Joint working and the production of a City Health Plan: the Liverpool experience

CAROLINE COSTONGS and JANE SPRINGETT
Institute for Health, Liverpool John Moores University, UK

SUMMARY
Several cities within the WHO Healthy Cities Project are developing City Health Plans, a broad strategy to improve health in the city. This paper examines the effectiveness of joint working during the production of the City Health Plan in Liverpool, from the point of view of the participants’ perceptions. The results of the study were used to inform the reform of joint planning. The results suggested that joint working had been reasonably effective in developing the City Health Plan in Liverpool, but that more attention should be paid to the process of people working together, rather than an emphasis on formal interorganisational structures.

Key words: City Health Plan; intersectoral collaboration; joint working

INTRODUCTION
A City Health Plan is a broad and extensive plan for improving health which cities have committed themselves to produce during the second phase of the WHO Healthy Cities Project. Setting out the city’s vision of health and the steps it intends to take to achieve that, is an important landmark for any city (WHO, 1994). City Health Plans acknowledge that opportunities to improve the health of citizens involve action by many different sectors of a city, and that all of these should be involved in health planning, not just the health sector alone. Accordingly, intersectoral collaboration is frequently stressed as an important strategy to implement health promotion activities and, ultimately, to achieve a healthy city. To make a City Health Plan successful, it is important to understand how the different participants organise themselves and how they work together in order to accomplish the targets they have set. The aim of this paper is to draw lessons from intersectoral collaboration in Liverpool during the development of its City Health Plan. The research outlined in this paper has been actively used to inform the development of joint working in Liverpool and stimulated a wider debate locally on joint working in other areas, including joint care planning. It is assumed that joint working and networking are cornerstones of intersectoral collaboration and that both facilitate change towards a holistic approach to tackle health-related problems in the city.

The first part of the paper will discuss the role of intersectoral collaboration in bringing about change, clarify the concepts of networking and joint working, and will search for an answer to the question: ‘what is understood by effective joint working?’ The second part will present an exploratory study, in which the effectiveness of joint working in the production of the City Health Plan in Liverpool was analysed.

INTERSECTORAL COLLABORATION AND CHANGE

Intersectoral collaboration, as a strategy for health promotion, can be considered as an instrument to initiate and facilitate change. In
an oft-cited definition by Gray (1985) it has been described as:

the pooling of appreciations and/or tangible resources . . . by two or more stakeholders to solve a set of problems which neither can solve individually. (p. 912)

But it is more than this. By its very nature it creates opportunities to exchange and share the beliefs and values of different sectors and organisations. In the process this usually raises an awareness of the participants’ own organisational culture which tends to stay invisible to its members until they are confronted with differences (Van Aken, 1993). Through intersectoral collaboration, they will notice that different value systems develop different solutions to health-related problems. This in turn creates an awareness of their own values and may contribute to their willingness to learn and change. Intersectoral collaboration thus creates ‘arenas for dialogue’. As Hazen (1994) argues, dialogue occurs when people speak with and listen to one another in mutuality, reciprocity and co-inquiry. In doing so, they change their shared reality, because naming their own experience, being listened to and hearing another’s experience encourages reflection on those experiences. As private knowledge is shared and becomes public knowledge, their shared reality is fundamentally altered and results in change. Thus, where an interdependent and co-ordinated joint working process incorporates the full range of possible participants, it can stimulate widespread processes of innovation and change (Engel et al., 1994).

NETWORKING AND JOINT WORKING

Intersectoral collaboration has been expressed and defined in many different ways and using different terms; for example, intersectoral co-operation or co-ordination, coalitions, healthy alliances, social movements or formal inter-organisational arrangements. However, independent of the term, there is always a degree of joint working and networking underlying intersectoral collaboration. Joint working and networking can be considered as two separate concepts. Joint working is defined here as ‘the process of working together irrespective of the boundaries of different organisations and public sectors in order to achieve a common goal’. Joint working implies equal ownership and an appropriate input from each participant (Speller and Funnell, 1994). Networking is ‘creating linkages between people so that they are mutually connected by means of many social relationships’ (Felling and Huttner, 1981, cited in Goumans, 1993). Often, people use networks or are networking without actually working together in the literal sense of the word. The chief goals for networking are establishing contacts that might be needed in the future and exchanging information or other resources, without being involved with each other in shared projects.

On the other hand, networking and joint working are closely related. Firstly, both have several common characteristics. Both involve a multitude of people and the existence of a degree of mutual dependence; there must be a high degree of trust between the participants and confidence in the outcome—it can cost a great deal of energy and time to network as well as to work jointly, while the returns can be often unclear. Secondly, joint working is an important foundation for the emergence and maintenance of networks. Joint working can generate a much wider network in a shorter period of time than one created by only relying on personal contacts. Thirdly, networks can in turn facilitate joint working. When people meet in joint working, their formal and informal networks are brought together, and this can provide new channels to involve new people that may improve the joint project. Indeed Zapka et al. (1992) recommended in their case-study on inter-organisational responses to AIDS that pre-existing networks should be analysed when initiating and/or trying to improve joint working amongst (community) organisations.

The focus of the research presented here is a pilot study on joint working, rather than on networking. Network analysis can involve collecting an overabundance of data (Tichy et al., 1980) with concomitant time-consuming analysis. Furthermore, Delaney (1994) argues that an emphasis on network structure is not sufficient, since the focus on channels does not explain the underlying behaviour of the people involved (Webb, 1991). Indeed, at the city level, qualitative studies of network formation and the dynamic process of networks are still rare in comparison with quantitative ones (John and Cole, 1995; Springett, 1996). Degeling (1995) has argued that such network studies are urgently needed for understanding the real barriers to change in developing healthy public policy. This present study, however, was time-bound, requiring quick feedback into the process of developing and implementing
the City Health Plan in Liverpool to aid decision-making. A more detailed research study of networking awaits funding.

THE EFFECTIVENESS OF JOINT WORKING

Nocon et al. (1993) stress the importance of investigating the added value of joint working in achieving health gain. Certainly organisations will be more prepared to share their resources, i.e. time, money, information or human capital, and to give up power in joint working, if they are aware of the likely benefits of it. (O’Toole, 1988; Dluhy, 1990; Butterfoss et al., 1993; Delaney et al., 1993). But what does effective joint working mean?

The effectiveness of joint working is as much about the outcomes of joint working as the process by which this outcome has been achieved. One could argue, therefore, that joint working is effective if it facilitates the desired change (outcome) with the best possible use of working together (process), and that it brings about ‘more’ change for health—in terms of quality as well as in quantity—than single organisations would have achieved on their own or in other ways. However, effectiveness is a value-laden concept and is as much about perceived cost benefits as objective indicators. As with all evaluation, it also depends on who is defining the criteria of effectiveness (Springett et al., 1995). Different perspectives place a different emphasis on process and outcomes. These can fall into two categories: those who take a top-down view and those who take a bottom-up approach to effectiveness. Ideally, of course, both need to be considered.

A planner taking a top-down perspective may assess the process in terms of a good administration structure, perfect co-ordination and measurable goal performance (Sanderson, 1990). This would be seen within the context of the local political and economic situation and national government policy, which can have an impact on the opportunities for effective joint working. Typical in such an assessment is the emphasis on compatible and consistent goals for joint working.

For those acting as reticulists (Friend et al., 1974; Hanf and O’Toole, 1992) and taking a bottom-up perspective, effective joint working has all to do with good communication and interpersonal skills, and issues such as trust, mutual respect, openness about self-interest, and the ability to learn from others take priority. Joint working is seen as a process of negotiation between the people involved and an interchange of their beliefs and values. From this point of view, a focus on clear goals and adequate control neglects the analysis of the underlying processes that influence effective joint working (Sanderson, 1990). After all, well co-ordinated joint working is not necessarily effective in accomplishing its mission (Butterfoss et al., 1993). It is from the latter perspective that the set of indicators for planning, evaluating and developing healthier alliances was developed by the HEA (Speller et al., 1995). The resultant simplified tool (Funnell et al., 1995) was based on a pack (Speller and Funnell, 1994) which describes five process indicators—commitment, community participation, communication, joint working and accountability—and six categories of output indicators—policy change, service provision and environment change, skills development, publicity, contact and knowledge, and attitude and behaviour change. The choice of indicators reflected the knowledge and perceptions of those who participated in the workshops that created them.

The research described in this paper does not attempt to develop a set of universal indicators. It takes the view that the effectiveness of joint working cannot be defined unambiguously and that the actual assessment of its effectiveness depends on people’s beliefs and values and what they think makes joint working successful. It thus explores participants’ perceptions and opinions of particular joint working processes. People’s perceptions of the process in relation to internally derived goals and expectations may well be a valid indicator of effectiveness.

THE CITY HEALTH PLAN IN LIVERPOOL

Liverpool is a relatively deprived city in the United Kingdom with ~477 000 inhabitants. The city is dealing with the consequences of an economic recession, due to the decline of its port and associated industries. The Liverpool Quality of Life Survey (1991) shows poverty in the city at twice the national average with a high unemployment rate (21.6%). The Liverpool City Health Plan recognises that these wider social, economic and environmental factors influence health and that action is needed (City Health Plan, 1996). The aim is to provide a strategy for working
together to improve health in Liverpool. The plan, which covers 5 years (1996–2000), seeks to influence, co-ordinate and integrate purchasing, service and business plans of the key organisations in the city. A ‘Joint Public Health Team’ (JPHT) was established in 1993 to direct action on the main health concerns in Liverpool, and is accountable to the ‘Joint Consultative Committee’ (JCC), which is a political body consisting of district health authority and local municipal authority members. The district health authority is responsible for the purchase of health services from hospital and community health service providers on behalf of the population within the National Health Service. The JPHT was an addition to traditional existing joint-care planning arrangements. The latter involve mainly social and health service providers and have been in place for some time due to statutory requirements.

In addition, there is a ‘Healthy City Unit’ to provide administration and support for joint working between the agencies in the city and the community. In order to formulate and write the strategies for the Plan, four ‘Task Groups’ were specifically set up to address key areas of the UK government’s ‘Health of the Nation’ document (1992) (heart disease, cancer, sexual health and accidents) as well as one Task Group on ‘housing for health’. The membership of the Task Groups comprised of purchasers of health services and consumers. A total of 160 people worked on the production of the City Health Plan. The organisations represented were: the City Council (Social Services, Environmental Health, Education), Health Authority, community health councils, Age Concern, universities, Health Promotion Agency, Trades Council and several voluntary groups. At the time of the study, a draft of the plan was presented for consultation with the wider community.

RESEARCH METHODOLOGY

Because a positivist and quantitative research design can be limited in measuring people’s beliefs and values about joint working for health, and does not have the power to respond to the particular research objectives as identified above, a qualitative research method was chosen for this study. As has been argued, subjective experiences are at least as important as any objective measures of joint working, since it is the subjective impression that influences collaborative working (Delaney et al., 1993). Time was an important consideration in choosing sample size. The JPHT wanted information quickly to inform its discussions concerning plan implementation so it could feed in that information into the annual cycle of operational planning.

Ten key informants were selected for semi-structured interviews. Two of the five Task Groups that had contributed to the City Health Plan were chosen and represented by six key informants. The Task Groups chosen had contrasting styles of working, which were thought to be representative of the range of differences between the different groups. To gain a wider perspective of the process of developing the City Health Plan, two key informants from the Healthy City Unit and two key informants from the JPHT and the JCC were also interviewed. Given the small sample, the ten informants were also chosen to reflect different categories of sectors: the statutory (health and local authority), the voluntary sector, independent organisations, and the community. Those informants interviewed were perceived to be knowledgeable about joint working and able to give a view from their respective backgrounds.

To avoid bias, the interviews were tape-recorded and conducted on site by one of the authors, who previously had not been in contact with the joint working process in Liverpool. The other author had closer contact with the JPHT as a participant observer and was able to contribute general knowledge of the City Health Plan development. Other information was obtained through consultation with the Healthy Cities co-ordinator; by observation during the attendance of the launch of the City Health Plan; and by analysing reports and minutes of the meetings from the JCC, the JPHT and the two Task Groups.

The interview schedule was based on a previously validated methodology called Rapid Appraisal of Agricultural Knowledge Systems (Raaks)-methodology (Engel and Salomon, 1994; Engel et al., 1994). Tools for the analysis and evaluation of joint working and intersectoral collaboration are rare and relatively unsophisticated. Rapid appraisal has been used extensively in research in developing countries, largely in rural areas. The value of the methodology used by Raaks is that it offers a way of enabling local actors (organisations, groups or individuals), their relationships and social learning to be recorded (Engel et al., 1994) in order to gain understanding of the factors that contributed to a
particular outcome. Thus, the City Health Plan was considered to be the outcome of a joint learning process which can be analysed from various different angles. In its original use by Engels, the Raaks methodology consisted of three phases with different research objectives. In the present study, several tools from the second phase, the constraint and opportunity analysis, have been adapted for investigating joint working. These tools are: actor analysis, task analysis, communication analysis and co-ordination analysis. The attraction of using the Raaks-methodology is its flexibility; every researcher is allowed to create their own unique, context-specific exercise (Engel et al., 1994). The adapted tools were tested and modified before they were used with the key informants in the study. Alongside the questions that were derived from the Raaks-methodology, the interview schedule also included open-ended questions about joint working in general, which were subject to a contents analysis. The following section is a summary of the research findings in Liverpool that are based on the perceptions of the ten key informants and the analysis of the developed tools. More detailed discussion can be found in the research report (Costongs and Springett, 1995).

THE LIVERPOOL EXPERIENCE

Who were the real partners?

The Health Authority and City Council were considered the main partners in joint working, mainly because they were seen as having the power to bring about change. The Healthy City Unit was indispensable because it maintained the vision, took care of the overall organisation and made it all happen. The voluntary sector and community groups, however, did not attend the City Health Plan meetings as regularly as the statutory sector. There was also difficulty in involving the business sector, for often no business representative existed, there was no time available or there was no pay-off for them. The research indicated the same problems for community participation:

Putting two people from the community on the Task Groups, is not enough for effective community involvement. (Task Group member)

To involve the community more, Liverpool chose to go for an intensive 5-month consultation process with the community about the draft of the City Health Plan.

While identifying the real partners in joint working, the relative influence of their personalities was also discussed. Several anecdotes suggested that various personalities had a different impact on the joint working process. However, although the quality of people’s input to joint working is often dependent on them as individuals, they are also influenced by the commitment of their organisation (Nocon et al., 1993). Some organisations, for example, sent junior officers to the meetings. These officers had ideas but not the political clout to deliver, nor the authority to make decisions, while senior officers made valuable contributions. Inevitably, the more influential people are, the greater potential intersectoral collaboration has to bring about change:

At the end of the day it is all about the right people, the right personalities, a sense of humour and to be in the right place where they have the power to influence! (Healthy City Unit member)

Working together

Generally, all people involved with the City Health Plan felt committed throughout the whole year. This was largely because it was expected that they had a clear and focused task, i.e. writing strategies for the plan in their specific field. The chair of each Task Group would support joint working and make sure that every participant had an equal input. According to Kumpfer et al. (1993), competent leadership is critical to the maintenance of joint working, as well as to the ultimate joint working outcome. Lists of qualities that chairs should have abound in management literature (Butterfoss et al., 1993). However, the chairs of the Task Groups in Liverpool were selected because of their seniority and their statutory background, and not because they had good facilitation skills. As a result, the process of working together occasionally suffered from the way the group was chaired, both in terms of facilitation skills (the ability to run the Task Group) and in terms of reticulist skills (the ability to network, to negotiate with others and to feedback to the Task Group) (Means et al., 1991).

Notwithstanding these problems with chairing, there was a recognition of degree of mutual dependence between the participants in carrying out the work. This awareness is, according to Hudson (1987), one of the prerequisites for joint working. Also, working together on clear tasks creates a bond between people and will increase networking in the future. To a certain extent, the success
of a City Health Plan depends on this network capacity—the capacity to mobilise, organise and to support. Unfortunately, a mapping exercise of newly formed networks was not included in this study for reasons mentioned earlier. This remains a serious limitation. In order to understand the scope for working together for the City Health Plan, it is important to know about these formal and informal network structures (Trasher, 1983). This will form the basis of future research.

Understanding each other

Joint working means continuous negotiation within the different contexts, perspectives and opinions, and trying to obtain the most beneficial possible outcome. Differences in perspectives, especially between the statutory sector and voluntary agencies, largely concerned the concept of health and about what should be prioritised to promote health in Liverpool. These different ‘world views’ influenced the nature of communication between the partners in joint working. Another issue that had a restraining influence on the communication process was the notions that participants held of their fellow group members. For example, there was a clear perception of people’s levels of seniority and their relative importance. Therefore, some of the participants felt intimidated by what they saw of the ability and power of others. Interestingly, this experience is put into the following words:

It is a bit weird, because you suddenly realise that your professional expertise is only a small cog in a big gear-box, and it makes you feel like ‘oh, you know, what is my contribution’. It does make you realise that you know very little about the complexity of the work other people put in their field. When you appreciate all that, you feel pretty insignificant. . . . Particularly if you are the sort of person who (I guess most of those people are) is open to other people’s experiences . . . your own experience wipe out, dramatically. (Task Group member)

If people are feeling confident and secure in their roles, they are much more willing to share information and ideas, with less need to prove the significance of their contribution (Delaney et al., 1993), and they are more in favour of an open communication process. This is a cumulative process and dependent, as in any group, on the building up of trust.

People are afraid to ask, afraid to look stupid. The most difficult thing in the world is actually to sit there in a meeting, turn around to somebody and say ‘look I am sorry, but I don’t think I understand what you are talking about’! (Task Group member)

This also highlights the role language can play. Even if participants share the same vision to promote health, the group’s language and the specific meaning assigned to key words can also have an impact on the communication process and, ultimately, on joint working. Some words will be interpreted differently according to the profession or the organisational culture of group members. For example, the community does not speak the same language as the statutory sector. A key informant from the community admitted having difficulties with abbreviations and thought there was too much jargon in the Task Groups’ language.

Power influence and conflict

The interorganisational structure in which the City Health Plan evolved created the ‘arenas’ for joint working. The importance of such a structure is stressed in the literature (Hudson, 1987; Butterfoss et al., 1993; Kumpfer et al., 1993; Delaney, 1994). It is argued that a degree of formalisation, the extent to which roles and procedures are defined precisely, is necessary for successful joint working. Some level of domain consensus needs to be achieved. Domain consensus is the set of expectations about what the other organisation will and will not do. There needs to be agreement amongst professionals and individuals on their roles and positions. However, the experience in Liverpool showed that this degree of formalisation was often accompanied by different levels of power, an absence of direct two-way communication and time constraints, which complicated

---

**Fig. 1:** Communication between the Joint Consultative Committee (JCC), Joint Public Health Team (JPHT), Healthy City Unit and the two Task Groups.
and restricted effective joint working. As the development of a City Health Plan was an innovative strategy for Liverpool, messages from the JPHT kept changing and Task Group members were confused about the guidelines for producing the plan. These power relations and perceived lack of communication appeared to be a potential source of conflict. Figure 1 is a reflection of the communication structure in Liverpool as perceived by the informants.

The communication between the two Task Groups and the Healthy City Unit was good and regular, because every Task Group meeting was attended by a Healthy City representative. However, there was hardly any communication between the Task Groups and the JPHT. Consequently, the Task Groups were not entirely aware of the JPHT’s activities, they received information second-hand rather than directly, and the Joint Public Health Team appeared to move the goalposts. (Task Group member)

Since the development of a City Health Plan was a new and innovative strategy for Liverpool, messages kept changing and Task Group members were confused about the guidelines for producing the plan. The strategic planning of the JPHT seemed rushed and Task Group members felt they were not really part of it. Often the communication was seen as one way only (top-down), and the chair of one Task Group only had the opportunity to present their work to the JPHT once every 5 months. By contrast, the JPHT perceived the Task Groups as occasionally developing a strategy which was not specific or focused enough and kind of dealing with the whole universe. (JPHT member)

But changing the Task Groups’ work without a direct dialogue, reduced the Task Groups’ ownership over the plan. At times this situation created a dilemma for the Healthy City Unit which, as mediator, was in between the Task Groups and the JPHT. Figure 2 demonstrates co-operation and conflict relations, experienced by most of the informants.

Conflict is an inherent characteristic of coalitions (Butterfoss et al., 1993), which in itself may not be bad. The results of conflict can be positive or negative, depending on how the groups and organisations involved handle it. In any case, it is important that conflictual issues are not ignored (Ewles and Simnett, 1992).

Power relations not only existed between the JPHT and the Task Groups, but were also identi-
Figure 3 shows that the City Council had more influence in one Task Group, while the Health Authority was the important prime mover in the other. As a result, the development of the City Health Plan was quite top-heavy. The statutory control of the agenda together with its management pressures, means that other participants may well exert little influence, which is a recipe for the failure of joint working (Nocon et al. 1993). However, the development of the City Health Plan had to start from somewhere and it is not realistic to expect 100% involvement right from the beginning. None the less, it is something that the more powerful actors need to be aware of, if they wish to really achieve their vision. It will be interesting to see if this changes over time.

Perceived benefits and constraints
As previously argued, any judgement as to whether joint working was effective during the production of the Liverpool City Health Plan depends on people's definition of effective joint working. The following three statements represent the views of the key informants.

Joint working is effective if it:

• adds value to the process—if you do not get more than the sum of the parts, then there is no point in working together;
• is changing your view of the issues by learning about other people’s work and their world, by which you arrive at decisions better informed, more co-ordinated and more mature;
• is producing a product that has the influence of all the key players in it.

A benefit of working together in interorganisational Task Groups was that people started to think in terms of what they needed to do in the community, rather than in their own organisation, and they began to see the importance of public health within their work. The boundaries between the organisations in Liverpool were thus softening up because of this joint working process. There was better understanding and appreciation of what other people and organisations do, which created a force to carry something through. Because the City Health Plan was developed together, it was open to discussion and therefore it was more accountable and more likely to be jointly owned.

Clearly, several constraints of joint working were experienced in producing the City Health Plan, of which time was the most frequently reported. Achieving consensus was a time-consuming activity and the time needed for joint working was often in addition to people’s other responsibilities. However, the extra time spent on working together was also seen as an investment and only a temporary disadvantage. Another constraint was that participants had different opinions about the best ways to work, they had their own agendas and interests, which made it difficult to compromise and to focus on a clear strategy. Consequently, people ran into the danger of becoming immobilised by talking. A City Health Plan is not an end in itself, but a means to achieve improved health in Liverpool.

So, you can’t start out on a journey because you haven’t got all the maps and you don’t know where the end point is. Well actually, sometimes you can . . . go out on journeys, on which you have a vague idea where you are going, and you will find it out on the way. (JPHT member)

DISCUSSION
Joint working is not only an instrument for change in the formulation of a City Health Plan, but also for its implementation. The exchange of people’s beliefs and values at the level that puts the formulated policies into day-to-day practice is extremely important in bringing about change in the city. As Somers (1994) argues, the stories by which people understand the world guide the action they take. These stories come from a limited repertoire of available social, public and cultural narratives, dependent of the relational settings in which people find themselves. Therefore, the arenas for joint working and the process of joint working for the City Health Plan need to be addressed effectively.

At the time of writing, the draft City Health Plan in Liverpool had reached the end of its consultation phase and was formally launched in April 1996. As a result of this present research, a number of recommendations, based on the longer report referred to above (Costongs and Springett, 1995), were placed before the JPHT and are currently being taken into account in revising all the joint planning structures in the city, as well as influencing patterns of working in a variety of areas. The research is only one part of the complex interplay of politics, pragmatism and information that will dictate the outcome. However, there are some wider implications of the research for joint working in other cities and contexts, and these are given below. The research supports the view...
that it is important to recognise that simply establishing formal joint structures, is not enough to guarantee successful joint working (Nocon, 1990). More attention needs to be paid to the ‘arenas for dialogue’ and the process of joint working. Such a view is supported by recent management and organisational literature on partnership and alliance building (e.g. Hall, 1991). In the specific case of partnerships for health in health promotion, the following are offered as practical guidelines.

- First, while joint working, try to avoid a division into a statutory ‘inner’ group and a community/voluntary ‘outer’ group. This can be addressed by taking care of the language and by getting all relevant organisations adequately represented by people with the right authority, abilities and skills. Furthermore, do not assume that all partners are aware of each other’s responsibilities and the functions of their organisations. Open the discussion on their abilities, expertise or professions and where that leaves them if they work jointly.

- Second, maintaining partnerships relies upon constant re-appraisal (Nutbeam, 1994), and an emphasis on short-term action and smaller tasks will help to show achievements. This implies effective monitoring and an ongoing evaluation. It might be preferable to attribute time to joint working and evaluation in the job description of the people involved, so that time is not taken from other obligations.

- Third, there should be direct and frequent contact between the partners involved in joint working. Open channels for two-way communication enable the more powerful to show that they are taking alternative ideas on board and ensure the less powerful that they are being heard. An open and visible communication structure increases trust and reduces potential conflict.

- Finally, the chair’s skilful handling of any conflict that has emerged, is essential for the success of joint working. Good leadership is required to built, maintain and improve joint working, and is necessary as a catalyst for action (Dluhy, 1990; Zapka et al., 1992; Kumpfer et al., 1993; Nutbeam, 1994). Training is recommended for the chairing role as well to enable all participants to benefit optimally from joint working (Butterfoss et al., 1993; Kumpfer et al., 1993). Delaney et al. (1993) have noted that training can raise issues such as individual management of change, coping with changed identity and conflict issues, many of which have been referred to in this research. It is clear, too, that while formal meetings are important, workshop-style approaches with a facilitator are effective for achieving rapid changes in perceptions and improving relationships.

**CONCLUSION**

This paper started with the assumption that joint working and networking are the two cornerstones for intersectoral collaboration. The importance of networking is acknowledged, because seeking relationships and developing linkages play a necessary role in getting a whole city committed to tackle urban health-related problems. However, it is through informal joint working that arenas for dialogue are created, that people really get to know one another, appreciate each other’s roles, exchange work values and beliefs, and learn from each other. In fact, the research findings have shown that producing a City Health Plan revolves round the way people work together. The extent to which joint working developed depended on the combination of (i) the participants’ backgrounds (from the community, statutory, voluntary, or private sector), (ii) the commitment of their organisation, (iii) their personalities and skills, and (iv) the facilitation skills of the chair. These four characteristics determine the degree of power the participants have, how they are perceived by other group members, and their functioning in the group. Accordingly, these characteristics have an impact on the process of joint working and therefore on the success of intersectoral collaboration. In addition, the research findings emphasised the importance of the Healthy City Unit. Having an independent, neutral body, such as the Healthy City Unit in Liverpool, which had an important ‘glue’ function and played a major co-ordinating, motivating and facilitating role, has been an essential and visible element in the joint working process.

This paper has tried to assess the effectiveness of joint working in Liverpool. The key informants uniformly agreed that, even with its faults, joint working had been effective in developing the City Health Plan. The City Health Plan is a product of the influence of the several key players, and the results suggest that some of the organisations, groups and individuals in Liverpool are indeed beginning to change their views about public
health issues in the city. However, assessing the relationship between this process and the actual health of the city is a much larger and more complex longer-term exercise.

ACKNOWLEDGEMENTS

The authors would like to thank: the City Health Research Network, funded by the European Union Training and Mobility Fund, which made this research possible; IVESP in Valencia for bringing the Raaks-methodology to our notice; the Healthy City Unit in Liverpool, especially Julia Taylor, for all their support; the anonymous key informants for their valuable contributions; Dr Paul Thomas, Maud van der Venne, Michelle Vogels and David Meiklejohn for their useful comments upon the draft of this paper; and, finally, an anonymous referee who also recognises the undervaluing of interorganisational relations and change management work in this area by the published health promotion and public health literature.

Address for correspondence:
Dr J. Springett
Institute for Health
School of Human Sciences
Liverpool John Moores University
Trueman Building
15–21 Webster St
Liverpool L3 2ET
UK

REFERENCES


Liverpool City Council (1991) Quality of Life Survey.


