner organisations and giving the green light for front line workers to become involved in the initiative.

Partnership working is also believed to be dependent on the level of engagement and commitment of partners i.e. the strength of the relationship (Amery 2000, Bliss et al 2000, and Evans and Killoran 2000, Goodwin and Shapiro 2002 and Sullivan et al 2002). The level of engagement and commitment of partners has previously been evaluated by examining the enthusiasm of partners for the partnership, as reflected in their behaviours and /or beliefs of the partnership (Dowling et al 2004, Smith et al 2009). However, Dowling et al (2004) and Smith et al (2009) stressed that many of the studies evaluating partnership work focused mainly on partnership work between health and social care organisations; and used mainly qualitative methods of enquiry which focused on capturing the perceptions of managers or other actors involved in implementing the partnership-based interventions. Summarised in Table 2.1 are some the factors thought to influence successful partnership working along with effectiveness criteria and selected practical issues.

**Table 2.1 A summary of factors thought to influence successful partnership working**

<b>Elements of successful partnerships</b>	<b>Effectiveness criteria</b>	<b>Selected practical issues</b>
Levels of engagement	Strength of relationship	Facilitating communication within and across different organisations and addressing areas of faltering or non engagement
Leadership/Management	Creation and maintenance of an organisational culture and administrative infrastructure which facilitates partnership working	Addressing organisational barriers to partnership working, providing adequate leadership and management, achieving commitment of both senior and frontline staff
Commitment of partners, agreement of the purpose and need for the partnership	Member commitment to partnership processes and aims	Addressing differences in the interpretations of the purpose and need for partnership working, in the prioritisation of activities, in the choice of success criteria
Formalisation of the partnership	Formalising ties between organisations to increase sustainability	Drawing up of explicit partnership agreements or frameworks
Partnership working mainstreamed into the normal activities of the organisation	The relationship between organisations permeates each organisation and has become institutionalised	Moving partnership work from project status and making it part of daily service provision
Funding for partnership working	Resource acquisition and allocation	Providing time, personnel, education and training
Trust in partner organisations	Levels of trust perceived between partners	Negotiation of and confidence in the roles and responsibilities of individual professions

It is important to note that while these factors have been cited in the literature as important characteristics of successful partnership working; they clearly fall short of any measures of outcome success related to service outputs, service delivery or health (Dowling et al 2004, El Ansari and Weiss 2006, Smith et al 2009). They simply refer to how the partnership is functioning (the process of partnership) rather than adding to understanding of the end results of partnership working i.e. the products produced by the partnership (outcomes). Dowling et al (2004) reported that much of the literature pertaining to partnership work has focussed heavily on these 'process' issues while there is less evidence that partnerships produce successful outcomes for staff, users, financial sponsors or other stakeholders. This may be due to a number of

reasons that are discussed in more depth in the following section which examines the literature on evaluating partnership working.

### **2.5.5 Evaluation of partnership working**

Holtom (2001) noted that it is difficult to find a contemporary policy document or set of good practice guidelines that does not have partnership as the central strategy for the delivery of welfare. The message appears clear: the pressure to collaborate and join together in partnership is overwhelming. However, this increased belief in partnership working is not necessarily borne out by research.

There are those that report that partnerships can in fact lead to governance failure, may generate more costs than benefits, and may not provide an unqualified answer to the problems they are set up to address (Davis 2002). Barnes et al (2005) reported on the evaluation of Health Action Zones (HAZ) in England; found that partnership working did not achieve the goals identified at the start of the programme. Mann et al (2004) also commented on the scant evidence that efforts using partnership working in the public sector have improved outcomes for service users and warn that it can in fact lead to losses for less powerful partners, particularly those from the voluntary sector. Despite the rhetoric of partnerships, reports of success in terms of the outcomes of partnership working for health improvement are rare (Dowling et al 2004, El Ansari and Weiss 2006, Smith 2009).

There are a number of tools available to assist in establishing the readiness for partnership working and actions that need to be undertaken to deal with the gaps identified (Audit Commission 1998,

Department of Health 1999, 2001, Hardy et al 2000). In general, these tools ask people considering partnership work to assess whether or not a partnership is appropriate, to evaluate the presence of factors associated with partnership formation and function (often used as a checklist) and to consider how to establish or improve these factors if they are lacking or poorly developed. Many of these tools are regarded as providing the 'ingredients for successful partnership working'. However, as Cameron and Lart (2003) noted many of the definitions of success in the literature are often unclear. They concluded that although there is a dearth of evidence to support the notion of successful partnership working both the definition and measurement of success is often unclear. Sullivan and Skelcher (2002) also report that theoretically informed and empirically supported analysis of the value, type and role of partnership working in delivering public services is severely constrained.

Evaluating partnership working raises substantial methodological challenges. First, as discussed earlier there is a problem with defining partnership. Most commentators have concluded that there is no clear and uncontested definition. The second problem relates to the concept of success, there are a number of possible criteria for success and different stakeholders may attach different weights to these various criteria (Glendinning 2002). Third process measures are sometimes classed as outcomes (Dowling et al 2004, Smith et al 2009). For example, developing relationships or trust might be seen as a process, while relationships and trust can also be viewed as outcomes of partnerships (Asthana et al 2002).

Most of the research on partnership work has assessed the process of partnership working rather than outcomes for those using services. (National Audit Office 2001, Hudson and Hardy 2002, Sullivan and Skelcher 2002). This may be largely due to the fact that emphasis on the process of partnerships may be seen as a pragmatic, albeit second-best, solution. This avoids the challenge of identifying outcomes that may take a long time to materialise and also be difficult to attribute to the partnership (Dowling et al 2004). Evaluating partnership working for health improvement may therefore prove difficult for a variety of reasons; the long time scale needed for achieving impact, different perspectives on what success means, the complexity and variability of partnership interventions, and the different contexts within which partnerships work (El Ansari et al 2001; Boydell 2007; Institute of Public Health in Ireland 2007, Shortell et al 2002).

The broad aim of community health improvement initiatives is to ultimately improve (often distant) population level outcomes. For Healthy Respect this meant a reduction in teenage pregnancy and a reduction in the rate of sexually transmitted infections (STI's). Yet partnerships face several challenges in measuring their contribution to these more distant level outcomes (Roussos and Fawcett 2000). First, visible changes in population level outcomes may take longer than the lifetime of many of the partnerships. Changes in most community health areas may not be detectable for 3-10 years (Roussos and Fawcett 2000). Also more fundamental health goals, such as changing income disparities or health inequalities in health outcomes associated with race, gender or social isolation may take generations to change. Second, there is an absence

of accurate and sensitive indicators for many community health concerns. For example delayed reporting or underreporting of cases (e.g. for pregnancy there is often an underreporting of pregnancies that did not result in a live birth). Some authors argue that in fact evaluating the effects of partnerships on population outcomes may not be prudent, given the minimal understanding of the contexts and mechanisms by which they operate (Nezlek and Galano 1993 and Roussos and Fawcett 2000).

Shortell et al (2002) suggested that process-outcome evaluations can better address the above issues by (1) assessing progress against a well specified and articulated vision of what is supposed to be achieved; (2) explicitly giving attention to issues of partnership on individual participating organisations; and, (3) developing a monitoring, evaluating, and tracking system that spans multiple stages of a partnership's evolution in order to assess the sustainability and impact of it's efforts over time.

In recognition of the above evidence, the author acknowledges that the measuring of the long term outcomes associated with young people's sexual health (i.e. reduction in the rate of both teenage pregnancy and STIs) may be out with the scope of this study and was in fact part of the main evaluation. The main purpose of this PhD study was to focus on the part partnership working played within the project. It was therefore felt to be more important to theoretically understand the context, form

and what could be achieved through partnership working from an organisational perspective.

#### **2.5.6 Theoretical Approaches for the Evaluation of Partnership Working in Healthy Respect**

Brickmayer and Weiss (2000) believed that theory led approaches allow the researcher to say with some confidence which parts of the programme worked and why, whether they would be applicable to different situations, and if there are any positive or negative effects which would otherwise not be anticipated. Gambone (1998) suggested that data collected without 'theory' has the status of 'information' and is limited to describing phenomena, while data collection guided by theory produces what can be called 'knowledge'. Weiss (1999) pointed out that because of the complexity of partnerships and concerns over issues of attribution, theory led evaluation has become more frequently embraced within partnership evaluations.

Two theoretical approaches to evaluation have become popular in the UK. First is the 'Theory of Change' which was used in the national evaluation of Health Action Zones in England (Judge and Bauld 2001) and second is 'Realistic Evaluation' which was used to evaluate the Health Education Authority's Integrated Purchasing Programme (HIPP) (Evans and Killoran 2000). At their simplest both the Theory of Change and Realistic Evaluation emerged to fill a deficit in policy and programme evaluation. There is also a third methodological approach which has been used to assess the relationship between organisations, which is social network analysis. Despite its use in other areas i.e. sociology and



organisational theory, it's uptake in the social sciences and in particular for public sector evaluations is less evident.

### **2.5.7 Theory of Change**

The Theory of Change has been developed over a number of years by the Aspen Institute (Connell et al 1995, Fulbright-Anderson et al 1998). It was developed in an effort to find ways of evaluating processes and outcomes of community based programmes that were not adequately addressed by existing approaches.

The approach is defined as a 'systematic and cumulative study of the links between activities, outcomes and the context of an intervention (Connell and Kubisch 1998). The evaluation process is used to determine the programmes intended outcomes, the activities it expects to implement to achieve those outcomes, and the contextual factors that may have an effect on implementation of activities and their potential to bring about desired outcomes. A logic model provides the basic framework for this type of evaluation. A logic model is a graphic representation of the intervention. It illustrates how the activities identified connect to the results or outcomes the intervention is trying to achieve. Similar to a flowchart, it lays out program activities and outcomes using boxes, and, uses arrows to connect the boxes, which shows how the activities and outcomes connect with one another. By developing a theory of change based on good theory, programme planners can then be better assured that their programmes are delivering the right activities for the desired outcomes. This study uses Healthy Respect's logic model to theoretically examine if and how

partnership working developed, what factors may have influenced its development within the project and whether it achieved its intended outcomes. The Healthy Respect logic model can be viewed in Appendix A.

As Weiss (1998) pointed out the theory of change is simply a ‘theory about how and why a programme will work’, according to those involved in the intervention planning process; in this case the Healthy Respect team. The primary benefit of this approach is that it makes explicit what are often implicit linkages between process and outcomes (Tilley 2007).

Connell and Kubisch (1998) offered three reasons for using a theory of change approach when evaluating comprehensive community interventions:

- The planning and implementation of the initiative will be sharpened. There will be less ambiguity among stakeholders about what outcomes are expected and what activities and processes are needed to achieve them. An emphasis on programme logic or theory during the design phase can increase the probability that stakeholders will clearly specify the intended outcomes of an initiative, the activities that need to be implemented in order to achieve them, and the contextual factors that are likely to influence them.
- The theory of change will suggest how and when to measure various constructs identified in the logic model, from inputs to mediating processes to outcomes.

- The problems with causal attribution of impact are reduced. If stakeholders agree, in advance, on the theory of change, then observed changes between relationships can be used to support or question the causal assumptions behind the theory.

Blamey and Mackenzie (2007) highlighted the importance of considering context as part of the evaluation process. They believe that considering context as part of the evaluation can be key to uncovering the circumstances in which, and the reasons why, a particular intervention works. The 'Theory of change' approach acknowledges that particular contexts can enhance or detract from programme effectiveness and that such contexts may include factors that are within or outside the control of programme implementers. An understanding of context is therefore vital in relation to attributing cause and is seen as important in terms of replicating the intervention in any future setting or in learning about possible generalisable causal pathways (Blamey and Mackenzie 2007).

However, while the use of a 'Theory of Change' (TOC) is attractive for this kind of study it is not without its problems. Mackenzie and Blamey (2005) in their paper 'Lessons from the application of a Theories of Change approach' highlighted several problems encountered in practice. The first being that the ideal time to undertake a TOC is at the planning phase of an initiative, the reality is, that for the vast majority of UK Government funded initiatives, external evaluation teams and project planners are rarely given this window of opportunity. This is consistent with Sullivan's analysis of limitations to a TOC approach in relation to the National Evaluation of Health Action Zones in England,

*Even though it is now common in UK public policy for an evaluation requirement to be part of the process of policy implementation, the time taken to invite tenders and negotiate the brief means that it will be rare for evaluation and programme to develop contemporaneously.* (Sullivan et al 2002)

There is therefore little opportunity for programme planners and evaluators to come together to produce a good comprehensive Theory of Change approach. Mackenbach and Bakker (2002) also acknowledged that a 'Theory of change' approach to evaluation cannot eliminate all alternative explanations for a particular outcome. What it can do is provide key stakeholders with evidence grounded in their own assumptions and experiences that will be convincing to them (Mackenbach and Bakker 2002). At a more general level the 'Theory of Change' approach assumes that the more the events predicted by theory actually occur over the lifetime of an initiative, the more confidence evaluators and others should have that the initiative's theory is right (Mackenbach and Bakker 2002).

#### **2.5.8 Realistic Evaluation**

Another theory led approach (not unlike a 'Theory of Change') is 'Realistic Evaluation' developed by Pawson and Tilley (1997). Tilley (2007) stated that traditional experimentation methods for evaluation asks "Does this work?" or "What Works"? Whereas the question being asked in Realistic Evaluation is "What works for whom in what circumstances?" The key problem in evaluation is to find out how and under what conditions a given measure will produce its impacts. Pawson and Tilley (1997) observed that "armed with an understanding of how measures will produce varying impacts in different circumstances the

policy maker and practitioner will be better able to decide what policies to implement in what conditions”.

Just like the ‘Theory of Change’ Realistic Evaluation (RE) places context as an important part of the evaluation process. Realist evaluators stress that context (and not outcomes alone) is crucial in the evaluation of any social programme. The ‘mechanisms’ which generate change - the choices and capacities which are made available to participants - and their operation is always contingent on context: ‘subjects will only act upon the resources and choices offered by a programme if they are in conducive settings’ (Pawson and Tilley 1997). Pawson and Tilley (1997) stated that context should not be confused with locality. Depending on the nature of the intervention, what is contextually significant may not only relate to place but also to systems of interpersonal and social relationships and even to biology technology, economic conditions and so on.

Realistic Evaluation is a method of ‘logical inquiry’ that generates distinctive research strategies and designs (Tilley 2007). Pawson and Tilley (1997) reported it could be used prospectively (in formative evaluations), concurrently (in summative evaluations) or retrospectively (in research synthesis). It has no particular preference for either quantitative or qualitative methods, and indeed it sees the merit in multiple methods, marrying the quantitative and qualitative, so that both programme processes and impacts may be investigated. The precise balance of methods to be used should be selected in accordance with the hypothesis being tested, and with the available data.

### **2.5.9 Social Network Theory and Analysis**

Social network theory and analysis is well established in assessing the links between organisations, but its utility has not been fully realised in the public sector or as a means of examining partnership working (Luke and Harris 2007 and Provan et al 2005). Provan et al (2005) stated that despite the use and acceptance of social network analysis in the academic literature, most notably in sociology and organisational theory, there have been few reported attempts to use the procedure to actually assist in the evaluation of partnership working. This they note is unfortunate, not only because the prevalence and importance of partnership work is extremely high, but also because a practical understanding of how partnerships operate and how they can be strengthened could be enhanced considerably through the use of social network analysis (Provan and Milward 1995, Provan et al 2005, Wasserman and Faust 1994, Weiner and Alexander 2009).

Based on the theoretical constructs of sociology, mathematical foundations of graph theory and recent developments in computer hardware and software, social network analysis (SNA) offers a unique methodology for visualizing and investigating social structures and relations (Wasserman and Faust 1994). While a general social survey usually allows for studying individuals' properties as the prime context for explaining outcome, SNA incorporates the social context to explain individual or group outcomes. The relationships between the actors become the focus of study and the properties of the actors themselves remain secondary.

The field of network study has also developed many measures to locate central agents, find groups, identify positions in a network, and describe overall network properties (Scott 2005). The data gathered for social network analysis is relational data which is the contacts, ties and connections, the group attachments and meetings, which relate one agent to another and so cannot be reduced to the properties of the individual agents themselves (Scott 2005).

In the process of working in this field, network researchers have developed a set of distinctive theoretical concepts and central principles underlying the network perspective;

- Focus on relationships between actors rather than attributes of actors
- Sense of interdependence: a molecular rather than atomistic view
- Structure affects substantive outcomes
- Emergent effects (Borgatti and Foster 2003).

### **2.5.10 Summary**

Overall, the review suggests that partnership work is not easy to evaluate, yet current government policy and public health practice both advocate and promote partnership working as being the most appropriate method of delivering services and tackling the wider determinants of health. Although it might appear that this preference for partnership work rests upon clear evidence of the superiority of partnerships this does not appear to be the case (Dowling et al 2004, El Ansari et al 2001, Smith et al 2009). Much of the research that has been

undertaken in the health field relates to partnership work taking place between health and social care agencies and does not relate directly to partnerships for health improvement (Smith et al 2009).

The literature highlighted that there was very little known about the outcomes of partnership working especially for public health interventions. This is despite the fact that a number of publications have attempted to draw out the key ingredients of 'successful' partnership working (Asthana et al 2002, Sullivan et al 2002, Smith et al 2009, Wildridge et al 2004). This appears to be because, partnership studies in the past have been concerned with the process and ingredients conducive to the success of the partnership (such as the level of trust between partners, clear aims and shared goals) than they have been with exploring the outcomes of partnership work (Boydell and Rugkasa 2007, Dowling et al 2004, Smith et al 2009). Evaluation studies using these types of frameworks have often been formative rather than summative in nature. Good processes, however, are not a guarantee of good outcomes and while process evaluation is important it should not stand alone (Boydell and Rugkasa 2007).

Using purely quantitative or qualitative methods led approaches to evaluation have proved to be insufficiently complex, and have largely failed to overcome the ability to attribute change specifically to partnership. In an attempt to overcome some of these methodological and conceptual issues, the literature review highlighted the importance and increasing use of theoretical approaches to evaluation. A social



network analysis was also highlighted within the literature as a useful tool for assessing and visualising partnership work in practice.

There appears to be an implicit assumption among policy makers that partnerships are a 'good thing' which will aid attempts by organisations to improve public health. The health promotion literature also emphasised the need for partnership working to tackle the wider determinants of health. And when reviewing the literature on sexual health intervention programmes those thought to show the most promise in promoting young people's sexual health and wellbeing were those programmes that were multi-faceted/multi-agency. However, the current evidence base on the effects of public health partnerships on producing positive outcomes for organisations and young people is scarce and methodologically limited.

Overall the review found that there was little evidence of the outcomes of public health partnerships. Where successes were observed, it was difficult to assess the extent to which these were directly attributable to partnership working. Partnership working was rarely defined and many of the studies assumed that evidence of supportive attitudes to working in partnership were themselves a positive outcome of success. The methods of evaluation used in the past have failed to assess the complexity of partnership working.

The fact that evidence on the effectiveness of partnerships is lacking does not necessarily mean that they are ineffective but, without such evidence, it ought to be acknowledged that the benefits attributed to this way of working are largely presumed (Smith et al 2009). The costs

associated with partnerships (both in terms of financial resources and staff time) are high and given the frequent use of partnership working in recent years, there is a need for studies like this to add to the current knowledge and evidence base on the subject.

Healthy Respect is an example of a public health programme that relied heavily on a partnership approach to deliver and implement a complex sexual health intervention to young people. This project allowed the author of this study the opportunity to examine and assess partnership working in more depth. Using the knowledge and evidence gained from the literature review it became apparent that there was a need to better understand partnership working in health at a theoretical level i.e. to understand what might work with regards to partnership working for health improvement and the benefits produced by it. A process-outcome evaluation was preferred and a mixed methods approach adopted.

The logic model produced by Healthy Respect was used as a framework and informed the evaluation. The logic model illustrated the inputs, outputs and outcomes of the project and this in turn was used to explain Healthy Respect's theory of how change was predicted to occur through partnership working in the project. It is therefore important to note, that the study did not apply a full 'Theory of Change' approach as developed by the Aspen Institute. The study used Healthy Respect's logic model to examine and measure the change predicted to occur through partnership work in the project. It also incorporated a social network analysis to visually display the links between the organisations involved

and the strength of these links. The approach used will allow the researcher to answer the following research questions:

- 1. What is partnership working:**
  - a.** Between the Healthy Respect Team and other organisations who deliver sexual health education, information and services to young people?
  - b.** Between the organisations who deliver sexual health education, information and services to young people?
- 2. What influenced partnership working between Healthy Respect and the other organisations?**
- 3. What were the outcomes of partnership working between the Healthy Respect Team and the other organisations?**

The study by using Healthy Respect's logic model will theoretically draw conclusions as to what might work in relation to partnership working for the sexual health improvement of young people. The design and methods adopted for the study will be discussed in more detail in the following chapter.

## **Chapter 3: Research Design and Methods**

### ***3.1 Introduction***

The evaluation of Healthy Respect (Phase 2) was conducted by a team of researchers managed by Health Scotland on behalf of the Scottish Government. As a member of the evaluation team the author has been fully involved in the study design and implementation of the research tools used for the main evaluation and in particular for the assessment of partnership working. This PhD study evolved from the main evaluation and remained a separate piece of research which focused exclusively on the assessment of partnership working. Whilst the methods adopted for the main evaluation were used in this study, the author was heavily involved in the construction of the evaluation tools and in the collection of the data. The analysis of the partnership data was undertaken solely by the author.

This PhD study aimed to 'Assess the extent and impact of partnership working in the Healthy Respect (Phase 2) National Sexual Health Demonstration Project' using a theoretical approach.

### ***3.2 Theoretical approach***

This PhD study makes a contribution to knowledge by evaluating partnership working in practice. The study adopted Healthy Respect's Logic Model and their 'Theory of Change' (TOC) to evaluate partnership working within the project as a means of overcoming some of the methodological issues outlined in Chapter 2, particularly relating to attribution and causation. Theory led evaluations aim to map out the entire process thereby drawing attention to predetermined links between

what is delivered and the intended outcomes (Weiss 1998). Although a Realistic Evaluation would have been an alternative theoretical model to use as a framework for this study, the existing logic model (developed by Healthy Respect) was already in place prior to the commencement of this PhD study.

The logic model and subsequent theory of change specifies, how activities will lead to interim and longer-term outcomes and identifies the contextual conditions that may affect them (Connell and Kubisch 1998). This helps strengthen the case for attributing subsequent change in these outcomes. This approach assumes that the more the events predicted by theory actually occur over the lifetime of the project, the more confident we can be the project's theory is suitable. In other words how partnership working may theoretically lead to the improvement in young people's sexual health and wellbeing.

The Healthy Respect team used a logic model to illustrate their theory of how Change was predicted to occur within the project. It was used to describe the rationale and process leading to both the short and long-term outcomes (Appendix A, Healthy Respect Programme Logic Model).

### **Healthy Respect's Theory of Change**

It was Healthy Respect's aim to improve the sexual health and wellbeing of young people in Lothian with an enhanced focus on tackling sexual health inequality (Evaluation of Healthy Respect Phase Two: Interim Report 2008). They believed that the best way to do this was by working in partnership with other organisations to deliver the multi-faceted

programme of education, information and services to young people (Healthy Respect 2004). This belief was informed by evidence suggesting that a multi-faceted approach was required to maximise the impact on young people's sexual health outcomes such as increasing knowledge, improving attitudes and changing intentions around delaying sexual activity and using contraception (Fraser 2006, Scottish Executive 2005, 2006).

### **The Theory of Change as applied to partnership working within the Healthy Respect Project (See Appendix A Logic Model)**

Actions: The Healthy Respect Team provided programme coordination functions i.e. leadership and advocacy for partnership working, provided resources i.e. training packages, funding, materials and printed media; delivered training and continued professional development courses, ongoing support to organisations, and delivered and encouraged attendance at networking events (Healthy Respect Programme Logic Model Appendix A).

People: Healthy Respect identified a range of professionals considered well placed to deliver education, services and information to young people in Lothian. These included teachers, school nurses, youth workers, social workers and staff within the voluntary sector. Healthy Respect aimed to provide a population based approach and so set out to engage professionals who could reach large numbers of young people. However it also wanted to target young people who were at particular risk of poor sexual health outcomes, and so focused their attention on engaging professionals who worked with young people who were looked

after and or accommodated by the local authority, excluded from school and attending youth work settings and those who had learning disabilities. Healthy Respect also targeted parents and saw them as mediators through which they would engage with young people (Evaluation of Healthy Respect Phase Two: Interim Report 2008).

Setting: Lothian wide with a particular focus on two areas, namely Midlothian and North West Edinburgh to demonstrate implementation across a whole local authority and an area of high deprivation, respectively (Evaluation of Healthy Respect Phase Two: Interim Report 2008).

Intended Outcomes:

- Engagement of partners in HR2,
- Partners committed to programme delivery,
- Increase in professional capacity and confidence (knowledge, skills and networking),
- Improvement in links between education and services,
- HR2 partners feel supported, increase in access to information and increase in professional networking opportunities,
- Increase in professional capacity and confidence of youth work for those professionals working with vulnerable young people,
- Increase in access to quality services (13-18 year olds and excluded groups). It is worth noting that sexual health services were not available to Primary School pupils.
- Leading ultimately to a partnership network with increased capacity to deliver a coherent and multi-faceted intervention

programme creating an environment that positively influences the cultural and social factors that impact on sexual health and relationships (See Healthy Respect's Programme Logic Model Appendix A)

The assumptions Healthy Respect made about partnership working within the project

- The context (political, social and environmental) within which the project was being established was amenable to change i.e. systems change (partnership working) and a change in the way programmes and services were to be delivered.
- Partners able and willing to engage with Healthy Respect
- Partners able to tackle sexual health inequality and other sexual health outcomes
- Healthy Respect's ability to increase both organisational and professional capacity and capability to undertake sexual health work with young people

The theory of how partnership work was predicted to occur in the Healthy Respect project was illustrated through the logic model. The logic model illustrated the purpose and content of the partnership programme, and evaluation questions emerged from a variety of the programmes vantage points context, implementation and results. (this includes output, outcomes and impact). These areas for assessment relate directly to the three research questions being asked, namely:



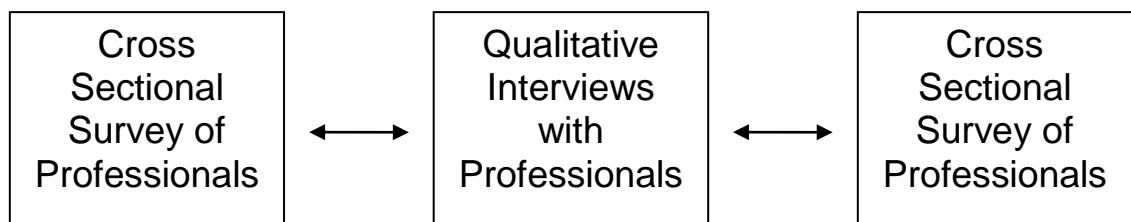
## Key Research Questions

1. What is partnership working:
  - a) Between the Healthy Respect Team and other organisations who deliver sexual health education, information and services to young people?
  - b) Between the organisations who deliver sexual health education, information and services to young people?
2. What influenced partnership working between the Healthy Respect Team and the other organisations?
3. What are the outcomes of partnership working between the Healthy Respect Team and the other organisations?

The following section examines the methods used as a means of answering these three questions.

### 3.3 Study Design

A mixed method research design was used to address the research questions and examine the underlying theory of change within the project (Figure 3.1).



**Figure 3.1 Research Design**

### **3.3.1 Why use two methodological approaches in this study?**

The TOC approach adopted for this study did not emphasise the use of one particular methodology over another. This along with evidence gained from the literature review suggested that past methodologies had not adequately accommodated and sufficiently captured the complexity and scope of partnership working (El Ansari and Weiss 2006); led the author to believe that a mixed methods approach to evaluating partnership working was optimal for this study.

Purely quantitative methods of enquiry used in the past have failed to assess and examine the processes within the partnership leading to attribution issues. While purely qualitative studies although able to give an in depth account of the process and context fail to quantify the outcomes of partnership working. The use of the two methodological approaches in this study therefore allowed the best chance of examining the underlying theory of partnership working in the project and answering the research questions set.

Much debate has occurred since the 1960's on the usefulness of combining quantitative and qualitative research methodologies in the same study (Creswell 2003, Taskakkori et al 1998). While a number of academics remain deep rooted in singular views of either quantitative or qualitative research methods, others advocate views of these methods which are complementary. For instance Curlette (2006) believes data collected using qualitative techniques can be used to support conclusions reached by performing tests on quantitative data and vice versa.

According to Frechtling et al (1997) one benefit of using a mixed method study is that combining the two approaches sharpens understanding of the research findings. For example, rejecting a quantitative null hypothesis can be clarified by using comments made from qualitative interviews. Mixed method research designs however, are not without their disadvantages. According to Creswell (2003), the mixed method researcher has to be knowledgeable in both qualitative and quantitative designs. This generally means more time and effort on the part of the researcher. The researcher benefited from the methods (and therefore the data) used in the main evaluation study which allowed the author to bring a large amount of information and data into the thesis, which may not have been possible for a single researcher. It also allowed the author to enhance her research knowledge and skills.

A mixed method design accumulates evidence from a variety of different sources and employs different research methods in order to generate conclusions concerning the outcomes of a project (Billings 2000). A portfolio of evidence that details the processes and events that take place during and as a consequence of a project is thus compiled (El Ansari and Phillips 2001).

Quantitative research methods such as the surveys answered questions like 'who was doing what and where' and to what extent, qualitative methods, were used to describe the change in process and answer the 'why and how the partnership worked within certain contexts. The current study was further enhanced by undertaking a social network analysis of data obtained from the second survey.

The quantitative data collected also allowed the researcher to measure how successful the partnership working was in terms of its strength and function (process). The outcomes of partnership working were measured by examining its impact on organisational outcomes. Inferential statistical techniques were used to examine the relationship between the process and outcomes of partnership working in this project.

The qualitative data allowed the researcher to get behind the thinking of partnership work in the project from the provider's perspective. It allowed data to be collected that enhanced and added value to the quantitative data and allowed for the identification of factors that impacted on the provider's ability to work in partnership with Healthy Respect. The social network analysis allowed for the examination of the structure, the links and the strength of the links between the different organisations involved in each of the geographical areas covered by Healthy Respect. In other words the researcher used a mixed method approach in this study to extend the breadth and range of inquiry into the assessment of partnership working in the Healthy Respect project.

The methods used in this study relate to the three research questions that emerged from the Logic Model and the assumptions made about how change was likely to occur through partnership working. Table 3.1 provides a summary of the three research questions, the methods used to extract the data and the type of analysis undertaken as a means of answering the research questions.

**Table 3.1 A summary of the research questions, data and type of analysis**

<b>Research Question</b>	<b>Data</b>	<b>Analysis</b>
<p>Question 1: What is partnership working?</p> <p>a) Between the Healthy Respect Team and other organisations delivery sexual health education, information and services to young people</p> <p>b) Between organisations delivering sexual health education, information and services to young people</p>	<p>Quantitative data: first and second wave survey data of professionals delivering sexual health education, information and services to young people</p> <p>Quantitative data: second wave survey (which included social network questions)</p>	<p>Descriptive statistics used to describe the organisations involved with Healthy Respect and the geographical areas covered. Bivariate statistical techniques to compare partnership at first and second wave survey data level. A partnership measure developed (partner engagement score) to examine the strength of the relationship between organisations and Healthy Respect.</p> <p>Social network analysis used to examine the links between organisations in each of the geographical areas covered by Healthy Respect. Partnership measure developed to examine the strength of relationship between the organisations</p>
<p>Question 2: What influenced partnership working between the Healthy Respect Team and organisations?</p>	<p>Qualitative data: Interviews with professionals</p>	<p>Content analysis of interviews to examine provider's perceptions of factors thought to influence partnership work between organisations and Healthy Respect.</p>
<p>Question 3: What are the outcomes of partnership working between the Healthy Respect Team and other organisations?</p>	<p>Quantitative data: first and second wave survey</p> <p>Qualitative data from interviews with professionals</p>	<p>Inferential statistical techniques used to examine whether there was an association between partnership working (as measured through the use of the partner engagement score) and professional and organisational outcomes</p> <p>Data extracted from interviews relating to the impact of partnership working with Healthy Respect used to better understand the quantitative results.</p>

### **3.4 Study Methods**

#### **3.4.1 Samples both surveys and qualitative sample**

An initial cross-sectional survey and further follow up survey were carried out with those professionals working in organisations providing sexual health education, advice or services to young people aged between 10-18 years old (Only those aged 13 years and over were targeted by sexual health services). The questionnaires used were developed and implemented by the author of this study and other members of the evaluation team.

#### **3.4.2 Survey Samples**

Both surveys were aimed at those professionals working in: Midlothian, Edinburgh City, North West Edinburgh, West Lothian, and East Lothian. A purposive sample was used and consisted of a) contacts provided by the Healthy Respect team and b) providers identified by the research team.

##### **a) Contacts provided by the Healthy Respect Team**

These consisted of teachers in secondary and primary schools, professionals working in agencies responsible for vulnerable young people, those in sexual health services such as drop-in clinics, pharmacies taking part in the Emergency Contraceptive 72 scheme (EC72), school nurses, and staff from voluntary agencies. The professionals responsible for vulnerable young people included Social Workers, Community Learning and Development Workers, those working in Pupil Referral Units and those working with young people with

learning disabilities. A full list of professionals was drawn up in collaboration with the Healthy Respect Team and each was sent a self completion questionnaire.

b) Providers identified by the research team

The research team sought to identify a sample of providers who may be less engaged with Healthy Respect. They had to deliver education, advice or sexual health services to young people, but did not appear on the Healthy Respect contact data base. These were drawn from the same geographical area in which Healthy Respect operated namely Midlothian, Edinburgh City, East and West Lothian and sector i.e., Education, NHS, Local Authority, and NGOs. The sample included teachers and staff working in non Healthy Respect primary and secondary schools, staff working in Higher education student services, General Practitioner (GP) practices, child protection advisors, C:Card workers, community paediatricians, staff working in youth clubs and staff working in voluntary organisations.

The Evaluation Team conducted an independent search for such organisations. A number of methods were used to identify these organisations consisting of a search of information web-sites available for young people, Google searches for organisations that operated in areas served by Healthy Respect, searching web-sites of statutory and non-statutory providers, using local knowledge and professional contacts. Each organisation was then contacted that was likely to offer sexual health education, advice, or services (the minimum being contraceptives such as condoms) to young people between the ages of

10 and 18 years and asked to confirm whether this was the case. Once an organisation confirmed they were involved in doing so they were contacted again, usually through a manager, and asked if they could provide a list of professionals in their organisation to whom questionnaires could be sent (A copy of the questionnaire can be found in Appendix B).

### 3.4.3 Qualitative Sample

The qualitative phase of the study involved undertaking semi structured interviews with a purposive sample of the providers who had previously participated by undertaking the first survey.

The sample was chosen to reflect the views of those engaged with Healthy Respect and those who were less engaged. Those that appeared less involved were those from some of the Local Authority organisations i.e. social work teams, and staff working with the most vulnerable young people. Table 3.2 gives some insight into the characteristics of those 42 providers sampled for the interviews.

**Table 3.2 Interviewees by service type and geographical area**

<b>Interviewees by Service Type</b>				
<b>Schools</b>	<b>Local Authority</b>	<b>Voluntary Organisations</b>	<b>NHS</b>	<b>TOTAL</b>
<b>14</b>	<b>12</b>	<b>7</b>	<b>9</b>	<b>42</b>
<b>Interviewees by Geographical Area</b>				
<b>Midlothian</b>	<b>North West</b>	<b>Edinburgh</b>	<b>Other*</b>	<b>TOTAL</b>
<b>14</b>	<b>11</b>	<b>12</b>	<b>5</b>	<b>42</b>

\*Other: East and West Lothian

An interview schedule was developed following preliminary analysis of the questionnaire data. In this way the researcher was better equipped



to adapt the interview schedule so that information gathered provided a deeper understanding of partnership work. A copy of the interview schedule can be found in Appendix C.

#### **3.4.4 Data Collection Surveys**

A structured questionnaire was developed by the research team which was used to generate quantitative data for analysis. Similar data was collected for both surveys and used the same questionnaire to allow for cross analysis of the data. However, the second survey incorporated social network questions to obtain the necessary data to undertake a social network analysis. The format and design of the social network questions was adapted from a previous study used by Provan et al (2005). The type of data obtained through the social network questions allowed an examination of the links between the respondents and the organisations they worked with. It also allowed an examination of the 'strength' of the links as measured by the frequency and importance of the contact.

The questionnaire design was informed in a number of ways:

- Results from a scoping exercise with providers (Conducted by the evaluation team)
- Healthy Respect's Logic Model
- Existing Literature
- Healthy Respect Team discussion

A pilot study was conducted with 15 providers. Each respondent was sent a copy of the questionnaire and asked to complete and then

provided feedback at a specially arranged interview. Their answers and comments were recorded using a digital voice recorder. Their feedback was then discussed among the research team and amendments made to the questionnaire. The revisions were substantive and included extending the likert scaling to create more choice, rewording questions to improve clarity and relevance, inserting routing to make the questionnaire less burdensome, and providing the option for those with little contact with Healthy Respect to express their views of it.

In the end two main questionnaires were developed for those organisations in the provider survey a long version for those with more contact with Healthy Respect and a shortened questionnaire for those with less contact with Healthy Respect. It is important however, to note that the pilot data was not included in the main study data.

### **The questionnaires**

Two questionnaires were used:

a) A long version which elicited more detailed information about the impact of Healthy Respect from those who were engaged with it. It gathered data on the type of support received, the impact of Healthy Respect on capacity and capability, their relationship with Healthy Respect, and sustainability. Only those who completed a long questionnaire were defined as 'engaged'. In other words their involvement with Healthy Respect was such that it allowed them to make detailed comments about it. All contacts provided by Healthy Respect were sent a long questionnaire. The others were asked to complete a short questionnaire (A copy of the questionnaire can be found in Appendix B).

b) A short version of the questionnaire was designed for those with little or no contact with Healthy Respect. The shortened version elicited more general perspectives of Healthy Respect such as the type of communication providers might have with Healthy Respect, their views on the Healthy Respect brand, the type of young people targeted by Healthy Respect and how the resources for Healthy Respect were allocated. The short questionnaire was sent to all those identified by the research team and those contacts provided by Healthy Respect who were unable to complete a long questionnaire. The short questionnaire allowed three further groups to be identified: Those with some engagement with Healthy Respect, those who were not engaged with Healthy Respect, and those who had not heard of Healthy Respect. Those with some engagement were defined as having interacted with Healthy Respect. Those who were not engaged with Healthy Respect were defined as having no interaction with them, but had heard of them. Those in the final group had not heard of Healthy Respect.

The final initial cross sectional self completion questionnaires were posted out to providers identified in the sample in November 2006. A stamped addressed envelope was provided for the respondents to return the questionnaire following completion. The follow up questionnaire was posted out to providers in April 2008.

#### **3.4.5 Data Collection Qualitative Interviews**

Five pilot interviews were undertaken using a draft version of the interview schedule. The schedule was then revised following the pilot interviews and after receiving feedback from the interviewer and the

interviewees. The interviewees were selected from each of the main groups of providers as indicated in Table 3.2.

The 42 subjects were then identified and contacted via telephone to discuss whether they would be willing to be interviewed for the study. At this time subjects were informed of the aims of the study, why they had been chosen and informed of the confidentiality procedures. If and when subjects were agreeable to be interviewed a date and time was arranged for the researchers to meet with them. The interviews were conducted by a member of the evaluation team and the author of this study. Discussions were held between both the interviewers to ensure that the interviews were conducted in the same way and an interview protocol was agreed that was followed for all interviews. This allowed for consistency and reliability throughout the interview process.

The interviews were semi-structured in nature; the interview schedule used an open framework which included general areas with which the interviews were guided (See Appendix C for a copy of the interview schedule). Using this semi-structured framework the interviews were focused, however they also allowed for conversational, two way communication to take place. The interviews lasted between 45 minutes and 1 hour and was recorded using a digital voice recorder following verbal consent from the interviewee. The audio voice recordings were then sent to a company for transcribing and a digital copy and the subsequent transcriptions were kept in secure files.

The following section describes in detail the analysis undertaken on the data obtained from both the quantitative surveys and qualitative interview methods.

### **3.5 Data Analysis (matched to the three research questions)**

#### **3.5.1 Question 1: What is partnership working a) Between the Healthy Respect Team and organisations delivering sexual health education, information and services to young people?**

Once the questionnaires (wave 1 and 2 surveys) were returned the data was coded and entered into a SPSS data file (with the exception of the data from the open questions). Data gathered from the open ended questions in the survey were analysed separately and grouped by theme. The quantitative data was stored in the computer and cleaned to eliminate errors occurring during the data coding and input stages.

Two levels of analysis were used to describe partnership and examine the process of partnership working between organisations and Healthy Respect:

##### **1<sup>st</sup> Level Analysis of Survey Data**

The type of questionnaire completed by respondents provided a basic measure of what partnership working was with Healthy Respect. Two types of questionnaire (a long and a short version) were developed as described earlier. Those providers classified as engaged completed a long questionnaire. This group required more detailed knowledge and experience of Healthy Respect and as such were classified as being most engaged. Those providers classified as having some engagement said they had some involvement with Healthy Respect but completed a short questionnaire. This questionnaire assumed less knowledge and

experience of Healthy Respect and did not contain in depth questions about it.

Descriptive statistics were also used to examine the level of involvement with Healthy Respect by service type (i.e. NHS, Education, Local Authority and Voluntary Sector) and geographical area. A comparison was then made between the first and second survey data to examine whether there were any differences in the levels of involvement with Healthy Respect across the two surveys.

### **2<sup>nd</sup> Level Analysis of Survey Data**

The second level of analysis examined partnerships between Healthy Respect and other organisations in more detail. A measure of the strength of the partnership was developed by constructing a score from the data obtained from the providers' responses to two questions in the long questionnaire. This level of analysis was only possible with those completing a long questionnaire, because it required respondents to have engaged with Healthy Respect to the extent that they could comment on their relationships and the resources they received from it.

The first question asked respondents to indicate the number and range of resources received from Healthy Respect (Question 9 Appendix B). Evidence from previous social network analysis studies (Provan and Milward 2001 and Provan et al 2005) found that the commitment and the strength of relationship between partners for partnership work was associated with the amount of support they received.

The second question in the questionnaire asked respondents to indicate the type of relationship they had with Healthy Respect (Question 14

Appendix B). The question covered the following areas; was the relationship built on shared aims and values, was there an element of trust and clear communication and an understanding of the aims of joint working. Responses were gathered using a six point likert scale. These questions were based on existing literature which highlighted factors thought to be associated with successful partnership working (Amery 2000, Audit Commission 1998, Bliss et al 2000, Cameron et al 2003, Evans et al 2000, Goodwin et al 2002, Sullivan 2002 and Sloper 2005).

A partnership engagement score was calculated by summing the scores to the first and second questions and then combining the scores. The score was used as an indication of the strength of partnership with Healthy Respect. It was assumed that providers with a higher mean partner engagement score had a stronger partnership with Healthy Respect than those with a lower score.

An analysis of the variance (ANOVA) followed by a Scheffe Post Hoc Test was used to compare the mean partner engagement scores across the different service types and geographical areas.

### **3.5.2 Question 1: What is partnership working b) Between the different organisations delivering sexual health education, information and services to young people?**

The second part of question 1 was used to describe what partnership working was between the different organisations delivering sexual health education, information and services to young people. Again two levels of analysis were used to 1) describe what partnership working between the different organisations looked like and 2) measure the strength of the relationship between the organisations.

### **1<sup>st</sup> level analysis of the social network data**

The network data analysis was conducted using UCINET a software package designed for the analysis of social network data (Borgatti et al 1999). This software package included a plotting feature called net-draw (Borgatti et al 1999) that allowed for visual; representation of the network participants and the links between them.

A dataset was constructed in Excel for each of the different geographical areas covered by Healthy Respect: Midlothian, Edinburgh City, North West Edinburgh, East Lothian and West Lothian. Matrices were then developed in excel which listed the organisations involved in the network and the links between them. A matrix constructed in this way has two cells representing the intersection of any 2 nodes, 1 above and 1 below the diagonal. If a connection or tie existed between 2 organisations, then a '1' was inserted into the matrix cell representing the intersection of these two nodes. If no tie existed, then a '0' was entered into the cell. Five matrices in all were developed in this way corresponding to the five different geographical areas.

The matrices were then copied into separate spreadsheets in the UCINET programme and saved as network data files. Using Net-draw, a programme within the UCINET suite, it was then possible to construct a sociogram of the networks for each of the geographical areas. The sociograms constructed displayed the respondents and the links between the different organisations they reported working with in relation to young people's sexual health.



## 2<sup>nd</sup> level analysis of the social network data

The 2<sup>nd</sup> level of analysis of the social network data involved measuring the 'strength' of the links between the different organisations. The strength of the link was defined as the frequency of contact multiplied by the importance of the relationship. For each ego (respondent) the strength of the links to alters (contact organisations) which they are connected are summed to give a measure of centrality i.e.

$$Centrality = \sum_{i=0}^4 F_i I_i$$

To give an example consider an ego with three contacts whose details are in Table 3.3

**Table 3.3 Example of an ego with three contacts**

Actor	Frequency of Contact	Importance of message	Strength
1	4	3	12
2	3	2	6
3	1	4	4

From Table 3.3 the centrality is  $12+6+4 = 22$

Therefore centrality was used in this study as a summary measure to give an indication of the strength of the ties (or links) between the respondents and the organisations they report working with. In social network analysis studies centrality is often defined as in-degree or out-degree. In-degree is a count of the number of ties directed to the respondent, and out-degree is a count of the number of ties that a respondent directs to others. In this study, no secondary data was available on the number of ties directed to the respondent. Thus, the data collected using the network questions were based solely on reports

by the respondents about the ties they direct to the other network members (out-degree centrality measures).

The centrality scores were constructed using data obtained from the social network questions in the questionnaire (Questions 4 (a) Appendix B) which asked respondents to indicate the:

- Frequency of the contact they had with other organisations
- The main reason(s) for contact and
- The importance of the relationship for each of the organisations they listed.

Rating scales were used to measure the responses given by respondents to the frequency of contact they had with other organisations, ranging from; 1=daily, 2=weekly, 3=monthly and 4=less frequently. A similar rating scale was used to measure the responses given by respondents regarding the importance of the relationship ranging from; 1=not important, 2=of little importance, 3=important and 4=very important. The scores respondents gave for each question were then multiplied together and transferred into a new matrix in the UCINET programme. One, was then able to compute a frequency x importance out-degree centrality score (partnership strength) for each organisation responding.

The scores were used in this study as a means of measuring the strength of the relationship between organisations. In other words when a respondent indicated that they had daily contact with an organisation and that the contact was perceived to be very important they would have a higher score than those respondents indicating they had less frequent contact with other organisations and that the contact was of little

importance to them. The results of the data analysis pertaining to this first research question (parts a) and b)) appear in Chapter 4.

### **3.5.3 Question 2: What influenced partnership working between the Healthy Respect Team and other organisations?**

The qualitative interviews with providers were used as a means of answering this second research question. The interviews allowed the examination of the providers' perceptions and beliefs regarding factors that may have influenced partnership working with Healthy Respect.

There are now several types of computer software programmes available to assist with coding, management and analysis of qualitative research data. A computer programme was used in this study (NVIVO 7 QSR International Pty Ltd 2007) which allowed the researcher to store the transcribed interviews into a database. The initial coding and preliminary analysis of the interviews was undertaken using this programme. It allowed the researcher to cut and paste large chunks of data from the interviews into broad topic areas which had previously been developed for the interview schedule and followed discussions with the research team (Basit 2003). Coding was carried out by three members of the team and once an interview was coded by one member it was passed on to another member for checking allowing for consistency, reliability and trustworthiness throughout the process (Mays and Pope 1995).

Following coding and preliminary analysis into the broad categories and topic areas further analysis was undertaken. This second level of

analysis used content analysis of the text which involved reading and re-reading the transcripts looking for similarities and differences in order to find and distinguish the themes and develop the sub categories. Following the second level of analysis the material was again checked by a second member of the team.

Trustworthiness is an essential component of qualitative research. Findings should reflect the reality of the experience. Research by Mays and Pope (1995) and Clark (1999) argued that reliability is enhanced when more than one skilled qualitative researcher is involved in the analytical process. The themes, codes and categories identified by each researcher can be compared and differences discussed. Furthermore, Marshall and Rossman (1995) & Silverman, (2000) suggested that a study's validity is enhanced when the researcher actively searches for evidence that contradicts as well as confirms, a finding. Team analysis therefore provided the researcher with an opportunity to gain many interpretations of the data and helped minimise the risk of any bias occurring during the process (Silverman 2000).

Following the analysis two broad categories were extracted 1) Influences that acted as barriers to partnership work between Healthy Respect and the organisations and 2) Influences that facilitated partnership work between Healthy Respect and the organisations. These broad categories were further broken down into the themes identified through the content analysis. The results of this qualitative phase of the study appear in Chapter five.

### **3.5.4 Question 3: What are the outcomes of partnership working between the Healthy Respect Team and other organisations?**

With regards to the outcomes of partnership working with Healthy Respect, inferential statistical techniques were used to examine the relationship between the strength of partnership working and professional and organisational outcomes identified within the logic model. As suggested previously the Theory of Change approach allowed the examination of the links between the activities used in a project and the intended outcomes, thereby helping to strengthen the case for attributing subsequent change in these outcomes.

Healthy Respect assumed that the outcomes of partnership working for the organisations involved would be an increase in their capacity and capability in terms of their skills, knowledge and confidence in sexual health work with young people. Providers were asked if working with Healthy Respect had any effect on two key areas:

- Their skills, practice and understanding of young people's sexual health issues (Question 11, Appendix B)
- Their ability to focus on sexual health issues with young people and on sexual health service delivery (Question 12, Appendix B).

Question 11 contained 8 sub questions relating to providers skills, practice, and understanding of young people's sexual health issues. The providers responses to these questions were recorded on a likert scale which ranged from 1 'Helped a lot' to 6 'Not relevant to my role'. Question 12 contained 9 sub questions relating to the providers ability to focus on sexual health issues and sexual health service delivery again

the answer to each question was recorded on a likert scale ranging from 1 'Helped a lot' to 6 'Not relevant to my role'.

Factor analysis was conducted (on both sets of questions) to identify groups or clusters of variables that were driven by the same underlying variable. The data reduction was achieved by looking for variables that correlated highly with a group of other variables, but did not correlate with variables outside of that group (Field 2005). The Kaiser-Meyer-Olkin measure of sampling adequacy was used to determine if the variables could reliably be grouped into a smaller set of underlying factors. Bartlett's test of sphericity was also undertaken to compare the correlation matrix to an identity matrix. The factor analysis was found to be appropriate (for both sets of questions) as the Bartlett's value was significant indicating that there was a relationship between the variables in the data. The rotated component matrices for questions 11 and 12 can be found in Appendix D.

Following the factor analysis a correlation statistical technique (Pearson R Correlations) was used to examine the relationship between the mean partner engagement score and the factor variables. An analysis of the variance (ANOVA) with a Scheffe Post Hoc Test was used to compare the mean factor scores across the service types and geographical areas to establish if there were any significant differences between the groups.

In the second survey respondents were asked if working with Healthy Respect had any affect on them linking with other organisations (Question 9 Appendix B). A *t-test* for independent samples was

conducted to examine whether those who had been helped in this way had stronger links with other organisations.

### **Impact of partnership working within the networks**

The data obtained from the social network questions in the survey also allowed the author to examine whether there was any relationship between the strength of partnership working at the level of the network and the outcomes for the organisations in the networks. It is important to note that the outcomes measured in this particular analysis are not those used above. Instead these are outcomes which resulted from links between organisations and exclude those resulting from Healthy Respect.

Each respondent was asked to comment on how their links with other organisations impacted on their ability to work on sexual health issues with young people and other organisations (Questions 4b, Appendix B). The respondents were asked a set of seven sub questions and a rating scale was used to measure their responses. The likert scale ranged from 1 'Helped a lot' to 6 'Not relevant to my role'. A factor analysis was not used as a means of data reduction for this question as the Bartlett's value indicated that there was no significant relationship between the variables in the data. Correlation analysis was used to examine the relationship between the strength of partnership score and the score obtained for each of the 7 sub questions.

### **3.6 Ethics**

Ethics approval was sought for the main evaluation study. Therefore as this study used the same methods and data collection process as the

main evaluation study no further ethical approval was sought. Ethical permission for the research was sought and obtained from Edinburgh Napier University's Ethics Committee. The following ethical standards were built into the research process as follows (The Economic and Social Research Council ESRC 2005):

### **Access and recruitment**

Individual participants may suffer from their participation in research if they are unhappy about participating, or feel vulnerable in the process. No pressure to participate was put on individuals who appeared reluctant to participate. With regards to the survey, the questionnaire contained details about the research and assured respondents that the information supplied by them would be kept strictly confidential. The qualitative phase of the study involved undertaking semi-structured interviews with a sample of providers. Full background details on the research were provided at the time of the interview request. Although no written consent was asked for; verbal consent was gained at the time of the interview request. In addition, all the individuals being interviewed were from professional backgrounds and were used to the idea of research; as such they did not present a particularly vulnerable group.

### **Consent (for both surveys and interviews)**

Permission was sought and granted from Edinburgh City, Midlothian, East Lothian and West Lothian Local Education Authorities to approach their school staff (Head Teachers and guidance staff who deliver sexual education programmes in schools) and other appropriate employees (from with the Local Authority) with the survey and subsequent interviews.



Permission was also sought and granted from the senior service managers of the NHS and non-statutory providers of sexual health information, support and services to young people to survey and undertake interviews with their staff.

Once access had been granted at each level of accountability in the organisation, the respondents received a detailed information letter together with the questionnaire (Appendix B) assuring them of confidentiality and stating their right not to fill in the questionnaire. Return of the questionnaire in the enclosed stamped addressed envelope was then taken as consent.

Participants were permitted to decline to answer particular questions within the qualitative interview schedule and efforts were made to hold the interview at a location convenient for the participant. Consent was also sought to tape record the interviews.

### **Confidentiality**

Issues of partnership working and evaluation are not particularly emotive, and participants were being interviewed about issues related to their place of work, rather than their personal life. However, in order to ensure that participants felt free to express their own opinions, the interviews were kept confidential and the anonymity of individuals ensured. Participants were given a code relating to the organisation they worked for and a number i.e. NHS 64.

Investigators have a duty to ensure that the evidence, both positive and negative, produced by well designed research projects is disseminated

(Bowling 2002). With regards to the ethical issues underpinning the writing up and dissemination of findings; no identification was made of the individuals who participated other than the organisations for whom they worked.

This chapter presented the research methods used to gather the data and discussed the type and nature of the analysis undertaken. The results of the data analysis will now be the subject of the next three chapters.

## **Chapter 4 Results: Partnership working in the Healthy Respect project**

### ***4.1 Introduction***

Contained in this chapter are the results of the analysis undertaken on the data obtained from the provider surveys. These results are used to address the first research question;

1. What is partnership working:
  - a) Between Healthy Respect and other organisations who deliver sexual health education, information and services to young people?
  - b) Between the organisations who deliver sexual health education, information and services to young people?

Healthy Respect identified a range of professionals from a broad range of agencies considered to be well placed to deliver sexual health education, information or services to young people and parents in Lothian. They also specifically focussed on engaging those professionals working with young people who were at particular risk of poor sexual health. Healthy Respect hypothesised that by communicating clearly with and providing high quality training and support; this would lead to an increase in organisational development and an ability to support and empower young people to make appropriate choices regarding their sexual health and wellbeing (HR2 Interim Report 2008).

The results are presented in three sections:

Section one outlines the characteristics of the 1<sup>st</sup> and 2<sup>nd</sup> survey samples. It uses descriptive statistical techniques to examine the type of services, the geographical areas and the level of involvement of organisations with Healthy Respect.

Section two uses a measure developed to examine the strength of partnership working between organisations and Healthy Respect.

Described in section three are the results of the social network analysis. It examines partnership work between the different organisations involved in the networks and visually displays the partnership networks in each of the geographical areas targeted by Healthy Respect. It then used a measure developed to examine the strength of the relationship between organisations in the networks.

#### **4.2. Target population**

Both surveys were aimed at those providing sexual health education, advice, or services to young people. Young people were described as those between the ages of 10 and 18 years old (but those aged 12 and under were not targeted by sexual health services). The survey was conducted in the Healthy Respect operational areas of: Midlothian, Edinburgh City, North West Edinburgh, East Lothian, and West Lothian. A total of 529 professionals were asked to take part in the first survey and 687 in the second. Most (approximately 80% in both surveys) were identified by the Healthy Respect Team, and the remainder identified by the research team. Those identified by the Healthy Respect Team originated from their contact data base. Those contacted by the research team were identified through an independent search for organisations

that might offer sexual health education, advice, or services (minimum condoms) to young people. All contacts were sent one of two self-completion questionnaires (a long or short version as previously described in Chapter 3).

### 4.3. Results

#### 4.3.1 Section 1: Sample characteristics

A total of 529 questionnaires were distributed in the first survey and 687 in the second (Table 4.1). A total of 275 providers were sent questionnaires in both surveys. The geographical profile was similar in both surveys however a greater number of local authority and less NHS providers were sent questionnaires in the second survey.

**Table 4.1** Number of providers sent questionnaires in the 1<sup>st</sup> and 2<sup>nd</sup> survey

	<b>1<sup>st</sup> Survey</b>	<b>2<sup>nd</sup> Survey</b>	<b>Total</b>
Number sent	529	687	1,216
<b>Type of Service</b>			
Education			
- Secondary Schools	154(29%)	179 (26%)	333
Primary Schools	64(12%)	101(14%)	165
Local Authority	101(19%)	205(30%)	306
Voluntary Organisation	65(12%)	71(10%)	136
NHS	145(27%)	131(19%)	276
<b>Area</b>			
Midlothian	152(29%)	212(31%)	364
North West Edinburgh	70(13%)	101(15%)	171
Edinburgh City	202(38%)	237(35%)	439
East and West Lothian	104(20%)	137(20%)	241

There was a higher response rate from the first survey compared with the second: 67% versus 41% (Table 4.2). A total of 97 providers returned questionnaires for both surveys. There was relatively fewer Healthy Respect partners in the first survey (46%) compared with the second (65%). The second sample consisted of fewer NHS staff and

more local authority staff and primary school teachers. This reflects the different profile of those who were targeted by Healthy Respect by the time of the second survey (Table 4.1). For example, at the time of the first survey, the Zero Tolerance Respect package was introduced in half of the primary schools in Midlothian as part of a randomised control trial, conducted by the evaluation team. The trial ended before the second survey began, and Healthy Respect then introduced the pack to other primary schools in Midlothian and in North West Edinburgh. This led to an increase in the number of primary schools in the second survey.

**Table 4.2 Providers returning a questionnaire 1st and 2<sup>nd</sup> survey**

	<b>1<sup>st</sup> Survey</b>	<b>2<sup>nd</sup> Survey</b>	<b>Total</b>
<b>Number returned</b>	356 (67%)	284 (41%)	640
<b>Number from those delivering education, advice or services to young people 10-18 years*</b>	328 (95%)	268 (95%)	588
<b>Level of Engagement with Healthy Respect*</b>			
Engaged	154 (47%)	174 (65%)	323
Some Engagement	67(20%)	51 (19%)	118
Not involved	45(14%)	0	45
Not heard of Healthy Respect	44(13%)	28 (10%)	70
Incomplete data	18 (6%)	15 (6%)	32
<b>Type of Service *</b>			
Education			
Secondary Schools	111(34%)	64(24%)	170
Primary Schools	34 (10%)	51 (19%)	83
Local Authority	42(13%)	59(22%)	101
Voluntary Organisation	30 (9%)	26(10%)	54
NHS	111(34%)	69(26%)	180
<b>Area*</b>			
Midlothian	85(26%)	80 (30%)	166
North West Edinburgh	47(14%)	36(13%)	81
Edinburgh City	129(40%)	92(34%)	218
East and West Lothian	64(20%)	53(20%)	114

There was an increase in providers responding from Local Authority organisations to the second survey. This may not be that surprising as following feedback of the results of the first survey to the Healthy Respect Team i.e. that there appeared to be less engagement between Healthy Respect and organisations from the Local Authority organisations. The Healthy Respect team made a concerted effort to encourage more professionals from the Local Authority organisations to become more involved in the project. This was of particular importance to Healthy Respect as it was assumed that professionals from within the Local Authority organisations would work with the most vulnerable young people who were a specific target group for Healthy Respect in this second phase of the project.

The results also suggest that there was a decrease in the providers involved from North West Edinburgh and Edinburgh City in the 2nd survey, whereas East and West Lothian stayed the same and Midlothian saw a rise in the numbers involved.

At a general level, involvement with Healthy Respect was reflected by the type of questionnaire completed. Those providers completing a long questionnaire required more detailed knowledge and experience of Healthy Respect and as such were broadly classified as engaged; 47% in the first and 65% in the second survey were able to complete a long questionnaire. Those providers classified as having some engagement said they had some involvement with Healthy Respect but completed a short questionnaire. This questionnaire assumed less knowledge and experience of Healthy Respect and did not contain in depth questions

about it; 20% in the first and 19% in the second survey reported having some involvement with Healthy Respect. In the first survey 14% of providers reported that they had heard of Healthy Respect but were not involved with it. The final 19% (1<sup>st</sup> survey) and 16% (2<sup>nd</sup> survey) had not heard of Healthy Respect or had returned poorly completed questionnaires and were excluded from the analysis.



**Table 4.3 Number and Percentage of involvement by service type and geographical area**

	<b>Engaged 1<sup>st</sup> Survey</b>	<b>Engaged 2<sup>nd</sup> Survey</b>	<b>Some Engagement 1<sup>st</sup> Survey</b>	<b>Some Engagement 2<sup>nd</sup> Survey</b>	<b>Heard of Healthy Respect but not engaged 1<sup>st</sup> Survey</b>	<b>Heard of Healthy Respect but not engaged 2<sup>nd</sup> Survey</b>	<b>Not Heard of Healthy Respect 1<sup>st</sup> Survey</b>	<b>Not Heard of Healthy Respect 2<sup>nd</sup> Survey</b>
<b>Type of Service</b>								
Education	83 (65%)	87 (83%)	8 (6%)	7 (7%)	17 (13%)	0 (0%)	19 (15%)	11 (10%)
Local Authority	14 (33%)	17 (30%)	16 (38%)	28 (49%)	6 (14%)	0 (0%)	6 (14%)	12 (21%)
Voluntary Organisation	19 (63%)	17 (68%)	2 (7%)	7 (28%)	3 (10%)	0 (0%)	6 (20%)	1 (4%)
NHS	38 (34%)	53 (80%)	41 (37%)	9 (14%)	19 (17%)	0 (0%)	13 (12%)	4 (6%)
<b>Geographical Area</b>								
Midlothian	48 (62%)	61 (79%)	10 (13%)	9 (12%)	12 (16%)	0 (0%)	7 (9%)	7 (9%)
North West Edinburgh	24 (53%)	16 (47%)	6 (13%)	6 (18%)	4 (9%)	0 (0%)	11 (24%)	12 (35%)
West Lothian	26 (68%)	22 (92%)	4 (10%)	1 (4%)	5 (13%)	0 (0%)	3 (8%)	1 (4%)
East Lothian	12 (54%)	21 (91%)	2 (9%)	2 (9%)	0 (0%)	0 (0%)	8 (36%)	0 (0%)
Edinburgh City	43 (34%)	49 (56%)	44 (35%)	31 (35%)	24 (19%)	0 (0%)	15 (12%)	8 (9%)

Table 4.3 provides an overview of involvement with Healthy Respect across each service type and geographical area. Education had the highest percentage of those most involved in both surveys i.e. 65% of those from education were engaged in the first survey and this rose to 83% in the second. The organisations least engaged were those from the Local Authority organisations with only 33% in the first and 30% in the second. Results from the first survey suggest that West Lothian had a higher percentage of those most engaged (68%) followed by those from Midlothian (62%) in the first survey. Results are similar for the second survey with an increase in the percentage engaged from both West Lothian (92%) and Midlothian (79%). However, the area that saw the largest increase in providers most engaged was East Lothian with 54% being most engaged in the first survey compared to 91% being most engaged in the second survey.

Results suggest that the level of involvement varied across organisations and on closer inspection of the data results also suggest that the level of involvement also varied within organisations. For instance when examining the data for each service type (in the first survey) all of the Healthy Respect Drop in staff, all of those in Healthy Respect Primary Schools, and 78% of those in Healthy Respect Secondary Schools were most involved with Healthy Respect. A total of 63% of those working in the voluntary organisations were most involved in the first survey. With the exception of Healthy Respect Drop-ins and Primary Schools, some respondents who worked in Healthy Respect partner organisations had some or no involvement with Healthy Respect. This occurred in the following organisations: Healthy Respect secondary schools, the School Nursing

Service, EC72 Pharmacies, Family Planning, and Genito-Urinary Medicine (GUM), Social Work, Community Learning and Development, and Pupil Referral Units, and Voluntary organisations.

Responses given by those who were not involved with Healthy Respect indicated why. Some individuals worked independently from Healthy Respect and did not wish to engage with it. In some cases there was a recent turn over of staff and those new in post knew very little about Healthy Respect. Some said the Healthy Respect team had not invited them to take part. Finally, for some, sexual health was not seen as a priority.

There were variations noted in the level of engagement among those completing the long questionnaire and the next section focuses only on the group of providers who were most knowledgeable about Healthy Respect i.e. those that completed the long questionnaire and were able to answer the more detailed questions regarding partnership working (N=154 1<sup>st</sup> survey and N= 174 2<sup>nd</sup> survey).

#### **4.3.2 Section2: Strength of partnership work with Healthy Respect**

This section of the analysis examines in more detail the providers engaged with Healthy Respect and used the measure discussed in chapter 3. A higher score indicates a stronger partnership with Healthy Respect. The mean partner engagement score for providers in the 1<sup>st</sup> survey was 218 (Std. Deviation 121). The mean partner engagement score for providers in the 2<sup>nd</sup> survey was 187 (Std. Deviation 137). Table 4.4 compares the mean partnership engagement scores (surveys 1 and 2) for each service type.

**Table 4.4 Mean partnership engagement score (Surveys 1 and 2) by service type**

			Mean	Std. Deviation	Confidence Levels	
					Lower Level	Upper Level
<b>NHS</b>	Partnership engagement score	Survey 1	294.86	144.81	247.55	342.17
		Survey 2	242.90	150.39	198.47	287.35
<b>Voluntary Organisations</b>	Partnership engagement score	Survey 1	235.43	108.15	182.44	288.43
		Survey 2	164.66	122.31	102.76	226.57
<b>LA</b>	Partnership engagement score	Survey 1	195.76	83.00	150.65	240.89
		Survey 2	216.35	142.42	148.65	284.85
<b>Education</b>	Partnership engagement score	Survey 1	175.80	93.25	152.78	198.84
		Survey 2	114.62	84.00	86.79	142.46

Table 4.4 displays the mean partnership engagement scores for each of the different services types involved; results suggest that the scores decreased for each service type with the exception of the Local Authority organisations where the mean partnership engagement scores increased in the second survey. This may reflect the concentrated efforts of Healthy Respect in trying to get more professionals from the Local Authority organisations to become involved in the project or it may be due to sample bias as significantly more professionals from Local Authority organisations returned the second questionnaire.

To examine whether there was a significant difference in the scores between the two samples an independent *t*-test was undertaken on the partnership scores from both surveys. An independent *t*-test is a test that uses the *t*-statistic to establish whether two means collected from independent samples

differ significantly (Field 2005). On average the mean partnership scores decreased between the first and second survey sample, first survey (M=218, SE= 10.809), compared to second survey (M=187, SE=12.784). However, this difference was found not to be significant  $t(255) = 1.773, p > .05$ .

The 95% confidence levels around the mean partner engagement score for each service type in survey 1 and survey 2 (Table 4.4) indicated that there appeared to be a significant difference in mean scores between the service types. An analysis of variance was undertaken followed by a Scheffe Post Hoc Test for each survey to confirm whether this was the case. In the first survey the mean score was significantly different between the NHS and those from Education (Difference 119.05,  $P=0.05$ ). This was also the case in the second survey the mean score was significantly different between the NHS and those from Education (Difference 128.28,  $P=0.05$ ).

Interestingly those from education had the lowest partner engagement score, yet this appears contradictory when looking at the whole sample characteristics (Table 4.3). There appeared to be a high percentage of those from education in the most engaged category i.e. 65% of those from education were most engaged in the first survey and this rose to 85% in the second survey. The differing results could be as a result of the partner engagement score used. For example, if those from education indicated that they received only the SHARE or Zero Tolerance resources from Healthy Respect and then had little contact this could account for their partner engagement scores being lower. Thus the partnership score represents a more refined assessment of the strength of the relationship with Healthy

Respect than automatically assuming that those who completed a long questionnaire were engaged with Healthy Respect.

This is supported by data from the qualitative research where teachers from both Primary and Secondary schools reported that they did not see themselves as directly working in partnership with Healthy Respect. They saw the partnership as being at the strategic level between the Education Department and Healthy Respect. This they say allowed them to undertake the work they were doing in schools i.e. delivering the SRE programme to young people. This will be picked up again in Chapter 5 and discussed in more depth in Chapter 7.

**Table 4.5 Mean partnership engagement score (Surveys 1 and 2) by geographical area**

					Confidence Levels	
					Lower Level	Upper Level
Geographical Area		Survey	Mean	Std. Deviation		
<b>Midlothian</b>	Partnership engagement score	Survey 1	213.73	108.01	177.43	250.04
		Survey 2	169.16	136.91	107.59	230.72
<b>North West Edinburgh</b>	Partnership engagement score	Survey 1	206.75	137.96	151.55	261.95
		Survey 2	192.33	147.03	109.14	275.53
<b>West Lothian</b>	Partnership engagement score	Survey 1	251.09	123.44	199.51	302.67
		Survey 2	184.89	136.54	123.49	246.29
<b>East Lothian</b>	Partnership engagement score	Survey 1	225.25	123.44	148.15	302.35
		Survey 2	215.58	153.91	146.37	284.79
<b>Edinburgh City</b>	Partnership engagement score	Survey 1	208.08	119.63	168.45	247.72
		Survey 2	187.25	136.25	144.49	230.02

Table 4.5 displays the mean partnership engagement scores for each of the operational areas targeted by Healthy Respect. West Lothian had the highest partnership engagement score in the first survey and East Lothian had the highest partner engagement score in the second survey.

An analysis of variance followed by a Scheffe Post Hoc Test was undertaken to examine whether there was any significant difference in partnership engagement scores between the geographical areas for both surveys and no significant differences were noted.

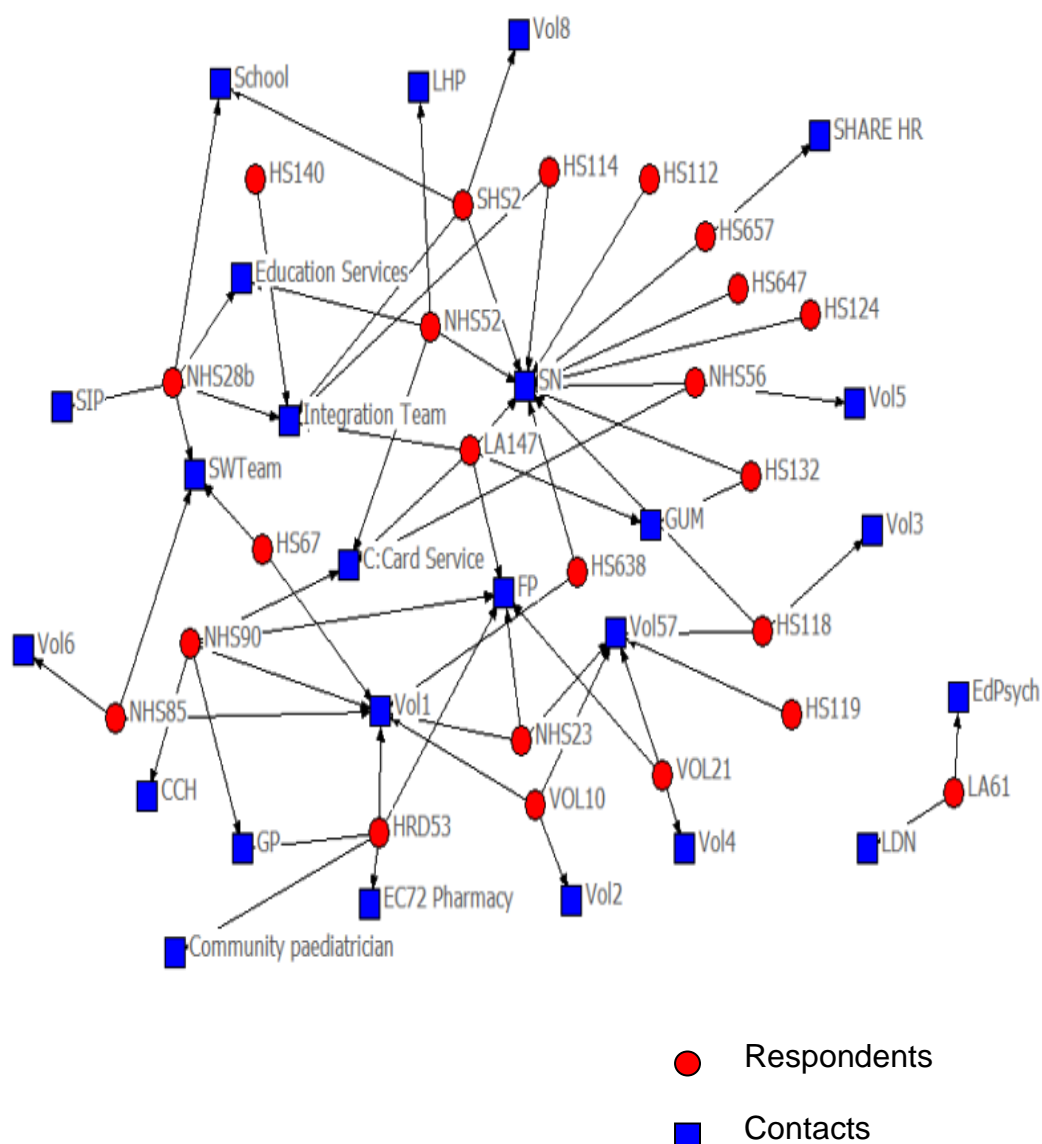
The results also highlight that the mean partnership engagement scores are lower in the second survey compared to the first in each of the different geographical areas. Both sets of results suggest that the level of partnership work taking place between organisations and Healthy Respect had decreased over the year between the first and second survey. However, an independent *t-test* undertaken found no significant difference between the samples.

#### **4.3.3 Section 3: Partnership work between the organisations involved in Healthy Respect**

The previous section focused solely on the partnership work taking place between organisations and Healthy Respect. This section concentrates on examining the partnership work that took place between the different organisations in the project. UCINET for Windows Versions 6 (Borgatti et al 1999) a software package for social network analysis was used in this part of the study. This package has a plotting feature called NETDRAW (Borgatti 2002) that allowed for visual representation of the network participants and the links amongst them. The links examined here relate to responses by providers regarding their work with other organisations in relation to sexual

health work with young people (excluding their links with Healthy Respect). The figures displayed in this section contain the network plots for the five different geographical areas covered by Healthy Respect i.e. East Lothian, West Lothian, North Edinburgh, Edinburgh City and Midlothian. The sociograms as seen in Figures 4.1, 4.2, 4.3, 4.4 and 4.5 depict the links between organisations.





**Figure 4.1 East Lothian Network**

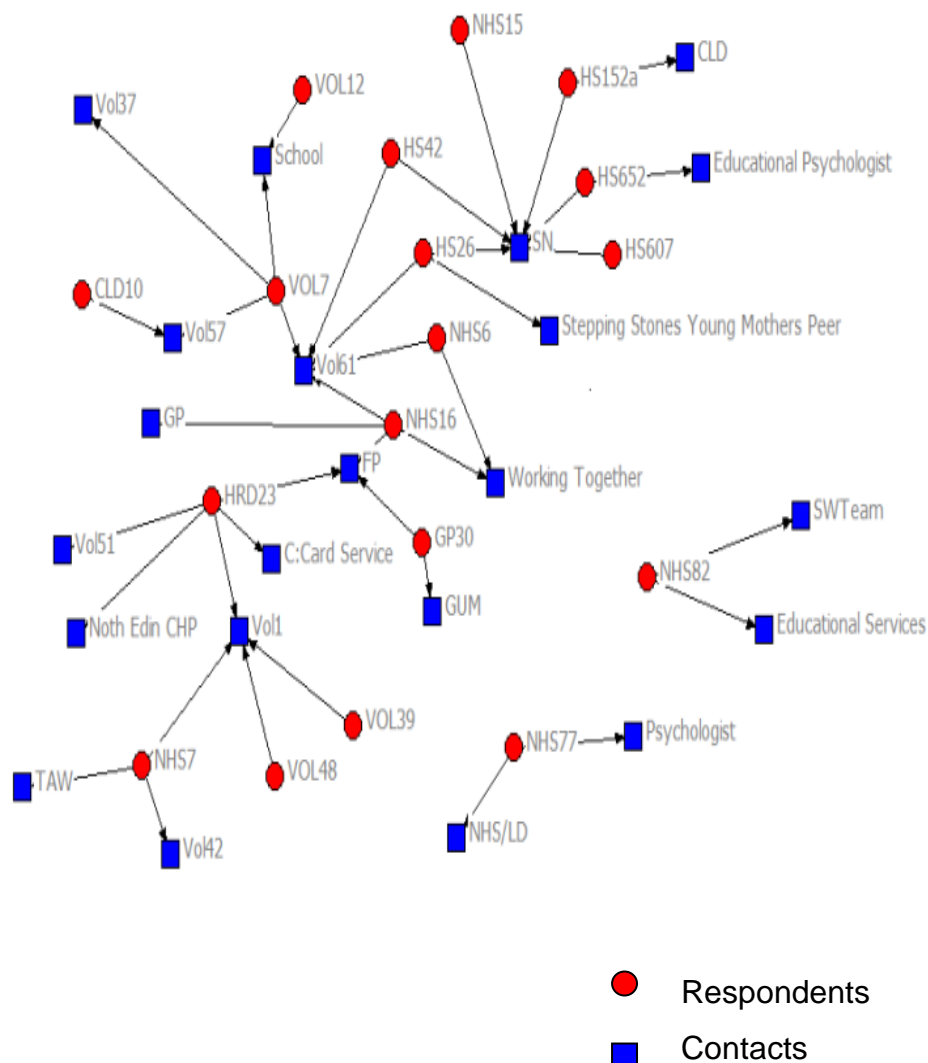
**Service Type Key**

C:Card Service = Condom Distribution Service  
 CCH = Community Child Health  
 EC72 Pharmacy = Pharmacy delivering Emergency Contraception  
 EdPsych = Educational Psychologist  
 FP = Family Planning  
 GUM = Genito-urinary Medicine  
 HS = High School  
 LA = Local Authority  
 LHP = Lothian Health Promotion  
 LDN = Learning Disability Nurse  
 SHS = Sexual Health Services  
 SN = School Nurses  
 SW Team = Social Work Team  
 Vol = Voluntary Organisation

Shown in Figure 4.1 is the network for East Lothian. The red circles are those professionals responding to the questionnaire and the blue squares are the organisations they report linking with in relation to issues regarding young people's sexual health. Four organisations stand out in East Lothian as having the most links from responding organisations, School Nurses, Voluntary Organisation 1, Family Planning Services and Voluntary Organisation 57. There is one organisation that does not share any links with the main network members as a whole that being LA61 (a specialised teacher working in a school for children with complex needs). The School Nurses are seen in this network as the main contact for the schools, although the schools in this network also appear to link with other sexual health services most notably Voluntary Organisation 1 and Family Planning services. Voluntary Organisation 1 referred to in this network was an organisation providing sexual services and advice to young people.



Shown in Figure 4.2 is the network for West Lothian. Two organisations stand out in West Lothian as having the most links, School Nurses and Voluntary Organisation 11. Voluntary Organisation 11 is both a respondent and a contact organisation for a number of other respondents. It is also possible to identify from this network a fragmented group, this group are respondents from one Secondary School who all report linking solely with a school counselling service but who do not report connecting to any of the organisations within the main network. Again within this network the school nurses appear to be important contacts for the High Schools in this area with the exception of the fragmented group. Voluntary 11 referred to in the network was an organisation providing general health (which also included sexual health) advice and information to young people.



**Figure 4.3 North West Edinburgh Network**

**Service Type Key**

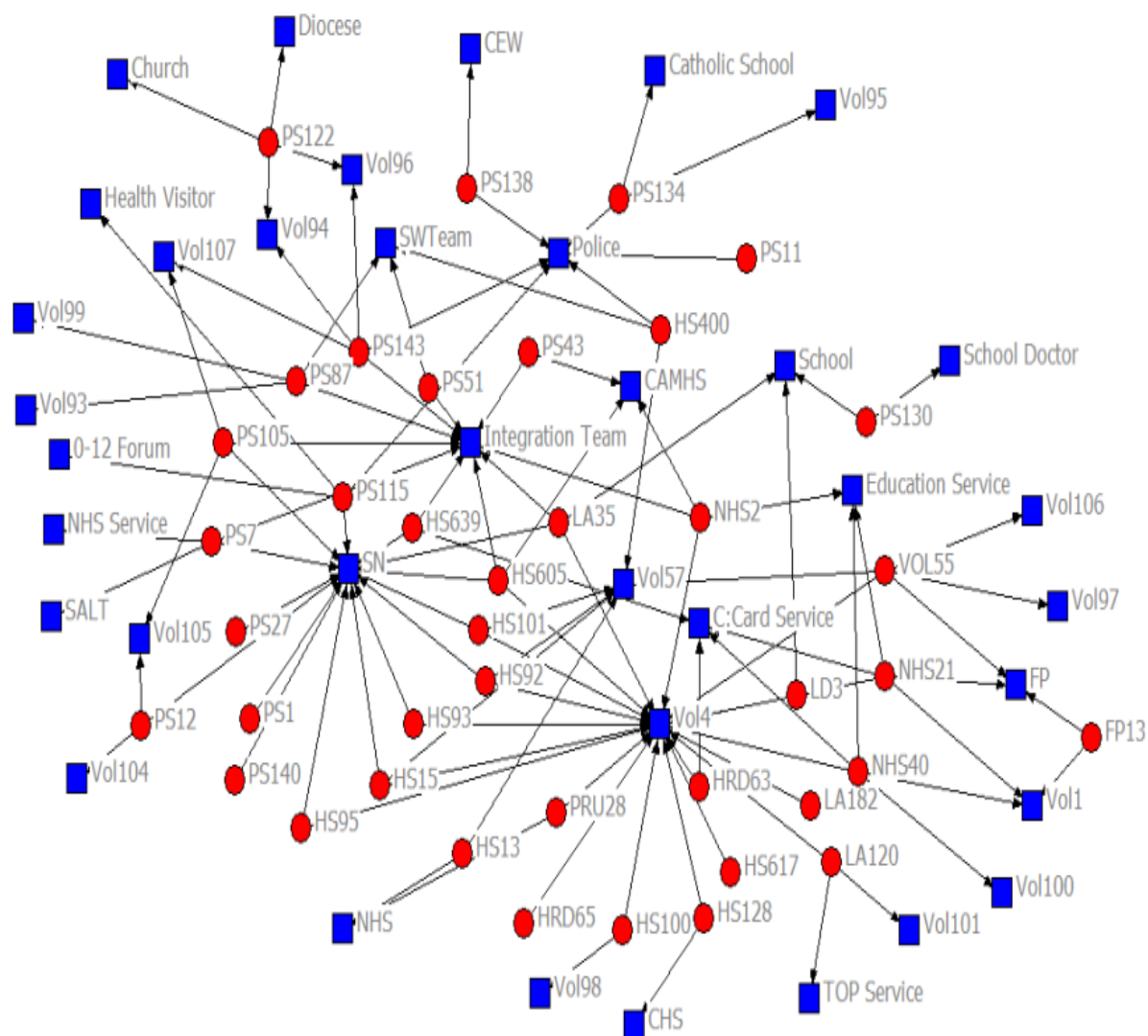
C:Card Service = Condom Distribution Service  
 CLD = Community Learning and Development  
 FP = Family Planning  
 GP = General Practitioner  
 GUM = Genito-urinary Medicine  
 HS = High School  
 LA = Local Authority  
 North Edinburgh CHP = North Edinburgh  
 SN = School Nurses  
 SW Team = Social Work Team  
 Vol = Voluntary Organisation

Shown in Figure 4.3 is the North West Edinburgh Network. Two organisations stand out in North Edinburgh as having the most links, School Nurses and Vol61. There are two fragmented groups with two respondents who report not sharing any links with the main network; NHS77 and NHS82 both these respondents are described as being community nurses. Voluntary Organisation 61 is an organisation specifically dealing with young people's health and wellbeing, and offers support, information and advice.



Shown in Figure 4.4 is the network for Edinburgh City. Three organisations stand out as having the most links; Voluntary Organisation 1, GUM (Genito-Urinary Medicine) and FP (Family Planning). There are two respondents who do not share any links with the other network members, LA140 (an educational psychologist) and HS681 (a catholic High School teacher). Although school nurses were mentioned as a link by one respondent in particular, the same respondent did not indicate the frequency and importance of that link therefore the graph was unable to display the link. There are fewer schools involved in the project from Edinburgh City which might explain the lack of links between School Nursing and education that have been seen in all the other areas. However of the schools that did respond to the questionnaire many did not mention the school nursing service but instead described their links as being with two Voluntary organisations in this area or directly with NHS Family planning services. Voluntary Organisation 1 is a large organisation providing sexual health services, information and advice. It is open to all ages, but operates specific clinics for young people.





**Figure 4.5 Midlothian Network**

- Respondents
- Contact Organisations

**Service Type Key**

CAMHS = Child and Adolescent Mental Health Services  
 C:Card Service = Condom Distribution Service  
 CHS = Child health Services  
 CLD = Community Learning and Development  
 FP = Family Planning  
 GP = General Practitioner  
 GUM = Genito-urinary Medicine  
 HS = High School  
 LA = Local Authority  
 PS = Primary School  
 SN = School Nurses  
 SW Team = Social Work Team  
 TOP Service = Termination of Pregnancy Service  
 Vol = Voluntary Organisation

Shown in Figure 4.5 is the Midlothian network. Similar to the Edinburgh City network the Midlothian network also appears to be quite a dense network. Two organisations stand out as having many links and appear very central to the network as a whole, Voluntary Organisation 4 and the School Nursing Service. The School Nurses are again seen here as being a vital link to the schools, both secondary and primary in the area. Voluntary Organisation 4 referred to in this network is an organisation based in the area offering general health and wellbeing (including sexual health) services to young people

### **General Synopsis**

The school nursing service was reported to be an important link for the schools in each of the geographical areas under study with the exception of Edinburgh City; where family planning and other sexual health services were seen as important. Each of the geographical network plots also show at least one voluntary organisation within each area that was seen as an important link and a central member within the network. Many of the Voluntary Organisations referred to in the network plots offered services in relation to young people's health generally, with the exception of Voluntary Organisation1 which offered specialised sexual health services.

Within a number of the networks there were also fragmented groups seen i.e. groups of respondents who did not share any links with the network as a whole. When examining who these respondents were and the organisational links they had it was possible to establish that they were a highly specialised workforce working with young people with quite specific needs. This suggests

that although many of the organisations in the network were able to offer services for the majority of the young people, there appeared to be organisations within the different areas that required more specialist services to be able to work with their client groups. Another group working on the periphery of the network were those from the Catholic Schools. The Catholic schools in each area appeared to have very few links within the main network as a whole, and instead linked with other Catholic Schools or organisations.

The networks also demonstrate that there appears to be quite a high level of connectedness between organisations in each of the geographical areas.

### **Measuring the strength of the partnership links between organisations**

This section examines the strength of partnership work taking place between the different organisations in the five geographical networks.

The frequency x importance centrality scores were used as a measure in this study to indicate the strength of the relationship between the respondents and the organisations they linked with. As mentioned previously the frequency x importance centrality score was calculated by multiplying the two scores respondents indicated to two questions in the survey namely how often they had contact with the other organisation (frequency), and how important they regarded this contact with the other organisation (importance). A higher score indicates a stronger relationship between the organisations. These scores were transferred from an excel spreadsheet into a matrix spreadsheet in the UCINET programme; the UCINET programme was then able to calculate the frequency x importance centrality score for each respondent.

The total number included in this data was N=163. The mean frequency x importance centrality score was 2.702 with a standard deviation of 1.951.

**Table 4.6 Mean Frequency x Importance Normalised Centrality Score by Geographical Area**

<b>Geographical Area</b>	<b>Mean</b>	<b>N</b>	<b>Std. Deviation</b>
<b>Midlothian</b>	<b>2.445</b>	<b>30</b>	<b>1.414</b>
<b>North West Edinburgh</b>	<b>3.747</b>	<b>19</b>	<b>1.847</b>
<b>West Lothian</b>	<b>3.292</b>	<b>23</b>	<b>2.508</b>
<b>East Lothian</b>	<b>3.845</b>	<b>23</b>	<b>2.578</b>
<b>Edinburgh City</b>	<b>1.979</b>	<b>65</b>	<b>1.303</b>

When comparing the mean frequency x importance normalised centrality score for each geographical area (Table 4.6). East Lothian had the highest mean score 3.845 while Edinburgh City had the lowest mean score of 1.979. An analysis of variance followed by a Scheffe Post Hoc test was carried out to examine whether there was any significant difference in the scores for each area. The mean score was significantly different between East Lothian and Edinburgh City (Difference = 1.865, P=0.05) and between North West Edinburgh and Edinburgh City (Difference = 1.767, P=0.05).

**Table 4.7 Mean Frequency x Importance Normalised Centrality Score by Service Type**

<b>Service Type</b>	<b>Mean</b>	<b>N</b>	<b>Std. Deviation</b>
<b>NHS</b>	<b>3.242</b>	<b>62</b>	<b>2.220</b>
<b>Voluntary organisations</b>	<b>3.155</b>	<b>18</b>	<b>1.9039</b>
<b>L.A</b>	<b>2.342</b>	<b>30</b>	<b>1.475</b>
<b>Education</b>	<b>2.121</b>	<b>53</b>	<b>1.686</b>

When comparing the mean frequency x importance normalised centrality score for each service type (Table 4.7). The NHS organisations had the highest mean score 3.242 while those from education had the lowest mean score of 2.121. To establish if there was any significant difference in the scores for each service type an analysis of variance was undertaken followed by a Scheffe Post Hoc test. The mean score was significantly different between the NHS and those from education (Difference = 1.121,  $P=0.05$ ).

These results are similar to those found when analysing the partnership working levels taking place between organisations and Healthy Respect. The NHS organisations had higher levels of partnership working with Healthy Respect and those from education had the lowest levels of partnership working with Healthy Respect.

### **Summary**

Results from both surveys have been useful in giving an insight into partnership working between organisations and Healthy Respect and between organisations themselves. The NHS and Education appear to be more engaged with Healthy Respect (at a general level). However, when using the more refined measure (developed to measure the strength of the

partnership relationship); the NHS organisations appeared to be most engaged and had a stronger partnership relationship with Healthy Respect compared with those from Education. Within the network data, many of the NHS organisations, but especially school nurses were seen as important partners by other organisations in all of the geographical areas examined (with the exception of Edinburgh City, where other health organisations appeared to be seen as important links for the respondents). Interestingly it would appear from the results that the Healthy Respect team were most successful in linking with one of the strongest partners i.e. the NHS (this point will be discussed further in Chapter seven).

When examining the results from the first survey (general level) it would appear that a higher percentage of providers from West Lothian were engaged with Healthy Respect. In the second survey the area that saw the largest increase in the most engaged category were those from East Lothian. When using the more refined measure to measure the strength of the partnership relationship with Healthy Respect the results were similar in that West Lothian had the highest partner engagement score in the first survey and East Lothian had the highest partnership engagement score in the second survey. Results also suggest that organisations in East Lothian had a stronger partnership relationship (statistically significant) with Healthy Respect than those from Edinburgh City. Results from the network data suggest East Lothian in particular had stronger partnership links between organisations working in that area.

The results for the geographical areas appear surprising in that Healthy Respect chose to focus on two areas in particular during this second phase

namely, Midlothian and North West Edinburgh. Yet results suggest that Healthy Respect were more engaged and had stronger partnership relationships with organisations from both East Lothian and West Lothian. There is evidence (Hardy et al 2000, Gray 1989 and Huxham 2000) to suggest that partnership work takes time to establish and this may account for these differing results geographically as both East and West Lothian had been involved in the Healthy Respect project from Phase 1 (this point will also be discussed further in Chapter 7).

Thus results suggest that:

- The NHS was the dominant partner for Healthy Respect
- Both the NHS and the Voluntary Organisations had a key role in the networks
- Higher percentage engaged came from West Lothian and East Lothian had a stronger partnership relationship with Healthy Respect.
- Within the networks, East and West Lothian appeared to have stronger links between the organisations working in these areas.

The following chapter examines factors that may have influenced the extent and level of partnership work taking place within the Healthy Respect project and may help to explain why variation in partnership work occurred between organisations and Healthy Respect.

## **Chapter 5 Results: Factors influencing partnership working**

### ***5.1 Introduction***

The qualitative stage of this study involved undertaking semi structured interviews with a sample of providers identified from the survey sample (N=42). An interview schedule was developed following preliminary analysis of the first survey data. In this way the researcher was better equipped to adapt the interview schedule so that information gathered helped explain and added to information already obtained from the questionnaire. This also allowed the researcher to include questions that could probe further to develop a deeper understanding of partnership working from the interviewee's perspective. The data obtained from the interviews provide an answer to Question 2 'What influenced partnership working between the Healthy Respect Team and the other organisations?'

The Chapter is divided into the following sections:

- 5.2 Sample and description of interviewees
- 5.3 Barriers to partnership working
- 5.4 Facilitators of partnership working

### ***5.2 The Sample: Description of interviewees***

The following section gives a brief description of the interview sample. Forty two participants were recruited using a purposive sampling strategy. It included proportionally more providers from whom explanations were needed. For example In order to explore the impact of Healthy Respect on those providers who targeted vulnerable young people, more of these providers (who consisted of practice Social Workers, Community Youth Workers, alternative care/education unit staff and voluntary organisation workers) were selected for an interview than from large NHS teams and from



school guidance teams. Table 5.1 displays the number of participating providers divided into the four service types: those from mainstream primary and secondary schools (Education), those from other local authority services (LA), those from the NHS and those from voluntary organisations (Voluntary Organisation).

**Table 5.1 Spread of Survey Respondents and Interviewees by service type**

	<b>Education.</b>	<b>LA</b>	<b>Vol. Org.</b>	<b>NHS</b>	<b>TOTAL</b>
<b>Survey Sample respondents</b>	127	42	30	111	<b>310</b>
<b>Interview Sample</b>	14	12	7	9	<b>42</b>
<b>Percentage of interviewees / respondents</b>	<b>11%</b>	<b>28%</b>	<b>23%</b>	<b>8%</b>	<b>13%</b>

Two thirds of those interviewed were female and the majority were experienced practitioners over the age of 30 years, qualified beyond a basic professional level. Voluntary organisation providers were on average younger than public sector providers.

### ***5.3 Barriers to partnership working***

Some of the barriers were linked to characteristics of the young people targeted by the organisations, some to the organisations themselves, some to the partnership with Healthy Respect and some to the environment within which Healthy Respect and the provider organisations operated.

#### **Young People**

Twelve interviewees from provider organisations suggested that some Healthy Respect resources, particularly SHARE but also drop-in services close to schools, did not meet the needs of their specific target groups. This

they argued impacted on their willingness and ability to engage with Healthy Respect. What follows is an anthology of quotes.

### **Anthology of quotes**

One interviewee thought the educational level of SHARE was high and better suited to mainstream school students than to young people out of school or at risk of dropping out – young people who might also miss out on the school-linked drop-ins:

*“SHARE in schools, it seems to be going really well and the drop ins with the schools. But it does seem very in the mainstream, do you know what I mean? and quite clever stuff for folk that are fairly articulate but if you need it spelt out...”* (Voluntary. Organisation. Worker)

One community youth worker thought the structured presentation of SHARE did not lend itself to unstructured work:

*“- Do you use your SHARE training at all for the street work?”*

*- ...for information, yeah, I suppose. But apart from having discussions with young people it's quite difficult because the SHARE training is a pack... you couldn't run a session like that out on the street”* (Community Youth Worker).

Three others from community youth work services thought the Healthy Respect model of education would not fit with their organisation's informal approach to young people:

*“[Healthy Respect] can do it in the schools, because the school regime, if you like, the way the school works, that fits well into it. And I wonder whether that's the problem... They've tried to take that model and fit it into an informal education model...”* (Community Youth Worker)

Another interviewee, who offered alternative information and services about sexual health to young people who had dropped out of school, said that these young people didn't engage with SHARE because they had missed out on the school context of SHARE or because they belonged to a different culture:

*“Excluded young people and those who don’t attend, you can’t take them through a SHARE programme because they have missed the bit at the beginning. And also their knowledge is slightly different”* (Voluntary Organisation Worker)

The same interviewee thought that disadvantaged young people might not access Healthy Respect drop-ins and services:

*“We work a lot with disadvantaged young people and they don’t access services the way that mainstream kids would. They don’t have the ability, they don’t have the knowledge”* (Voluntary Organisation Worker)

A focus group in a unit for young people with emotional and behavioural needs talked of difficulties in conveying the SHARE message that sexual activity belongs within a trusting and respectful mutual relationship. For young people who have experienced unreliable and abusive relationships, this is hard to grasp. An interviewee explained that this unit had delayed the implementation of SHARE while they grappled with the challenge:

*“I think it’s been a while [since training in SHARE] because people [staff] weren’t sure, you know, what it was in terms of how they actually teach relationships to what you would class as disaffected young people, or socially excluded young people, or whatever term you want to class them as”* (Unit Staff Member).

The findings suggest that some providers found it difficult to use a number of Healthy Respect resources in the context of their work with ‘disadvantaged’, ‘excluded’, and ‘disaffected’ young people, to use their own terms. This raises the question of how much resources might be tailored to the sexual health needs of specific target groups. It was Healthy Respect’s intention that their resources be accessed by young people sexually at risk via the partner organisations they invited to work with them but the interviews reveal that some organisations found this difficult and therefore they found no reason for partnership work to take place between themselves and HR2.

## **Organisations**

Some interviewees drew attention to internal organisational constraints. One such issue was the conflicting responses some strategists and their frontline workers had to Healthy Respect. This was highlighted in the case of social workers whose local authority had agreed to work in partnership with Healthy Respect. Whereas a social work strategist interviewed envisaged Healthy Respect's influence on practice social work as a good thing, the frontline interviewees disagreed or were not able to implement it. What follows is an anthology of quotes.

### **Anthology of quotes**

Five social workers were interviewed from three different teams in Healthy Respect 2 areas; one operated at a strategic level, one was a local team leader and three were frontline social workers in practice teams. The strategic manager was positive about Healthy Respect and expected practice social workers on the ground to engage with the project, take up training opportunities and incorporate sexual health work into their jobs. Initial difficulties did not alter this view:

*"I had contact with [Healthy Respect] and we had some discussions about how they might influence and become part of it but because I think there was some resistance to outsiders within the team it wasn't something we could have achieved at this, at that time but we can now" (Social Work Manager).*

However, this was not the view of the frontline social workers from practice teams interviewed. They expected others to deal with sex and relationship education, mainly the schools. When they came across young people who did not go to school, they gave them leaflets from voluntary organisations and referred them to local sexual health services as they had done before

Healthy Respect 2. They offered several reasons for not attending to sexual health themselves.

One reason was time. A social work team leader stressed how difficult it was to make space for young people's sex and relationship issues when teams were faced with reorganisation and new computerisation and when everyone needed training in new child protection guidelines, anti-discrimination and equal opportunity legislation.

*"I think the thing is it comes back to what our role is... and how much training is actually needed really, for our staff here to be spending a huge amount of time focusing specifically on that one issue"* (Social Work Team Leader).

Another interviewee reported finding it difficult to make plans for training in advance because much of her work consisted of emergencies.

Yet another reason was that sexual health was not a priority. The leader of a team of eight social workers, two of whom had attended a Healthy Respect training day, reported that while his colleagues had found the day useful, they had not found the material new. It had been decided that they would share the information with the rest of their team and that no-one else would attend training days.

Another reason voiced by the social workers interviewed for not engaging with Healthy Respect was the ambiguity it introduced into their roles regarding the under-16s whose sexual activities they were trained to police, not to support:

*"A social worker's job is to prevent sex under the age of 16"* (Social Worker)

They told of the stress of working with widely publicised child protection failures behind them in two local authority areas. They felt they had to give priority to child protection with limited resources, watched by the public and the media.

Two newly qualified social workers had found a Healthy Respect half training day valuable. Both reported that their initial training lacked input on young people's sexual health and both thought it was difficult for social workers to address the subject directly with young people but important to do so. One of these young social workers had extremely limited knowledge and understanding of Healthy Respect. No Healthy Respect resource was used in their teams.

For all the interviewees, there had been no contact with Healthy Respect other than Continuing Professional Development training (CPD) and they received no funding from Healthy Respect.

One other reason for not taking up the sexual health agenda and working in partnership with Healthy Respect was offered: a team leader was aware that her client group's poor sexual health was deprivation-related, which led her to think that the solutions offered by a national health demonstration project were not proportionate to the problem of inequalities in health.

*"if you are living in poverty with a parent who doesn't give a damn about you... it's these things that need to be tackled, and it's not just by putting in a programme like Healthy Respect...It is a much much wider, more complicated issue. It's massive"* (Social Work Team Leader).

Interviews with community youth workers highlighted a similar problem in a team where Healthy Respect contact had been perceived as interference.

Interviewees pointed out that their management supported Healthy Respect, nurturing expectations which were not welcome at the frontline. As a result workers had responded in an irritated and resentful manner and partnership with Healthy Respect had not developed:

*“And [Healthy Respect] had seemingly been given the idea that [they had] been invited into the area... [Managers] had done deals with Healthy Respect, decided that [X] would be the particularly right [geographical] area to do it, and then said ‘right, come into [X] and do it. ’ So that the [Healthy Respect] practitioners were expecting the welcome that you would get from hosts that had invited you to come – and didn’t get that at all” (Community Youth Worker)*

Two other examples of internal constraints impeding the impact of Healthy Respect were described: in one case the manager of a residential institution explained it had been difficult to implement SHARE because of an institutionalised group of staff who were reluctant to change. Another respondent described how the secondary schools’ aging population of teachers were putting at risk a recently established Healthy Respect school culture because Healthy Respect trained guidance teachers retired.

It is worth pointing out however, that the conflict of interest between management and front line workers was not seen in all the services. In fact interviewees most notably from education and the NHS spoke about managerial support in a very positive light. Secondary school teachers in particular spoke about their ability to deliver the SHARE programme because it had been endorsed by the Education Department within their Local Authority. This, they felt was important and without the backing from that level they would not have been allowed to just go ahead with it.

*“I think the fact that people feel that they are getting trained in something even though I’m sure they’re more than capable of delivering it. I think*

*there's confidence to know you are going through as sort of training. I think it is nice to know that you're doing something that's being delivered elsewhere as well. So there's certain consistency there"* (Secondary School Teacher).

Many others discussed the need for support at managerial level for partnership working to take place.

*"If the key people are there at ground level if they don't get managerial support for partnerships it might be more difficult for them".* (Voluntary Organisation)

Problems within an organisation, especially one as large as a local authority, were common, whether internal disagreements about staff remits, poor communication, resistance to change or a high turnover of staff. Interviews with providers in these organisations showed that these internal problems became obstacles in their ability to work in partnership with Healthy Respect, in using training and resources and in sustaining a relationship between themselves and Healthy Respect. Apart from the high turnover of staff which was taking place in mainstream schools, the other constraints mainly took place in organisations targeting vulnerable young people.

### **Relationship with Healthy Respect**

Some providers were critical of Healthy Respect on grounds of top-down communication with them, one sided negotiations regarding branding, lack of involvement in decision making and lack of awareness regarding their remit. These comments were few and came mostly from voluntary organisations, social work and community youth teams that had not engaged well with Healthy Respect. What follows is an anthology of quotes.

### **Anthology of quotes**

One community youth worker made an interesting comment about the way Healthy Respect went about trying to partner with them. Again this also



highlights the conflicting responses by management and frontline workers.

Although they didn't want to put all the blame at Healthy Respect's door they thought that:

*"Some suits (managers) in the council had done deals with Healthy Respect and told them to come in and do some work in this area". This felt very much like they were parachuting in to save us" (Community Youth Worker).*

Another NHS middle manager thought the barriers to partnership with Healthy Respect were around Healthy Respect concepts being imposed upon them rather than being discussed and debated. This same manager felt they were also being left to carry on services previously developed by Healthy Respect with no extra funding or resources to carry it on, and had they previously been involved from the beginning they might have developed and maintained these services differently:

*"Hmm, I don't know. They have certainly taken a major shift. The major shift is that there is definitely an agenda that I can see, and the agenda is that they have to develop services and then pass it onto us, and they have to try to do it without any cost incurred, so they are imposing it on us, and quite a few other people would, I'm not speaking on my own, a lot of the senior people here would feel that it is a criticism that we're not doing well enough on our own, that somebody has to tell us how to do things. That doesn't sit well; I have to be honest with you" (NHS Sexual Health Worker).*

The same barriers were identified by a community youth worker and voluntary organisation worker:

*"My perception of what we were being asked to do at that point was almost turn over our sexual health provision to Healthy Respect, and have it branded as Healthy Respect in return for some publicity materials and very little resources, on the basis that young people would respond to a continuity of branding" (Community Youth Worker).*

*"I think Healthy Respect has done a lot but then there is that feeling that we were already doing it, so what's different? And I think that's an honest feeling" (Voluntary Organisation Worker).*

*"I have to say that that's pretty much the feeling I have when we've worked with Healthy Respect, it's 'we have an agenda.....,we have to achieve results'...I think the obstacles to partnership are that....it (healthy Respect) is*

*too much goal driven, it's too much time orientated"* (Community Youth Worker).

Power differentials between partners were another issue. Some providers viewed themselves as weaker partners when it came to making decisions regarding sexual health services for young people. This was particularly the case for voluntary organisations that depended on funding from partners in the NHS and the local authorities.

*"It's one of those things with the voluntary sector, that we get marginalised when it comes to decision making and that we're kept, like mushrooms, we're kept in the dark a lot because we're up against powerful people who hold the purse strings and the power"* (Voluntary Organisation Worker).

For these organisations, another aspect of the power differential between themselves and their partners was to take on the Healthy Respect brand. Interviewees said they felt their work would not be seen and they might lose their funding.

*"Voluntary sector mentality is – and it has to be, right? - we need to constantly remind our funders who is doing this work... And we don't want to then say 'we're not doing the sexual health work, Healthy Respect is doing it'"* (Voluntary Organisation Worker).

*"...it's almost like Healthy Respect would come in somewhere where all the hard work has been done...brand it Healthy Respect and take all the glory for it"* (Voluntary Organisation Worker).

It also transpires from a few interviews that some providers did not respond well to Healthy Respect because they felt their remit was not understood. This was true of the frontline social workers and the community youth services that had negotiated with Healthy Respect through their management structure. As we saw earlier, some of the misunderstanding came from differences in agreement about the nature of sexual health work between managers and frontline staff.

Another issue highlighted in the interviews with the local authority organisations was that the structure, certainly within social work, meant that working with HR was perhaps more relevant to some teams than others.

*“Well, I think the problem is with the organisation when one department was recently amalgamated with another department, there’s been massive change and massive change in the structures within these departments. There are huge competing pressures in terms of time available as to what’s on the agenda.*

*The other thing, which is on the agenda, is equality, equal opportunities, anti-discriminatory stuff, and it’s that sort of thing which I would say is competing with issues such as sexual health. There are much broader issues of lack of resources, child protection training, and multi-agency working with different organisations. Sexual health would be a very small part of that, you know?”* (Social Worker)

One interviewee within an NHS organisation worried about the effects of shortages i.e. staff and resources to carry on and undertake partnership work. She felt that

*“When you were pressurised to get all of your own work done with limited staff and resources there was no time left to undertake work that although you feel it is important, it will be the work that just doesn’t get done”* (NHS Worker)..

These negative comments about communication, the management of power and the understanding of remits made by interviewees about their contact with Healthy Respect were few. However, they do seem to point to reasons why some partnerships did not work well, lowering the level of impact Healthy Respect had on some provider organisations.

### **External Constraints**

At least two constraints out of the control of either Healthy Respect or their partner organisations were mentioned by interviewees as influencing their sexual health work: the reorganisation of local authority social work and the

NHS in Lothian and the contribution of socio-economic deprivation to the sexual vulnerability of certain groups of young people.

The disruption caused to services and providers by the re-structuring of Local Authority social work departments one in 2005 and the other in 2006 as well as the re-organisation of NHS Community Services were frequently mentioned during interviews. For example it was clear that the reorganisation of the Local Authority social work departments following a negative child protection report, resulted in many social workers leaving, and caused extreme disruption to social work teams. Social workers from two areas in particular mentioned their anxiety regarding child protection and their need to give it top priority. It does seem that this made the progress of sexual health work with young people, particularly those under 16, more difficult.

With regards to the NHS, the school nurses interviewed described how the school nursing teams had been dismantled to scatter school nurses across Local Health Care Partnerships (LHPs) where they were isolated and found it more difficult to be heard. They were also sceptical about the ability of LHPs to allocate funding to sexual health drop-ins for young people.

Two providers, a social worker and a community youth worker, also raised the issue of exclusion and socio-economic deprivation as the real cause of poor sexual health in some young people. They suggested that Healthy Respect would not reach these young people because few services reached them:

*“You have young people who are not going to school and young people who have left school... who are floating around doing nothing... And I think that what we need is, we need a bigger emphasis on working with those young folk; I think we [as a society] are letting those young folk down” (Community Youth Worker).*

## **5.4 Facilitator's of partnership working with Healthy Respect**

The interviews revealed a number of factors which may have acted as facilitators to partnership work taking place between Healthy Respect and the provider organisations. The facilitators were linked to; the characteristics of the Healthy Respect team, their ability to drive the sexual health agenda forward, the resources and funding made available and the networking events provided.

### **Characteristics of the Healthy Respect Team**

Healthy Respect's leadership role had been well received by interviewees and was thought to have raised the profile of young people's sexual health in Lothian, kept the topic on providers' agendas and facilitated sound policy making. This in turn had a positive impact on providers of sexual health education, information and services to young people and the quality and consistency of provision was perceived to have increased. While it was more difficult to be sure that the impact had reached young people and their parents, most providers thought there was some evidence that it had. Many providers praised the Healthy Respect team for being approachable and friendly. What follows is an anthology of quotes.

### **Anthology of quotes**

The facilitating factors highlighted by interviewees appeared to focus on the approachability, friendliness and the ability to talk to and work with HR2 staff. The Healthy Respect 2 team appeared to have pursued their aims in a friendly manner; to highlight one comment in particular seemed to sum up the feeling:

*“Behind the brand there’s very human people that you can be straight with and up front and they’ll be the same with you and that cuts through a lot of flannel which makes a difference” (Voluntary Organisation Youth Worker).*

*“I think the way that Healthy Respect has, not just tried, but succeed in working with staff has all been positive... Because I think in this whole area... people have got a lot of sensitivities and quite a lot of baggage in how they deal with sexual health and I think, you know, Healthy Respect has really worked well at trying to take people with them” (School Strategist).*

Generally Healthy Respect was perceived to have raised the profile of teenage sexual health and more than half the providers interviewed explicitly valued Healthy Respect as a champion and advocate of young people’s sexual health:

*“You need somebody to take ownership and say, ‘this is worth keeping, this is worth fighting for’” (School Nurse).*

Most interviewees thought Healthy Respect had opened the debate about young people’s sexual health, had raised social awareness and had been instrumental in keeping the topic on the agenda of frontline providers, managers, policy makers and the public. It was suggested that Healthy Respect was influential in the production of a coherent sexual health policy:

*“I do think that we wouldn’t have the sexual health policy we have now... without Healthy Respect” (Community Youth Worker)*

Some service providers described Healthy Respect as a key factor in changing the culture of teenage sexual health provision:

*“I think sexual health probably has been highlighted through Healthy Respect... Six/seven years ago health was way down the agenda, when you worked with social work and residential care. And it’s very much on the agenda now. I think that’s because there’s always health professionals represented at strategic groups and stuff like that” (Specialist Nurse).*

The project was described as responsible for making it more acceptable to talk about young people's sexual health and to have drop-in clinics for teenagers. Concerns were expressed that without Healthy Respect's continued input, teenage sexual health would slip off stakeholders' agendas and perhaps not achieve the desired impacts:

*"I think they've managed to bring it up the agenda but that will get lost again unless they retain workers to continue that work... And it's really beneficial to have an overview, particularly when there is so much going on in different places"* (Voluntary Organisation Worker).

*"Hopefully when Healthy Respect goes people maintain that partnership working and hopefully mother hasn't gone, the one that kind of kept it going, hopefully individual agencies or organisations see the importance of it for themselves to take ownership of it"* (Voluntary Organisation Worker).

Increased awareness among providers themselves led to taking on a more proactive role in providing sexual health information and guidance to young people. Providers felt better equipped to help young people and parents deal with sexual health issues. Due to Healthy Respect training and resources many felt they had become more comfortable, confident, knowledgeable and competent in talking to young people about sexual health matters. The availability of a network of support (consisting of the Healthy Respect team and other providers) enabled them to deliver more appropriate and evidence-based content to young people:

*"I think it does create a culture of confidence and a culture where people are more relaxed and feel empowered to discuss [sexual health matters] in a professional way and a humorous way and in a way that helps people access and identify... and a position where they feel confident to learn"* (School Teacher).

The welcoming atmosphere at training events was mentioned explicitly by several service providers:

*"The stuff that I've been on through Healthy Respect have been quite good and the people that I've worked with in the past have been really positive"* (Community Youth Worker).

## **Funding and Resources**

Another factor highlighted was the funding and resources that were made available to some services and organisations to set up and develop drop in clinics (although not all were given this funding).

*“Well the money allowed us to pay a doctor to come into the drop in. It gave us an In reach/Outreach project worker for the three years. It gave us funding for branding. It gave us funding to refurbish a couple of our rooms. It gave us access to more leaflets, so yes; I mean there were direct effects from the funding, yes” (NHS Worker).*

The availability of Healthy Respect resource folders, including but not solely consisting of the SHARE (Sexual Health and Relationship Education) resource, has influenced the sexual health education practice of service providers considerably. While the sexual health services in some organisations were not changed by Healthy Respect, they felt that their services had been endorsed by Healthy Respect’s activities.

Reasons for the impact Healthy Respect’s materials had on sexual health education include the quality of the materials, the structure it provides, its alignment with good teaching practice, the expertise of the staff producing the materials, its knack for sparking new ideas, and the internal consistency of the resource.

## **Networking Events**

Many of the organisation’s and in particular the Voluntary Organisations spoke about the networking events and felt they had been useful to meet other people doing similar work to themselves and also helped with making links into other organisations. Twelve interviewees commented positively on the partnership Healthy Respect had fostered with provider organisations and



across individuals and organisations. Some of them said it had helped agencies working with young people to know about each other; it had enhanced existing partnerships and promoted new ones to address young people's sexual health needs:

*"I didn't know a lot about [other organisations] at all. The majority of my knowledge has come about especially through the CPDs [Continuing Professional Development days] and... and again through other networking days, you know, that we have"* (Community Youth Worker)

However contrary to this many organisation's when asked if these events and network meetings had facilitated any partnerships with other organisations many said no they hadn't, most felt that the partnerships they had with other organisations had come about through their own doing and had nothing to do with input from Healthy Respect. Several providers claimed they knew about the value of partnership before Healthy Respect and already had links with other agencies but these providers agreed with the emphasis Healthy Respect had put on partnership working:

*The more you are in partnership with anybody, the more likely you are to solve issues, get lots more information, and do the job that you need to do* (School Teacher).

Some Interviewees reported that Healthy Respect had also played a facilitating role within organisations. For some the delivery of sexual health was restructured, the sharing of resources was increased and it had become easier to involve colleagues in young people's sexual health.

However, while some services felt endorsed by Healthy Respect's activities, others were wary of giving too much credit to Healthy Respect for their evolution:

*"I suppose they have learnt lessons, yes... It is difficult to say whether the organisation would want it to be said that Healthy Respect changed everything or whether they would have evolved anyway...Whether they would accept that I don't know"* (Voluntary Organisation Worker)

The focus on sexual health prior to Healthy Respect had been described as being quite random because schools were able to decide what materials they used and in the words of one provider:

*“I was around a long time before Healthy Respect and without the money and without the focus we’d still be piddling around” (NHS worker).*

## **5.5 Summary**

The interviews were useful in highlighting many factors that providers felt had impacted (both positively and negatively) on their ability to work in partnership with Healthy Respect. On the whole Healthy Respect’s leadership role was well evaluated by most providers, even by those who were critical of other aspects of the project. Those interviewed also felt that the Healthy Respect team were able to drive the sexual health agenda forward and without them feared that young people’s sexual health would not be seen to be a priority. These factors were all seen as having a positive influence on providers working with Healthy Respect.

However, many barriers were also identified that helped to explain why providers didn’t engage with or were less likely to work with Healthy Respect. Some of these factors were linked to characteristics of the young people targeted by the organisations, some to the organisations themselves, some to the partnership with Healthy Respect and some to the environment within which Healthy Respect and the provider organisations operated.

Healthy Respect did not aim to take an exclusively population based approach but aimed to target vulnerable young people by working in partnership with those organisations thought to provide sexual health information or services to these young people. Yet the findings show that this was difficult to achieve as many of the factors that challenged partnership

working in the project appeared to affect those providers offering services to the vulnerable young people i.e. social workers, community youth workers and in some cases the voluntary organisations. The results from this chapter (just like the previous chapter) have raised many issues that need to be discussed further. For instance, it does beg the question of whether Healthy Respect was the most appropriate method by which to reach either the vulnerable young people or the organisations working on their behalf.

The results from the interview data will be brought together with the results of the quantitative data (in Chapter 7) where the findings will be interpreted and discussed in more depth.

## **Chapter 6 Results: The outcomes of partnership working with Healthy Respect and other organisations**

### ***6.1 Introduction***

This Chapter answers the third research question which determines the outcomes of partnership working between Healthy Respect and other organisations namely, whether it helped increase the professional capacity and capability of providers (knowledge, skills and networking) (Healthy Respect programme Logic Model Appendix A). It also examines whether partnership working between organisations was influenced by Healthy Respect. The Chapter presents the results of the survey data but also utilises data obtained from the qualitative interviews and thus provides an in depth account of the perceptions and beliefs of the providers who were in contact with Healthy Respect.

The results are presented in three sections:

Section one examines whether partnership working with Healthy Respect is associated with an impact on the organisations.

Section two examines whether partnership work in the networks was associated with an impact on the organisations involved in the network. . It also examines whether Healthy Respect had any influence on the partnership work taking place between organisations.

Section three examines the qualitative data with regards to the provider's perceptions of the impact of partnership working with Healthy Respect.

## **6.2 Section 1: The impact of partnership working with Healthy Respect**

Healthy Respect assumed that the outcome of partnership working would be an increase in the organisational capacity and capability of organisations, particularly staff's skills and understanding, and confidence in working with young people. This section examines the relationship between partnership working with Healthy Respect as measured by the partnership engagement score and these organisational outcomes.

### **Impact on Providers' Understanding**

The first area examined relates to the providers understanding of issues which relate to the sexual health of young people. Question 11 from the survey (Appendix B) was used to measure providers' understanding and consisted of eight sub questions which asked the extent to which Healthy Respect helped their:

1. understanding of sexual health issues,
2. confidence in approaching sexual health matters with young people
3. understanding of young people's own perspective on sexual health
4. ability to share ideas on sexual health issues with other professionals
5. advocacy skills concerning young people and their sexual health
6. child protection knowledge and skills
7. administrative workload
8. workload in other areas of job

A factor analysis was undertaken and 2 components were extracted:

1. Effect on Understanding
2. Effect on Workload

The Kaiser-Meyer Olkin measure of sampling adequacy was 0.827 indicating that a factor analysis was appropriate for this data. The Bartlett's test for sphericity was significant ( $P < 0.001$ ) indicating that there was some relationship between the variables. The rotated component matrix (outlining the loading factor scores) for this Question can be found in Appendix D.

A Pearson product-moment correlation was used to examine the association between understanding and workload and the mean partner engagement score. Understanding was found to be positively associated with partnership working with Healthy Respect ( $r=0.264$ ,  $P=<0.01$ ). However, there was no statistically significant association found between workload and the mean partner engagement score.

An analysis of variance including a Scheffe Post Hoc Test was undertaken to examine whether there was any significant difference in mean factor scores (understanding and workload) between the different service types. No significant differences were noted for factor scores between the different service types. It is perhaps worth noting, that when looking specifically at the association between partnership working and workload there was negative association for two organisations in particular; the NHS and Education. Whilst for those in the Voluntary organisations, Local Authority and Primary Schools working with Healthy Respect had no impact on their workload neither making it worse or better.

The same procedure was applied to the mean factor scores between the different geographical areas and again there were no statistical differences noted for the factor scores between the geographical areas. There was however, a negative association noted for partnership working and workload

in three areas; North West Edinburgh and East and West Lothian. Suggesting that in these areas, working with Healthy Respect had a negative impact on their workload.

### **Impact on staff's ability to focus on sexual health issues**

Question 12 (Appendix B) in the questionnaire asked respondents nine questions about whether Healthy Respect had helped them to focus on sexual health issues with young people:

1. Enhancing young people's ability to make choices about their sexual health
2. Increasing the quality and consistency of sex and relationship education for young people
3. Improving access for young people to sexual health education and services
4. Increasing the quality of sexual health drop in services for young people
5. Addressing unintended teenage pregnancy
6. Addressing sexually transmitted infections
7. Improving the support available to parents
8. Facilitating opportunities to refer young people to other services
9. Improving staff's awareness of young people's perspective regarding sexual health and relationships

A factor analysis was undertaken and 2 components were extracted:

- Focus on specific sexual health improvement for young people (STI's and unintended teenage pregnancy)

- Focus on service delivery (including access and quality)

The Kaiser-Meyer Olkin measure of sampling adequacy was 0.869 indicating that a factor analysis was appropriate for this data. The Bartlett's test for sphericity was significant ( $P < 0.001$ ) indicating that there was some relationship between the variables. The rotated component matrix (outlining the factor loading scores) for this Question can be found in Appendix D.

A Pearson product-moment correlation was used to examine the association between the two factor scores and the mean partner engagement score. There was a statistically significant association found for focus on sexual health improvement and partnership working with Healthy Respect ( $r=0.426$ ,  $P < 0.01$ ). There was also a statistically significant association found for focus on service delivery and partnership working with Healthy Respect ( $r=0.231$ ,  $P < 0.05$ ).

Question 12.7 asked whether Healthy Respect had helped them to focus on 'Improving the support to parents'. The value attached to this question in the rotated component matrix (Appendix D) was found to be very low, suggesting that this was a poorly answered question. This could be due to the fact that providers were reluctant to answer this question; certainly findings from the main evaluation study had found that working with Healthy Respect had a relatively low impact on helping organisations support parents. Therefore, a separate analysis of the data was undertaken examining whether partnership working was associated with 'Improving the support available for parents'. When examining the mean partner engagement score with the scores for 'Improving the support available for parents' no association was found. Suggesting that partnership work



with Healthy Respect had not influenced or impacted on an organisations ability to support parents in their role regarding sexual health work with young people.

An analysis of variance including a Scheffe Post Hoc Test was undertaken to examine whether there was any significant difference in mean factor scores (focus on sexual health improvement and focus on service delivery) between the different service types. No significant differences were noted for factor scores between the different service types. The same procedure was applied to the mean factor scores between the different geographical areas and again there were no statistical differences noted for the factor scores between the geographical areas.

### ***6.3 Section 2: The impact of partnership working between organisations***

Further analyses was undertaken to examine whether the partnership work taking place in the networks had any impact on the organisations involved in the networks. Question 4b in the questionnaire (Appendix B) asked respondents seven different questions about whether linking with other organisations had helped them in:

4.1 Working more effectively with young people

4.2 Working more effectively with parents

4.3 Pooling resources

4.4 Increasing the number or referrals to specialist organisations

4.5 Establishing professional roles between you and other organisations you work with

4.6 Establishing clear communication between you and other organisations you work with

#### 4.7 Building trust between you and the other organisations you work with

A factor analysis was not used for this question as the Bartlett's value indicated that there was no significant relationship between the variables in the data.

A Pearson product-moment correlation was used to examine the mean strength of partnership between organisations as measured by the frequency x importance centrality score (strength) with data obtained from the questions outlined above (Table 6.1). (A greater mean score = stronger partnership relationship).

**Table 6.1 Correlation of Q4.1-4.7 by Frequency x Importance centrality score**

<b>Question 4.1 – 4.7</b>	<b>Mean Partnership Score</b>
<b>4.1 Working more effectively with young people</b>	<b>.264**</b>
<b>4.2 Working more effectively with parents</b>	<b>.003</b>
<b>4.3 Pooling resources</b>	<b>.251**</b>
<b>4.4 Increasing the number of referrals to specialist organisations</b>	<b>.173*</b>
<b>4.5 Establishing professional roles between you and other organisations you work with</b>	<b>0.53</b>
<b>4.6 Establishing clear communication between you and other organisations you work with</b>	<b>0.82</b>
<b>Building trust between you and the other organisations you work with</b>	<b>.207*</b>

**\*\* Correlation is significant at the 0.01 level (2-tailed)**

**\* Correlation is significant at the 0.05 level (2-tailed)**

Results demonstrate that being involved in partnership work in the network was positively associated with an organisations ability to work more effectively with young people ( $r=0.264$ ,  $P< 0.01$ ). There was also a positive association found for pooling resources ( $r=0.251$ ,  $P<0.01$ ), increasing the

number of referrals to specialist units ( $r=0.173$ ,  $P < 0.05$ ) and building trust between themselves and other organisations they work with ( $r=0.207$ ,  $P < 0.05$ ). Although there was no significant association found for three of the questions (4.2, 4.5 and 4.6); when checking for linearity there did appear to be a linear relationship between the questions and the frequency x importance centrality score, suggesting there was a weak relationship between the variables.

### **The relationship with Healthy Respect and partnership working between organisations**

Another area that was examined was whether Healthy Respect had influenced the partnerships between the different organisations involved in the networks. In the second survey respondents were asked if working with Healthy Respect had any affect on them linking with other organisations (Question 9, Appendix B). 115 respondents answered this question in the second survey and 40% of them said yes working in partnership with Healthy Respect had helped them link with other organisations. An independent *t*-test was used to examine whether those receiving help from Healthy Respect in linking to organisations had stronger links to other organisations compared with those not receiving help.

The mean partnership score for those receiving help was 3.378 (SE, 0.238) compared with 2.494 (SE, 0.238) for those not receiving help. This difference was significant  $t (-2.288) = 0.024$ ,  $p < 0.05$ . These results suggest that those with better network centrality scores were helped by Healthy Respect to link with the other organisations involved. However, what must be taken into account is that the majority (60%) said no to the question.

#### **6.4: Impact of Healthy Respect on Sexual Health Inequalities**

One way in which Healthy Respect (Phase 2) differed from Healthy Respect (Phase 1) was its explicit focus on tackling health inequalities. They chose to focus on specific groups of young people whose sexual health may be particularly affected by their social status:

*‘For the purpose of Healthy Respect Phase 2, we chose to concentrate on young people experiencing deprivation, and to focus on the following groups, for which little evidence is available on effective interventions:*

- *young people who are excluded, or at risk of exclusion from school, and are in receipt of additional support*
- *young people being looked after and accommodated by local authorities*

*We also chose to work with young people with learning disabilities, as their sexual health needs are varied and complex, and are often missed out in mainstream interventions.’*

(Statement provided by Healthy Respect March 2008).

As a means of targeting these groups Healthy Respect aimed to work in partnership with organisations they assumed worked with these groups of young people. Providers were asked which vulnerable groups their organisations worked with in relation to the sexual health of young people. Table 6.2 provides the percentage of those providers working with Healthy Respect (by service type) that said ‘yes’ they work with the targeted groups in relation to their sexual health. Results highlighted that a slightly higher percentage of Voluntary organisations and Local Authority organisations work with young people either not attending or excluded from school and those who are looked after and accommodated by the Local Authority, compared with those from the NHS and education. Those from the voluntary organisations and education had a slightly higher percentage of professionals working with young people with learning disabilities.

**Table 6.2 Percentage of providers by service type saying ‘yes’ they work with a Healthy Respect target group (1<sup>st</sup> Survey)**

<b>Vulnerable Groups</b>	<b>Service Type</b>			
	<b>NHS</b>	<b>Voluntary Organisations</b>	<b>Local Authority</b>	<b>Education</b>
Young people excluded or at risk of exclusion from school	70%	94%	92%	30%
Looked after and accommodated young people	89%	100%	92%	76%
Young people with learning disabilities	86%	94%	77%	89%

Table 6.3 provides the percentage of those providers working with Healthy Respect (by geographical area) that work with the targeted groups in relation to their sexual health. Figures for both Edinburgh City and Midlothian show a slightly higher percentage of providers who reported working with all three of the targeted groups. Results for North West Edinburgh highlight a lower percentage of providers (44%) from this area who reported working with young people excluded or at risk of exclusion from school.

**Table 6.3 Percentage of providers by geographical area saying ‘yes’ they work with a Healthy Respect target group (1<sup>st</sup> Survey)**

<b>Vulnerable Groups</b>	<b>Geographical Area</b>			
	<b>Midlothian</b>	<b>North West Edinburgh</b>	<b>Edinburgh City</b>	<b>East and West Lothian</b>
Young people excluded or at risk of exclusion from school	60%	44%	70%	53%
Looked after and accommodated young people	95%	84%	85%	79%
Young people with learning disabilities	86%	85%	93%	86%

In the first survey respondents were asked whether any groups of young people were missed by Healthy Respect. A total of 141 responded: 98 of those partners, 25 of those with some involvement and 18 of those with no involvement. 70% of partners and 72% of those with some involvement with Healthy Respect said 'yes' compared with 50% of those not involved (Table 6.4).

**Table 6.4 Percentage of providers responding by level of involvement (1<sup>st</sup> survey)**

	<b>Partners</b>	<b>Some involvement</b>	<b>No Involvement</b>
<b>Yes</b>	69 (70%)	18 (72%)	9 (50%)
<b>No</b>	24 (25%)	1 (4%)	1 (6%)
<b>Unsure</b>	5 (5%)	6 (24%)	8 (44%)
<b>Total</b>	98 (100%)	25 (100%)	18 (100%)

Respondents were asked to state which groups were missed by Healthy Respect. There was no discernable difference between the responses in each provider group thus Table 6.5 provides an overview of the responses of the whole sample. The largest single group of responses (28%) were for young people not at school. This was followed by socially excluded young people (15%) and young people with learning disabilities (13%).

**Table 6.5 Groups missed by Healthy Respect (1<sup>st</sup> survey)**

<b>Categories of YP being missed</b>	<b>Total</b>
Young people not at school	34 (28%)
Young people socially excluded / hard to reach / vulnerable	19 (15%)
Young people with learning disabilities or special needs*	16 (13%)
Lesbian, Gay, Bi-sexual, Transgender young people	11 (9%)
Travellers	8 (7%)
Looked after and accommodated young people	7 (6%)
The majority of young people**	7 (6%)
Timid / quiet young people.	7 (6%)
Black, minority and ethnic young people	5 (4%)
Religious young people	4 (3%)
Other: YP with physical disabilities / Homeless / abused & neglected / well off / sex workers	5 (4%)
<b>Total</b>	<b>123 (100%)</b>

Results suggest that the majority of the providers responding to this question believed that there were still certain types of young people being missed by the Healthy Respect project, the majority of those being young people not attending or excluded from school.

In the second survey a total of 55 (39%) of partners suggested Healthy Respect missed certain groups of young people compared with 70% in the first survey (Chi-square  $p=0.0001$ ). Of the 55, 40% were from schools and 38% were from the NHS. A total of 53 indicated which groups were missed and these appear in Table 6.6.

**Table 6.6 Groups missed by Healthy Respect (2<sup>nd</sup> survey)**

<b>Categories of YP being missed</b>	<b>Total</b>
Young people not at school	30%
Young people with learning disabilities or special needs	19%
Lesbian, Gay, Bi-sexual, Transgender young people	11%
Looked after and accommodated young people	6%
Young people socially excluded / hard to reach / vulnerable	6%
Travellers and migrants	4%
Black, minority and ethnic young people	4%
The majority of young people i.e., those who want to be married	2%
Religious young people	2%
Other: primary school children/ those unable to access existing services/ those not recognising the HR brand	17%
<b>Total</b>	<b>53 (100%)</b>

### ***6.5 Sections 3: Impact of partnership working with Healthy Respect – Results from the Qualitative Interviews***

The majority of those interviewed felt that the focus, expertise, and resources provided by Healthy Respect had a considerable impact on their capacity and capability in terms of them delivering sexual; health education, information and services to the young people. The Healthy Respect training and materials helped service providers become more comfortable, confident, knowledgeable and competent in talking to young people about sexual health matters.

#### **Anthology of quotes**

Many said they felt “more at ease” and explained this was due to the fact that they had access to up-to-date and accurate information and knowledge on sexual health matters. The availability of appropriate services and support made available to service providers enabled them to deliver more appropriate and evidence-based content to young people.



Others spoke about the ability to deliver the SHARE programme because it had been endorsed by the Education Department within their Local Authority, this they felt was important and without the backing from that level they would not have been allowed to just go ahead with it.

*“I think the fact that people feel that they are getting trained in something even though I’m sure they’re more than capable of delivering it. I think there’s confidence to know you are going through as sort of training. I think it is nice to know that you’re doing something that’s being delivered elsewhere as well. So there’s certain consistency there” (Secondary School Teacher).*

Healthy Respect was also described by service providers as being a key factor in changing the culture of teenage sexual health provision. Healthy Respect was described as responsible for making certain types of sexual health services (i.e. drop-in clinics) more acceptable, for making it more acceptable to talk about young people’s sexual health matters. It moved sexual health provision from a crisis-led to a preventive culture and from a predominant focus on knowledge and information provision to also focus on changing attitudes and increasing confidence.

With regard to Healthy Respect’s impact on sexual health provision to young people some caveats were however, raised by service providers. Whereas SHARE has been used by many service providers some wonder in what way and how comprehensively it has been used by individual providers or organisations. Moreover, Healthy Respect’s work in schools and on a policy level was described as successful but some providers described only minimal impact on service provision outside schools. This raises the question of whether Healthy Respect managed to reach the most vulnerable and excluded young people. For example, one voluntary organisation felt there

was no financial or personnel resources available to set up and run clinics for young people with learning disabilities.

Most interviewees thought Healthy Respect had opened debate about young people's sexual health, had raised social awareness and had been instrumental in keeping the topic on the agenda of frontline providers, managers, policy makers and the public. It was suggested that Healthy Respect was influential in the production of a coherent sexual health policy.

*"I do think that we wouldn't have the sexual health policy we have now... without Healthy Respect" (Community Youth Worker).*

Some service providers described Healthy Respect as a key factor in changing the culture of teenage sexual health provision:

*"I think sexual health probably has been highlighted through Healthy Respect... Six/seven years ago health was way down the agenda, when you worked with social work and residential care. And it's very much on the agenda now. I think that's because there's always health professionals represented at strategic groups and stuff like that" (Specialist Nurse).*

Many providers thought it was difficult to determine the impact of Healthy Respect on sexual health outcomes such as sexual transmitted infections (STIs) and teenage pregnancies. Twenty-four service providers thought they did not know what impact Healthy Respect had on young people. They argued that there was generally no evidence available, or they thought it was too early to know about long term effects.

*"Whenever the figures [statistics about STIs and unwanted pregnancies] are broadcast and they are higher than they should be, I think people are sceptical because we want it to be different for young people, we want it to be sorted and it is not as easy as that. We want parents on board but they don't necessarily want to be" (Voluntary Organisation).*

A few providers stressed the counter-influence of alcohol, reporting limited awareness of sexual health services among young people at risk, and highlighting young people's difficulty in retaining the information provided.

*"Yes it had an impact on some of our children, our needy kids. And if it saves one from being pregnant, if it helps somebody through a dramatic experience then that's fine. I still think it's a service that's needed. It perhaps hasn't in this area had as big an impact because we're fighting the demon alcohol..."*  
(School Guidance Teacher)

However, a number of service providers were confident that sexual health activities associated with Healthy Respect had increased young people's sexual health knowledge and information about, for example, issues surrounding consent, relationships, prevention, emergency contraception (EC72), use of condoms, safe sex, STIs, availability and accessibility of services.

Some reported that young people had developed an increased appreciation of the providers' skills and knowledge on sexual health matters, which had had positive effects on young people's engagement with their organisation.

*"It is very difficult to look at infection rates, teenage pregnancy rates and all sorts of things like that and come to a conclusion... but I don't have any doubt that what we've been doing through Healthy Respect in our Schools has had a positive impact on the youngsters, their lives, the reaction of parents and certainly it has had a positive impact on staff"* (Education Strategist).

## **6.5 Summary**

The data obtained from both surveys examined whether working in partnership with Healthy Respect and with each other had any impact on the organisations involved. Results suggested that partnership work with Healthy Respect was associated with having an impact on provider's capacity and capability to undertake sexual health work with young people. Results also

suggested that partnership work between organisations was associated with having an impact on the organisations ability to work more effectively with young people, pool resources needed for sexual health work and build trust between organisations.

Results also suggested that those with better network 'strength' scores were helped by Healthy Respect to link with the other organisations involved. The qualitative data confirmed these results; with many of those interviewed reporting that the focus, expertise, and resources provided by Healthy Respect had a considerable impact on their capacity and capability in terms of them delivering sexual; health education, information and services to young people. These results are important and suggest that where partnership working was taking place there were clear organisational benefits for the participating organisations, which theoretically could impact positively on young people's sexual health and wellbeing. This is an important issue and one of the main findings of the research it will therefore be discussed further in Chapter 7.

Although these results appear positive, there were certain areas, where partnership work may have had less of an impact on organisations most notably on their ability to work with parents. The results also suggested that Healthy Respect had been less successful in having an impact on sexual health inequality; a main target area for Healthy Respect in this second phase of the project. In fact when questioned providers indicated that the groups of vulnerable young people being missed by the initiative were in fact the very same ones Healthy Respect assumed would be targeted by the programme. This may be due to the fact that Healthy Respect were less

successful in working with the organisations they assumed could work with these young people i.e. social workers and community youth workers. This point had been raised previously and will be discussed in more depth in the following chapter.

## **Chapter 7: Discussion, Conclusion and Recommendations**

### ***7.1 Introduction***

In this chapter results are drawn together and discussed in relation to previously published research. The contribution to knowledge made by this study is also examined and this will be followed by an outline of the limitations of the research. The chapter concludes by presenting a number of recommendations for further research in this area and for future interventions.

### ***7.2 Revisiting the Research Objective***

The aim of this study was to:

‘Assess the extent and impact of partnership working in the Healthy Respect National Sexual Health Demonstration Project’

On examining the literature it became apparent that partnership working was an approach being promoted and adopted as the most appropriate mechanism by which to bring about both system level change and health improvement. Although partnership working was frequently employed as a mechanism to implement and deliver public health initiatives, evidence of how these partnership arrangements actually worked in practice and whether they produced the benefits predicted was lacking. This study therefore aimed to address this gap in knowledge, by assessing partnership working in a complex public health intervention programme – Healthy Respect. The literature review suggested that by its very nature partnership work was difficult to evaluate. Partnership working was poorly defined and no one definition of what was meant by partnership working was found. Methods used in the past had not adequately accommodated for the complexity and

scope of partnership work and many had failed to attribute the process of partnership work to its intended outcomes. As a means of overcoming some of these problems and as a way of addressing the main research objective this study utilised Healthy Respect's logic model and used a Theory of Change (TOC) framework to systematically assess the key outcomes which were to occur through partnership working.

## **7.3 Discussion**

### **7.3.1 What is Partnership Working?**

This first research question set in the thesis was used to examine what partnership working was with; a) Healthy Respect and b) between organisations in a network of sexual health organisations. The author chose to describe what it looked like and its inherent strengths. Partnership work with Healthy Respect was found to vary between and within the organisations identified by Healthy Respect.

First level analysis of the survey data suggested that those from Education and the NHS were most engaged with Healthy Respect. Those in Education had the highest percentage of those in the engaged category with 65% in the 1<sup>st</sup> survey and 83% in the second. The Local Authority organisations had the lowest percentage in the engaged category 33% in the first survey and 30% in the second survey. Involvement with Healthy Respect also varied within the same service type. For instance within education there was a small percentage of providers classified as having some involvement or not having heard of Healthy Respect. And there were significantly more classified as having only some involvement from the Local Authority organisations; with

nearly half of the local authority providers (49%) classified as only having some involvement with Healthy Respect in the second survey.

A second level of analysis was undertaken on those initially classified as being engaged with Healthy Respect to examine partnership in more detail. Results demonstrated that the NHS appeared to be the dominant partner; having a stronger partnership relationship with Healthy Respect.

The geographical analysis of the data demonstrated that Healthy Respect had not concentrated their resources in the intended areas i.e. Midlothian and North West Edinburgh and consequently they were spread over a wider area than anticipated for this second phase of the project. Partnership work with Healthy Respect varied across the different geographical areas. First level analysis suggested that those in West Lothian were most engaged in partnership work with Healthy Respect, while those in Edinburgh City were least engaged. The second level of analysis also demonstrated that levels varied between the different areas (although these were found not to be statistically significant). During the second level of analysis providers from West Lothian had higher partner engagement scores in the first survey and providers from East Lothian had higher partner engagement scores in the second survey.

The social network analysis demonstrated what partnership work looked like between the different organisations in each of the geographical areas. Results demonstrated that there was a high level of connectedness between the organisations and illustrated the dominant position of sexual health services within the networks.



Furthermore, analysis of the second survey data suggests that those who received help from Healthy Respect in linking with other organisations also had better contact with organisations. Although these observations are based on associations between variables in the data, and could mean that some providers may have been more open to collaborative working before Healthy Respect began. It may still suggest, that if organisations are amenable to collaborative working then clear benefits of partnership may follow. Thus some organisations may be keen to sustain any possible benefit which might accrue from the relationship with Healthy Respect.

Overall results suggest that there was varying levels of engagement with Healthy Respect and variation in the level or degree to which partnership work was taking place. This may therefore have an impact on the benefits predicted to occur through partnership working. Partnership working was thought to produce certain benefits for both the organisations involved and for service delivery (the benefits or outcomes examined within this study will be discussed in more detail in section 7.3.3). However if the level of partnership work varied (as the results suggest) then not all organisations (and ultimately young people) will gain from the benefits proposed. Therefore, the level of support, education and services young people receive will also vary depending on which organisations or agencies the young people find themselves in.

### **7.3.2 Possible reasons for the variation in partnership working**

Certain factors were identified that appeared to influence partnership working with Healthy Respect these were linked to four themes.

## **1. Characteristics of the Young People**

With regards to characteristics of the young people targeted, the findings show that Healthy Respect was better received in mainstream schools and healthcare services than in provisions targeting specific groups of young people. Some providers found that the standard Healthy Respect resources (the structure and content of the SHARE programme and the school drop-ins) did not work well for their client group; and so there was reluctance on their part to become involved in partnership work with Healthy Respect

In phase 2, Healthy Respect did not aim to take an exclusively population based approach but aimed to target those providers who were known to work with vulnerable young people. Yet the findings show that this was difficult to achieve. If the providers targeting these young people did not work with Healthy Respect and become involved in the project then it would appear that the most vulnerable young people were being missed by this intervention programme.

This appears consistent with evidence found in the first evaluation of Healthy Respect (Phase 1 evaluation) in that it found that Healthy Respect appeared to concentrate most of their efforts into two programmes in particular (and so targeted organisations able to deliver these programmes) the Sexual Health and Relationship education package (SHARE) delivered predominately through schools and the Drop-In services delivered predominately by NHS employees (Tucker et al 2006). Tucker et al (2006) found that the heavy focus by Healthy Respect on universal in-school education drew attention (and resources) away from the demands of targeting and working with hard to reach or excluded young people (Tucker et al 2006).

Healthy Respect was an NHS led project whereas many of the providers targeting vulnerable young people were local authority employees. The interviews revealed difficulties in establishing stable partnerships with these providers, particularly with those at the frontline. One enduring issue reported was raised by social workers, special needs teachers and a residential care worker and relates to the sexual health of young people under the age of 16. They found it difficult to discuss sexuality and sexual health with young people whom they knew may have had sexual experiences under abusive conditions (either as the abusing or the abused party). They feared that discussing sex education might overlap with talk of abuse and they were not confident they would know how to deal with this. Residential workers and social workers also found it difficult and confusing to protect under-16s from sexual abuse but to support sexual activity that was consensual and to recognise the difference between the two. These sensitive challenges seemed more acutely felt in local authority services than in the NHS.

## **2. Organisational Factors**

Partnership working takes time to establish and is known to be more effective when there has been a history of previous partnership work. Brinkenhoff (2002), Sloper (2004) and Vanclay (1996) suggested that it takes a long time to build a trusting relationship between organisations. A past history of partnership working between organisations allows those involved to build on previous arrangements, increase opportunities for communication between staff, and promotes understanding and information sharing (Barnes et al 2005, Sloper 2004). This offers some indication as to why certain areas may have been more engaged with Healthy Respect than others. East and West

Lothian were two areas that had been involved with Healthy Respect from Phase 1, suggesting that they had more time to build up partnership relationships with Healthy Respect. Certainly results from the first and second survey analysis demonstrated that providers from East and West Lothian had higher levels of engagement with Healthy Respect in comparison to other areas, most notably Edinburgh City. The social network analysis also highlighted how East Lothian in particular had stronger partnership relationships between the respondents and the organisations they reported linking with. The scores were significantly different between East Lothian and Edinburgh City.

Although the highest percentage of those engaged with Healthy Respect in the first level analysis came from education, the second level of analysis highlighted that their level of partnership work was variable. A possible explanation for this, was that although the teachers delivered the SHARE and Zero Tolerance Respect package they didn't believe they were directly involved in partnership work with Healthy Respect. They saw the partnership agreement as being at the strategic management level i.e. the education department within the Local Authority. The teachers believed that endorsement of Healthy Respect at that level allowed them to deliver the education pack to the young people in school.

This is consistent with findings from previous studies into partnership working. Glasby et al (2004) reported that senior commitment and support is vital as workers on the front line are less than willing to become involved in something when it has not been clarified or supported by management. Frost (2005) reports that the ability of front line workers to work together is

beyond their control – the funding, the planning, the location and the protocols are all established by managers. Therefore Frost (2005) believed that effective partnership working at the ground level requires a supportive policy and managerial context. Certainly difficulties in the implementation of the first phase of Healthy Respect were observed when managerial support was lacking. And therefore working with managers was prioritised by Healthy Respect as a means of engaging with partners. Thus, it is perhaps unsurprising that managerial support was identified as an important influencing factor for providers within education in becoming involved with Healthy Respect.

However, although managerial support played an important part for those from education becoming involved this was not the case for all service providers. There were conflicting responses from management and frontline workers noted from both social workers and community youth workers. Although the social work managers envisaged Healthy Respect's influence on practice social work as a "good thing", the frontline workers often disagreed or were not able to implement it. The interviews suggested that tension arose because frontline youth workers and social workers did not see it within their remit to deliver sex and relationship education to the young people. In the case of social work they reported other pressing priorities as being the focus of their attention (namely child protection issues) as well as the aforementioned problems of working on sexual health issues especially with those under the age of 16 years.

### **3. Facilitators and Barriers to partnership with Healthy Respect**

The interviews highlighted many factors that facilitated partnership working between Healthy Respect and the providers of sexual health education, information and services to young people. Healthy Respect's leadership role had been particularly well received by interviewees and was thought to have raised the profile of young people's sexual health in Lothian, kept the topic on providers' agendas and facilitated sound policy making. The importance of leadership to partnership work has been highlighted many times in the literature (Rosenbaum 2002, Roussos and Fawcett 2000, Stewart 2007, and Teenage Pregnancy Strategy Evaluation 2005). Results from the Teenage Pregnancy Strategy Evaluation (2005) highlighted the important role the Teenage Pregnancy Coordinators played in acting as leaders in the promotion of teenage sexual health and also highlighted the important part they played in supporting partnership work between the organisations involved; *"the teenage pregnancy coordinator's were regarded as the lynchpin of the strategy"*.

It was therefore encouraging that providers felt that Healthy Respect provided and fulfilled this leadership role. It also emphasised the importance of having the appropriate leadership in place to drive the public health agenda forward and to sustain the work already established. The idea that the appropriate leadership must be in place to drive the agenda forward was further emphasised by the providers when they raised concerns about the sustainability of the project when Healthy Respect was no longer there to support the promotion of young people's sexual health.

Another influential facilitating factor for those providers working with Healthy Respect appeared to be the resources they received from Healthy Respect. The Healthy Respect resources consisted mainly of; training and materials and these helped service providers become more comfortable, confident, knowledgeable and competent in talking to young people about sexual health matters. The availability of the training and support also helped them to deliver more appropriate and evidence-based content to the young people.

However, there were also a number of constraints to partnership work with Healthy Respect that were raised by the providers. Some respondents from Community Youth Teams and Social Work reported that the way in which Healthy Respect had tried to get them on board with the project did not sit well with them i.e. the feeling that Healthy Respect had a job to do and everyone was going to have to just fall in line and take this idea on board. This they believed added to tension between the two organisations and a lack of understanding of their role and remit regarding youth work with young people.

These barriers appear consistent with evidence from previous literature that highlighted the difficulties which can arise due to differing organisational cultures and professional values. Wills and Ellison (2007) discussed the widespread misunderstanding about the breadth of each service's activities and the values underpinning their professional and organisational culture and how this lack of knowledge and understanding can act as a barrier to partnership work taking place. Berkeley and Springett (2006) reported on how organisations from the Local Authority organisations may refuse to get involved in health related initiatives when they see their own professional

expertise and remit as being completely unrelated to health. Ideology, politics and organisational issues interact with professional issues leading to an impasse on partnership work taking place (Berkeley and Springett 2006). There appears the need to acknowledge that these barriers do exist in practice and only by exposing how these barriers influence partnership working in practice can we then go on and uncover methods to try to overcome them.

Voluntary organisations also brought their own challenges to partnership work: they valued Healthy Respect's financial help when it was available because they were always short of funding for service development. However, they found it frustrating when funding was absent or withdrawn. They also felt overpowered at the decision-making table when their partners came from powerful organisations such as the NHS and the local authorities, even more so when these happened to be their own funders. The interviews suggested that partnerships between Healthy Respect and the voluntary organisations were progressively undermined by such issues. This issue had been highlighted in previous research when Mann et al (2004) reported how partnership work can lead to certain losses for some partners, especially those from voluntary organisations.

#### **4. Environmental Factors**

The environmental and broader contextual factors that appeared to have acted as barriers to partnership work within the project centred around the restructuring of some departments within the Local Authority organisations and within the NHS. It is important to note however, that these factors



appeared to be out with the control of both the organisations themselves and Healthy Respect. The restructuring of these services at this time caused extreme disruption internally for the employees, and this perhaps made it difficult for providers to become involved in a new project (which may well have been important to them) that they could not give enough focus or time to. Another area highlighted appeared to focus on the socio-economic factors affecting sexual health, and two respondents in particular spoke about how Healthy Respect could not possibly hope to have an impact on these broad factors when no organisation could.

### **7.3.3 Impact of Partnership Working**

The final research question asked 'What are the outcomes of partnership working between the Healthy Respect Team and other organisations?' A major part of the thesis was to establish whether partnership work was associated with any benefits to the organisations involved. The use of a 'Theory of Change' approach for this study allowed for the examination of the link between partnership working and organisational outcomes - something which had been lacking in previous studies of this nature. Results suggested that partnership work was associated with several organisational benefits.

There was a positive association between partnership working and an increase in organisational capacity and capability. Results suggest that partnership work with Healthy Respect was associated with improvements in providers understanding of sexual health issues with young people. It was also found to be associated with an increase in the providers' ability to focus on sexual health improvement issues with young people and their ability to focus on sexual health service delivery for young people. Results also

suggested that those with higher levels of partnership working were better able to deliver services, information and education to the young people.

Thus, given Healthy Respect's closest links were with the NHS, the results suggest that NHS organisations would benefit most from Healthy Respect. This perhaps indicates an increase in their ability to deliver clinical sexual health services to the young people. Although providers from education had a lower partner engagement score in the 2<sup>nd</sup> level of analysis, results from the qualitative data highlighted the fact that they felt able to deliver the SHARE package within the schools because it had been endorsed at a higher strategic management level. Therefore it would also appear that these providers were able to deliver the appropriate educational component of the programme to young people in mainstream education.

Results from the social network analysis also suggested that being involved in a partnership network was positively associated with an organisations ability to work more effectively with young people with regards to their sexual health. It was positively associated with pooling resources required for sexual health work with young people, as well as increasing the number of referrals to specialist units and building trust between organisations. Interestingly providers from within the NHS organisations (especially school nurses) were also seen as important partners for the other organisations in the network. This along with the knowledge that there appeared to be good links between the NHS organisations and the schools in each of the networks suggests that young people in contact with these organisations may benefit more from such contact.

However although these results were encouraging, not all of the outcomes predicted in the logic model were observed. There were areas where Healthy Respect had a relatively weaker impact than had been anticipated; namely supporting parents, and their ability to help address sexual health inequalities. And thus young people in contact with these components of Healthy Respect may derive less benefit.

### **Supporting Parents**

Healthy Respect had a relatively lower impact in helping providers to support parents. Results from this study suggested that working in partnership with Healthy Respect had no association with an organisations ability to support parents. One way parents were targeted was through the Home Activity Resource, the aim of which was to assist family engagement and discussion. Findings from one of the component studies of the main evaluation found that the uptake of this resource was extremely poor. With only 5% of non-denominational secondary school parents reporting that their child had brought work home (Evaluation of Healthy Respect Phase two: Interim Report 2008). The study also found that only 20% of secondary school teachers and 53% of primary school teachers actually used the Home Activity Resource (Evaluation of Healthy Respect Phase Two: Interim Report 2008). Reasons given by teachers for not doing so included, having little time, not knowing about it or not receiving it, thinking it had no realistic chance of success, thinking parents may not understand it, and not being trained to use it. Furthermore, although 52% of providers associated Healthy Respect with support aimed at parents 89% thought Healthy Respect provided high quality services for young people.

The Home Activity Resource was only one part of Healthy Respect's work with parents the others being a social marketing campaign and family connectedness theory embedded in the SHARE pupil education package. Nevertheless it was specifically designed to engage parents directly in a way which was not apparent in the other aspects of the Healthy Respect programme. Given the problems encountered in the uptake of the homework resource by teachers and parents it is possible that any impact on parents resulting from the resource would be low. Thus, from the second survey and research from other parts of the evaluation, Healthy Respect's work directly with parents appeared to be less well implemented compared with its work with young people. This must mean that as far as Healthy Respect is concerned the impact on parents and subsequently their children would be minimal.

### **Vulnerable Young people**

Although adopting a predominately population based approach to health improvement. Healthy Respect stated that they also aimed to work in partnership with those organisations targeting young people with specific needs namely, young people excluded or not attending school, young people looked after and accommodated by the Local Authority and young people with learning disabilities. However results suggested that Healthy Respect may have had less of an impact on targeting the more vulnerable young people. Results from the first survey suggested that the uptake of Healthy Respect was uneven among organisations that targeted vulnerable young people and that 70% of providers missed certain groups of young people, including those classed as vulnerable by Healthy Respect.

Although some encouraging findings emerged in the second survey. In the region of 90% of providers in the second survey said they worked with key Healthy Respect target groups namely young people who experienced deprivation, those excluded from school, those looked after by the local authority and those with learning disabilities. Less in the second survey (39%) thought that Healthy Respect missed these groups compared with the first survey (70%).

It is puzzling however, why so many providers say they worked with at least one Healthy Respect target group yet, so many suggested Healthy Respect missed these groups of young people. There may be some possible explanations for this. The first is that respondents could be referring to certain sub-groups of young people in each category who remain out of contact with their own service and therefore believe these particular young people remain out of reach of Healthy Respect. Second, it may be possible that their response is based on a lack of knowledge of what Healthy Respect did to address health inequalities, particularly its work with organisations who specifically engage with vulnerable young people. Third, that sexual health work with vulnerable young people was difficult to implement and may not have progressed as planned. All three explanations are plausible. It is likely that providers will contact certain groups of young people and not others. For example, school teachers may lose contact with young people who need more specialist support from alternative educational settings.

The qualitative work with providers outlined a number of reasons why sexual health work with vulnerable young people was difficult and may not have progressed as planned. This includes the complex issues faced by young

people themselves and the capacity of existing resources to address these issues. The time needed to build working relationships with organisations who work with vulnerable young people, achieving adoption at all levels within these groups, providing staff training on sensitive issues such as child protection and consensual sex between people under sixteen years of age, and working with young people who have learning difficulties. Together these explanations reflect the complex nature of working with vulnerable young people as well as the issues around working with partner organisations who engage with these young people.

Evidence from studies examining drug intervention programmes for school pupils suggest that although universal intervention programmes show that such programmes can reduce or delay students' initiation into drug use. They have little role in preventing drug use amongst young people from vulnerable groups who are most at risk of developing drug problems. They state two reasons for this firstly they may not be attending school because they have been excluded or because they have stopped attending. Secondly, young people most at risk tend to be unresponsive to universal programmes because they do not address their specific needs. These studies state that in order to reduce drug problems in high risk groups, there is a need to provide carefully designed and targeted programmes (European Monitoring Centre for Drugs and Drug Addiction 2003, Lloyd 1998, Hawkins et al 1992).

The results from this study suggested that the Healthy Respect programme being adopted may not have been the most appropriate means of addressing the needs of the more vulnerable young people. Perhaps suggesting that

more research needs to be undertaken to examine the usefulness of a combined approach i.e. a population based approach with a more specific programme (and resources) targeted at more vulnerable young people. Also highlighted were the problems Healthy Respect encountered in trying to work in partnership with organisations thought to target these vulnerable young people.

### **What did Healthy Respect achieve in terms of partnership working?**

Although Healthy Respect recognised the importance of partnership working as a means of delivering this complex sexual health intervention programme, the previous results and discussion suggest that they were only partially successful in working in partnership with organisations involved in sexual health work with young people. A close partnership was formed with approximately half of the existing providers, and the most engaged with Healthy Respect were from the NHS (including school nurses) and voluntary organisations which offered advice and contraceptives to young people. This may be relatively unsurprising given that the Healthy Respect team were based in the NHS and as such were able to form more natural alliances with other NHS services. Providers across Lothian also reported that their strongest links were with sexual health services in the different geographical areas.

Other organisations most notably those from the Local Authority organisations were less willing to work in partnership with Healthy Respect. Many of the barriers (identified through the qualitative interviews with providers) to working in partnership with Healthy Respect came mostly from

the Local Authority organisations and offered an explanation as to why partnerships with these organisations didn't develop as planned.

Results did suggest that where partnership work was taking place, this impacted on an organisations ability to deliver sexual health information, education and services to young people. However, partnerships with Healthy Respect were only formed with approximately 46% of the providers targeted, therefore not all organisations and subsequently young people would have benefitted from Healthy Respect.

### **Were the outcomes predicted by Healthy Respect in their logic model met?**

Shown in Table 7.1 is the short/medium term outcomes predicted by Healthy Respect in their logic model (in relation to partnership working) with a summary of the key findings (Healthy Respect Logic Model Appendix A). Not all the outcomes predicted by Healthy Respect were met suggesting that the longer term outcomes predicted by Healthy Respect i.e. the creation of an environment that would to the long term improvements in young people's sexual health and wellbeing may not be met. This was especially true for the most vulnerable young people who Healthy Respect targeted through their work with professionals working specifically in the Local Authority organisations.



**Table 7.1 outcomes predicted in Healthy Respect's logic model with key findings**

<b>Short/Medium Term Outcomes</b>	<b>Findings</b>
Engagement of partners in Healthy Respect 2	Results suggest that only half of the providers engaged with or worked in partnership with Healthy Respect
Provision of a partnership network to coordinate services to young people	Networks of providers were already operating in the areas covered by Healthy Respect and results suggest that less than half (40%) of providers in partnership with Healthy Respect were helped by them to link with other organisations.
Partners committed to programme delivery	Where partnerships were formed with other organisations, partners appeared committed to programme delivery. However what must be remembered is that not all organisations worked in partnership with Healthy Respect so therefore not all organisations were committed to the intervention programme.
Links between education and services	Results from the network analysis demonstrated that there were links between education and health services, in fact the NHS services held a prominent position within the networks. However many of these links may have been made previously and results suggest Healthy Respect may have had only a minimal impact in helping organisations link with other organisations within the networks.
Healthy Respect partners felt supported to deliver sexual health education, information and services to young people	Results from the qualitative interviews with providers did suggest that providers felt that Healthy Respect's leadership role and the materials produced by them did make them feel supported and better able to deliver sexual health education, information and services to the young people.
Increase in professional capacity and confidence of sexual health work with young people	Results suggest that where partnership work was taking place it did lead to an increase in professional's knowledge, understanding and ability to work with young people regarding their sexual health. However, this was not the case for all the professionals, as those professionals working specifically with the vulnerable young people did not engage with or work in partnership with Healthy Respect
Increase in support for parents to engage with young people regarding sexual health and values	Results suggest that Healthy Respect had little or no impact in helping professionals engage with parents and that there was limited uptake of the resources produced for parents by the professionals involved.

In light of the findings from previous literature and the discussion it would appear that Healthy Respect had more success with certain aspects of the programme than others. There was a strong thread running through the

findings that Healthy Respect were able to work in partnership with organisations delivering certain aspects of the programme i.e. SHARE (delivered by education) and the drop in services delivered predominately by the NHS. It can be argued that these parts of the programme may therefore have been able to target young people in mainstream education settings i.e. those young people attending school and those able and willing to attend the drop in facilities either in school premises or in the wider community. These results were similar to those found in previous literature on the subject including the results from the first evaluation of Healthy Respect 1, which found that interventions of this nature were perhaps more able to reach the general population of young people but were unable to reach the most vulnerable or those more at risk of poor sexual health outcomes.

Certainly findings from the main evaluation (Evaluation of Healthy Respect Phase Two: Final Report due for publication in 2010) suggest that approximately 70% of young people may have been reached by Healthy Respect. However, it would appear that the remaining 30% of young people were not reached by this intervention programme. The young people not reached by this intervention programme were those who may not attend mainstream school settings and perhaps can be classified as more vulnerable and in need of more intensive work regarding their sexual health and wellbeing. There were a number of reasons why work with these young people was difficult, including organisational priorities and issues around partnership working with Healthy Respect. Further work in this area is likely to be resource intensive and raises the question of whether a public health intervention such as Healthy Respect should allocate disproportionately more resources in reaching and working with young people who are socially

deprived. This dilemma is faced by other public health interventions whereby the potential benefit to a small but needy section of the population takes precedence over the majority.

#### **7.4 Contribution to Knowledge**

As discussed in Chapter Two research existed on the topic of partnership working before this PhD began. However there was little documented evidence of the contribution partnership working could make to health improvement initiatives, particularly to organisational outcomes. This study has contributed to knowledge in this field by examining the part partnership working has played in a complex public health initiative. Existing research also lacked theories of action which outlined partnership formation and functioning and its relationship to systems change and more distant level outcomes for health improvement.

This study used a 'Theory of Change' framework which allowed a systematic assessment of how change was likely to occur through partnership working in the project. It identified how partnership could lead to organisational outcomes i.e. an increase in organisational capacity and capability.

This was a fairly large study using multiple methods including the use of a social network analysis which was both sophisticated and innovative in the field of health improvement initiatives. The study was able to draw its results and implications from both quantitative and qualitative research data. In fact the strength of many of the studies conclusions lie in the blending and overlap of these two types of data. In some cases, as with the provider's perceptions of the impact of partnership working, the qualitative data corroborated the quantitative statistics. The quantitative data was used to measure engagement and partnership strength and its association with

outcomes. Whereas the qualitative phase allowed for the contextual factors influencing partnership work in the project to be identified and examined which helped in understanding the reasons why there was variation in engagement between organisations.

This study's findings would have been weaker if they had been based on only one type of data. Instead the study has shown that a mixed method research approach can be highly useful for the type of research undertaken in this thesis. This study can lend support to the arguments advanced in support of mixed methods research. The mixed method design employed allowed this study to evaluate something which in the past had been fairly ill defined (partnership working). It defined and described what partnership working was by using a range of measures which moved beyond supportive attitudes (Dowling et al 2004, Entwistle 2008). The methods used for this study could also be employed by other researchers, to examine the process and outcomes of multi-faceted intervention programmes for health improvement.

While the use of a social network analysis was not new to other studies most notably in the field of organisational theory and psychology it was a new approach adopted for a study in this area and the author believes the social network analysis allowed a further dimension of partnership work to be examined. The social network analysis has been a useful approach with its ability to visually display the organisations involved in each of the geographical areas assessed as well as being able to examine the connectedness between organisations This is important information that can be useful to both the Healthy Respect Team and organisations participating in the network to examine where ties between organisations could be

strengthened and identify which central organisations could be further supported to continue providing the services for both the organisations and young people. As noted previously the findings of the study benefitted from the overlap and blending of the methods used. This is also true of the results of the social network analysis whereby the results and findings from the social network data added to the findings from both the quantitative and qualitative methods used.

Finally, this study informs the wider evaluation of Healthy Respect and its impact on young people, in particular why the intervention worked in this context. The outcomes of the project on young people in the main evaluation study will be compared with those from a comparison area.

## **7.5 Limitations**

Although the findings appear compelling, and make a significant contribution to the field of partnership working for health improvement, the current research is limited. The quantitative data analysis was based largely on descriptive or correlational statistical techniques, which cannot substantiate a causal link between partnership working and outcomes. This despite, several statistically significant relationships found which were further explained by the qualitative data and the application of the theoretical framework employed i.e. the Theory of Change and its associated logic model. Furthermore, the research did not involve a comparison with another intervention and thus some commentators may view this as a potentially serious flaw.

The choice of survey sample acted as a constraint in that it relied on the Healthy Respect team to identify providers with whom they had contact. It is

therefore conceivable that some organisations were missed. This constraint was most likely in the non-government sector where there are a large number of agencies devoted to young people and youth work, or in large government sectors such as social work where it is extremely difficult to construct a sampling frame of all parts of the organisation engaged in sexual health work with young people. Further, the research team also relied on the managers of services to provide a list of professionals who worked in sexual health in their organisation.

Second level analysis of the survey data focussed on those providers classified as most engaged, i.e. those able to complete the long questionnaire. This potentially constrained the survey results by excluding results from those who were less engaged. Thus the findings of the surveys in particular may not reflect the views of those providers who were not included. There is therefore no way of knowing whether there was any impact on the organisations with only 'some involvement' with Healthy Respect

The social network analysis used in the study has contributed greatly to the overall findings on partnership working in the project and enhanced our understanding of this complex approach. However, it must also be noted that the appeal and the opportunity offered by adopting such an approach to the study of partnership working for health improvement has perhaps not been fully realised within this study. A social network analysis of the partnership data was only applied to the second survey therefore a great opportunity was missed to examine how the partnership networks may have changed over time. Conducting a social network analysis approach throughout the full course of the partnership and beyond the time of the study may have given further insight into how the networks developed, matured, functioned and

were sustained over time. The study was unable to examine all the links between the organisations in that it was only able to examine the links between the respondents and the organisations they reported working with. It was therefore unable to confirm these links which is unfortunate as confirmed ties between organisations is a much more precise measure of the interaction taking place between organisations.

A further limitation of the study was that although able to examine the short and medium term outcomes associated with partnership working i.e. organisational development and the establishment of partnership networks. The study was unable to examine the impact of partnership working in the longer term i.e. whether there was an improvement in young people's sexual health. Arguably this may have been out with the limits of this study in the given time frame as previous literature notes the difficulties in measuring such long term outcomes such as population level health outcomes which may not be detectable for 3-10 years. Fundamental health goals such as a change in sexual health attitudes or a reduction in sexual health inequality may take generations to achieve (Roussos et al 2000). Therefore, while an obvious limitation of this study the author believes it should also be seen as challenge for future researchers in this area to build.

Another limitation of the study was that it did not examine whether there was any social capital inherent in the networks that may have contributed or influenced the links (and strength of the links) between providers. For example had any of the links (between providers) come about through already established friendship or social links between providers'?

The findings of the study highlighted a number of issues that need to be addressed in future studies and practice. The following section presents recommendations for future work on this area to build.

## **7.6 Recommendations for Research and Future Interventions.**

### ***7.6.1 Recommendations for Future Research***

- Partnership working represents only one approach to public health interventions, (versus for example the independent actions of separate agencies or other population-based interventions such as taxation and legislation). It is therefore recommended that future studies consider comparative analysis of the different approaches.
- The study recommends work be undertaken to examine approaches to overcome the barriers to partnership working. Numerous studies have identified the actual and potential barriers to partnership but there is a paucity of studies examining methods of overcoming these barriers.
- The study suggests that the Healthy Respect project had little impact on either working with parents or working with the most vulnerable young people. Therefore more work needs to be undertaken to establish the most appropriate means of targeting these two groups.
- Within the literature reviewed there appeared to be no Health Economic studies establishing the overall cost effectiveness of partnership working for health. A study examining the costs over time and examining the added value of what partnership work can achieve is recommended to enhance the evidence for partnership working for health improvement. A cost-benefit or cost-utilisation analyses may



also help yield enhanced methods for understanding and improving collaborative partnerships as a public health strategy.

- It is recommended that a future research study using a social network analysis approach is commissioned. This approach offers a unique opportunity to study both the structure and the relationship between partners and allows for the examination of the partnerships over time. Although this study focused only on the links between respondents and the organisations they report working with, it would be beneficial for future studies to examine the relationship between organisations (confirmed ties). This would involve not only gathering data from the organisations targeted but also the collection of data from the organisations they report working with. This would then allow for the examination of confirmed data and give a much stronger measure of the relationship between organisations.
- Social network analysis and social network studies also show potential to uncovering the social support and social capital inherent in networks which are seen as important factors in a population's health and wellbeing. It would therefore be beneficial if more studies could be undertaken to examine whether partnership working within networks could lead to an increase in social support and social capital for both the organisations involved and for the groups targeted.

#### **7.6.2 Future Interventions**

- Future interventions need to consider the population based approach versus the targeted approach. Although a population based approach may be appropriate for the majority of young people, it may not be

appropriate for all young people in society. It is recommended that future intervention programmes find a way to involve organisations targeting the more vulnerable young people, as:

- a) they know and understand the needs of their client group and therefore would be able to aid the development of more appropriate programmes and
  - b) by offering them the opportunity to become involved in a project from the beginning may help in fostering a more trusting and respectful partnership
  - c) reduce health inequalities rather than maintaining or widening any gap between social classes.
- This study has highlighted the importance of specifically evaluating the part that partnership working plays in these complex health initiatives. It is therefore recommended that future interventions using partnership working as a mechanism to bring about change include strategies to examine if and how it was successful. Only by evaluating partnership working during the initiative can participants be sure that it is working the way anticipated and any obstacles or barriers hampering partnership can be explored and dealt with at the time.

To conclude, this takes us to a particularly interesting question of whether Healthy Respect fulfilled its broader strategic objective of creating an environment that would lead to long-term improvements in the sexual health and well being of young people.

Leaving aside the question of long term impacts for a moment, the evidence provides some insight into the first part of this objective – the creation of an environment. It is unlikely that Healthy Respect created an environment if what we mean by environment is sexual health provision. Leaving the 22 Healthy Respect drop-ins aside, most of the organisations already existed across Lothian and were set up in Lothian through different funding mechanisms. However, results suggested that Healthy Respect made a positive impact on the existing environment through its leadership i.e. raising the profile of sexual health, and improving professionals' knowledge and ability to work with young people. Results also indicate that Healthy Respect may have enhanced existing links between organisations particularly for those who were keen to benefit from these links. Those most likely to benefit were those with whom Healthy Respect had longer or more natural links, for example the NHS, some voluntary organisations and those in the education sector. It is likely that many of these links formed in phase one which gives support to the argument raised by the Healthy Respect Team and others in the literature that it takes time to build relationships which lead to substantive partnerships (Barnes et al 2005).

The findings suggest the need to reconsider more fundamentally how we tackle poor sexual health outcomes amongst young people. Overall the findings suggest that a large scale, multi-component, multi-sector sexual health intervention for young people had limited beneficial effects. This is broadly in line with the rigorous evaluation of other sexual health interventions in the UK, such as RIPPLE (Stephenson et al 2008) and SHARE (Henderson et al 2007). While this evaluation provides evidence of the benefits of high quality school based sex education and the widespread

implementation of sexual health services, it also shows that different approaches are probably necessary to achieve more substantial impacts on sexual health outcomes (Evaluation of Healthy Respect Phase Two; Final Report due for publication in 2010).

The Healthy Respect programme was reliant on partnership working to be able to deliver the complex intervention. Yet results suggest that they were only partially effective in working in partnership with the organisations involved and may have had little impact on the sexual health and wellbeing of young people (especially the most vulnerable). Partnerships take a long time to build and require a great deal of time and resources to be invested in them to work. Should all this time and effort be allocated to partnership working for what could be very little impact on young people's sexual health.

A key question for policy makers is whether there is value in conducting long term evaluations like this one of Healthy Respect. We do not know how cost effective Healthy Respect was compared to other initiatives. This is important, because policy makers need this information to help them choose how to allocate scarce resources. These choices will be increasingly difficult to make in light of the current financial climate and government spending review. Any discussion on cost should include the findings of this and the main evaluation of Healthy Respect 2 (Evaluation of Healthy Respect Phase Two: Final Report due for publication in 2010) including the differential impact on young people. It should also consider the costs and effects observed in the comparison area i.e. an area that was not using a large complex partnership intervention programme.

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