Strengthening Partnerships: Building Collaborative Capacity

Wider Partnership Conference
24 November 2025

Partnerships – what are they?

"A joint working arrangement where partners are otherwise independent bodies, who agree to cooperate to achieve a common goal, through creating an organisational structure or process and agreed programme, and share information, risks and rewards."

(A Fruitful Partnership – Audit Commission)

Eyes Down!

Has been a member of a cross-sector partnership	Has led a partnership steering group	Has collaborated with community groups
Has faced barriers in partnership working	Has developed a successful partnership	Has delivered a joint-funded project with others
Has successfully negotiated a partnership agreement	Has had to resolve a partnership conflict	Has worked with multiple stakeholders on a joint initiative

Our Plan for Today

1. The power of partnerships
2. What makes a good partnership?
3. Challenges & barriers to partnership working and ideas to overcome them
4. Types of partnership governance models – and when to use them
5. Partnerships in practice!
6. Useful resources

The Power of Partnerships

"Tell us about when you have been involved in an enjoyable and effective partnership."

Tease out the characteristics that made the partnership successful:

- What made the partnership enjoyable/impactful?
- What strengths did each partner bring to the collaboration?
- How did you communicate effectively with your partners?
- What role did trust play in your collaboration?
- What specific actions, attitudes or behaviours contributed to the partnership's effectiveness?
- How did you navigate challenges or disagreements within the partnership

9 characteristics of effective partnerships

Shared vision and purpose

Partners develop and own a common purpose, built on shared outcomes and aligned local priorities.

Why does this matter? *Co-created goals strengthen commitment and clarity.*

Mutual trust and respect

Strong relationships are based on honesty, dependability, and a willingness to manage tension constructively.

Why does this matter? *Trust sustains collaboration, especially in challenging times.*

Clear roles, responsibilities and governance

Defined roles, agreed decision-making processes, and transparent governance reduce confusion and increase efficiency.

Why does this matter? Good governance enables collective accountability.

Equity, inclusion and power balance

All voices matter. Power is shared, and partners actively include voluntary, community, and lived experience contributions.

Why does this matter? *Equality is embedded, not assumed.*

Effective communication

Open, honest and timely information sharing keeps everyone informed and aligned.

Why does this matter? *Both formal and informal channels matter.*

Strong, distributed and visible leadership

Leadership is facilitative and shared. All partners take ownership, enabling joint action and collective voice.

Why does this matter? *Leadership is a shared responsibility, not a single role.*

Commitment to learning and continuous improvement

Partnerships reflect, review, adapt — and use evidence to grow and evolve.

Why does this matter? *Learning partnerships deliver better outcomes.*

Resourced, sustainable collaboration

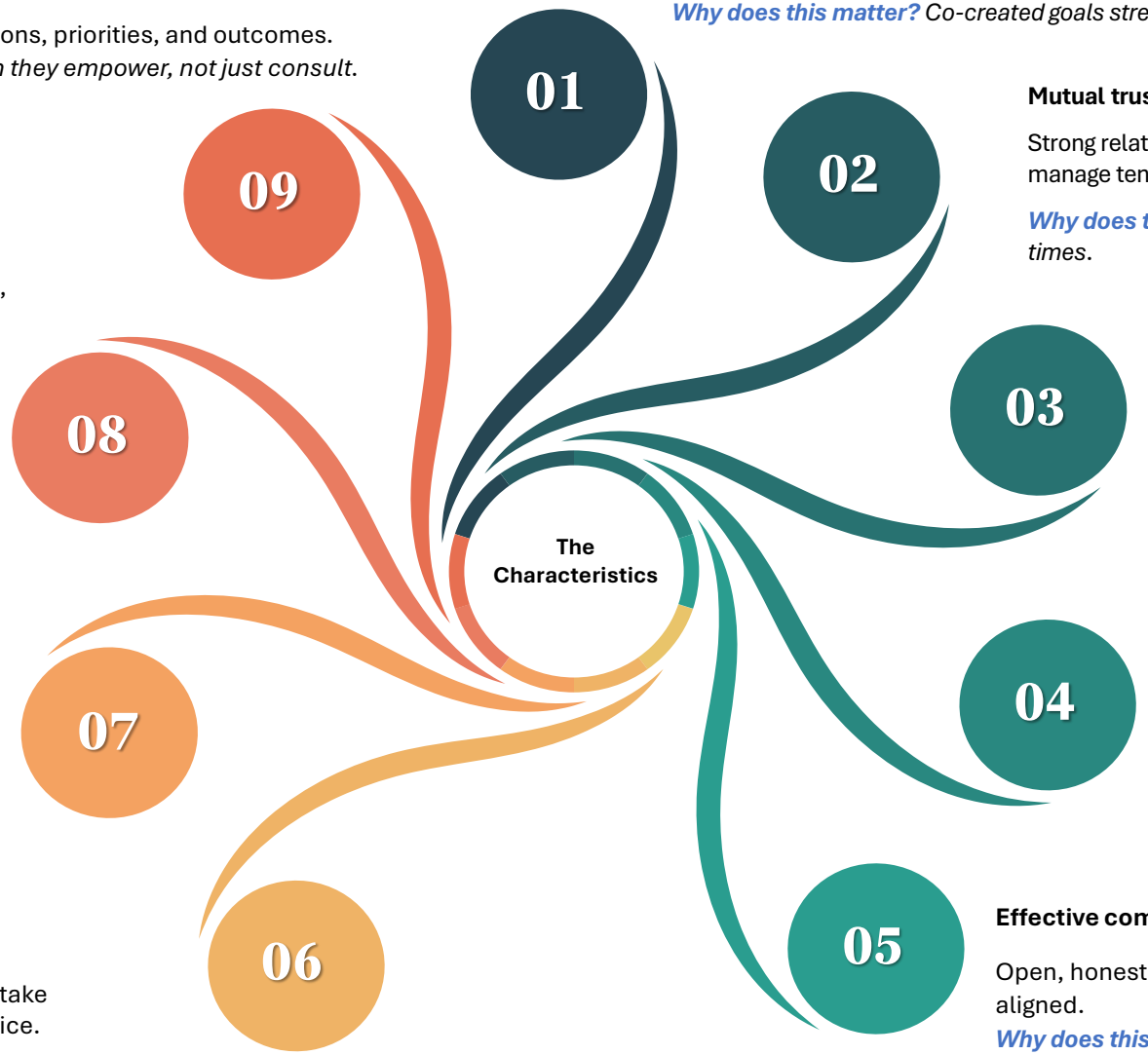
Collaboration requires investment in time, people, infrastructure and — where possible — funding.

Why does this matter? *Effective partnerships are properly resourced partnerships.*

Community engagement and empowerment

Communities are active partners in shaping decisions, priorities, and outcomes.

Why does this matter? *Partnerships succeed when they empower, not just consult.*



Challenges & Barriers

- Cultural
- Communication
- Lack of Trust/Immature Relationships
- Time Restraints
- Limited or Insufficient Resources
- Conflicting Goals and Priorities
- Different Rules and procedures
- Data Sharing

Summary of types of Partnership governance

- Informal collaboration
- Steering Group
- Memorandum of Understanding (MoU)
- Lead Partner
- Consortium/Co-Location
- Contractual
- Separate Organisation
- Statutory Partnerships

What is not a Partnership?

Lots of collaborative work wouldn't be classed as partnerships however some of the information we will cover today could equally apply!

- Contractual arrangements
- Procurement arrangements
- Appointments and financial commitments to external organisations
- Consulting & engagement with partners and the public
- Allocating grants to other organisations
- Networking functions
- Service level agreements
- Local committees, which have separate governance arrangements

Route One to Wellness

Harrogate & District's Mental Health and Wellbeing VCS Partnership

CLARO

mind for better mental health in Harrogate

community arts for positive mental health

wellspring therapy & training

Craven Mental Health & Wellbeing Hubs

Partnership Example

Gemma Umpleby

Director Strategy and Development

North Yorkshire Hospice Care

What is HELPSS

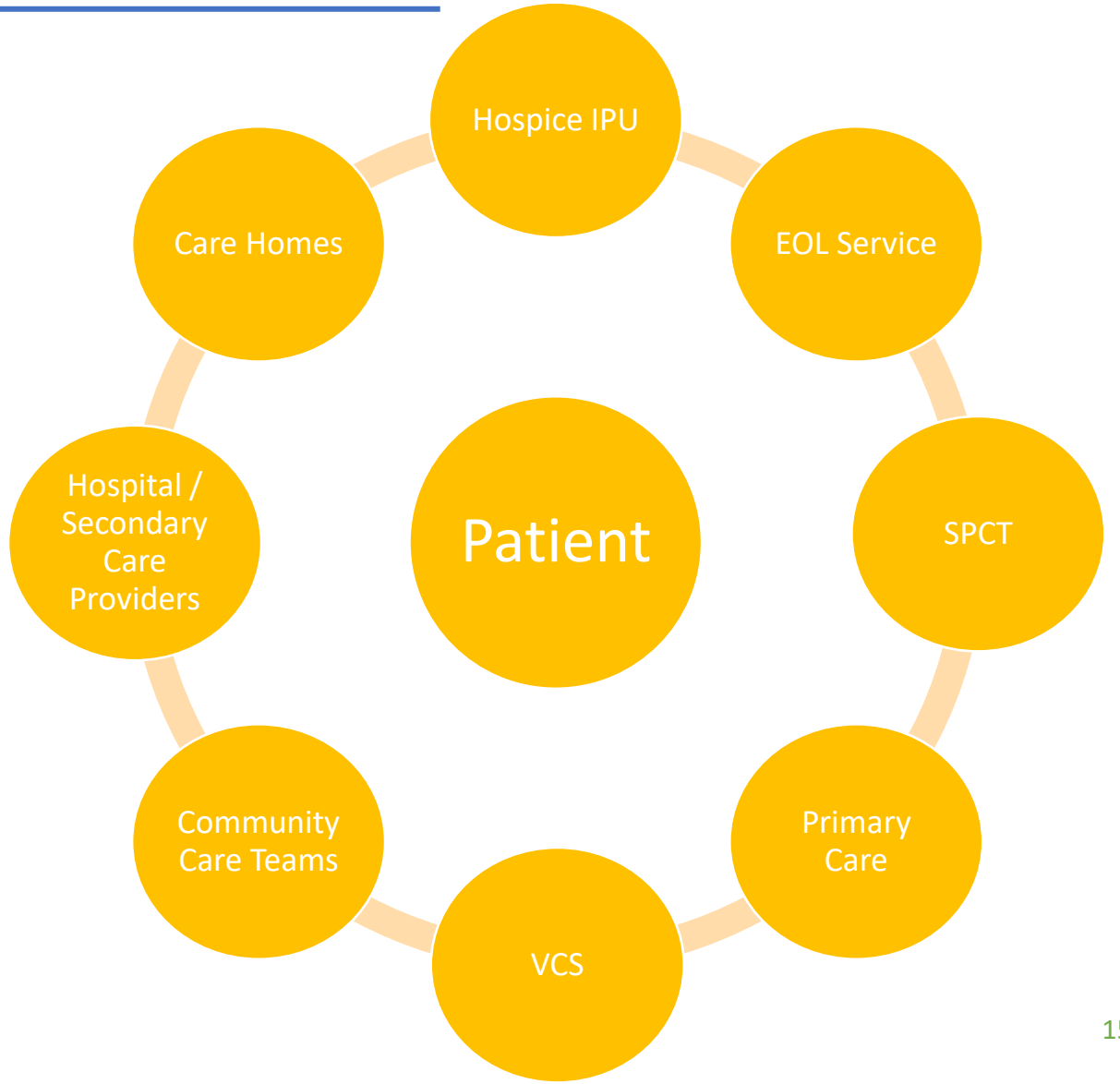
The Harrogate End of Life Planning and Support Service (HELPSS) is being led by the Harrogate and District NHS Foundation Trust, in partnership with Saint Michael's Hospice, Airedale NHS Foundation Trust, Macmillan Cancer Support and Social Finance for patient under care of a Harrogate & Rural GP.

HELPSS will:

- **Improve identification of patients who may be in the last year of life in the Harrogate locality.**
- **Improve access to advance/future care planning for those with a palliative diagnosis who may be in the last year of life.**
- **Provide access to Goldline, a 24/7 telephone service for patients who may be in the last year of life and their carers**

Partnership Working: HELPSS

Forms of Partnerships



Case Study: Comprehensive advance care planning supports decision making and care

SITUATION

April 2025: Patient identified as approaching last year/months of life by Consultant Geriatrician during hospital admission and discussion with wife. Lives in Nursing Home.
Diagnosis of severe frailty.
DNACPR decision made in hospital and minimal information included on ReSPECT plan
Referred to Advance Care Planning Team (ACPt) on discharge.

ACTION

May 2025: assessed by ACPt with wife present

- Updated ReSPECT form completed – 'not for admission unless absolutely necessary'
- Comprehensive discussion of wishes and preferences for future care (About Me).
- All electronically documented on SystmOne (Future Care Planning template) and paper copy provided for care home
- Referred to Goldline for support

OUTCOME

- June 2025: Call to Goldline for advice as acutely unwell with hypoxia and vomiting.
- Goldline supported staff with decision to call ambulance noting ReSPECT plan.
- All documents (ReSPECT and ACP plan) sent into hospital, uploaded to EPR as 'Additional information'. Highlighted to staff next morning
- Treated with 24hours of intravenous antibiotics but condition continued to deteriorate. After discussion with wife, focus of care changed to support care in last days /hours of life in hospital setting as too unwell to transfer out of hospital.
- Died in hospital

LEARNING

Lack of Intra-operability of current IT systems: ongoing challenges in viewing even when shared and uploaded. To consider solutions with new hospital EPR

Unplanned Hospital Admissions: not always avoidable but ACP can support clinical decisions and care provided

Added Value of detailed ACP

- Hospital admission was appropriate despite preference
- Although ReSPECT + DNACPR completed on admission – limited detail (see next slide example)

ReSPECT Plan on discharge from hospital

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition

Summary of relevant information for this plan including diagnoses and relevant personal circumstances:
Chronic neurological decline, previous Guillian Barre Syndrome
Details of other relevant care planning documents and where to find them:

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8	No

3. What matters to me in decisions about my treatment and care in an emergency

Living as long as possible matters most to me / Quality of life and comfort matters most to me

What I most value:	What I most fear / wish to avoid:
No specific preferences/ values when asked	No specific fears when asked

4. Clinical recommendations for emergency care and treatment

Prioritise extending life	or	Balance extending life with comfort and valued outcomes	or	Prioritise comfort
				Dr D Norman

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:
For ward based care

CPR attempts recommended Adult or child	or	For modified CPR Child only, as detailed above	or	CPR attempts **NOT** recommended Adult or child
				Dr D Norman

Updated ReSPECT Plan after ACPt involvement

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition

Summary of relevant information for this plan including diagnoses and relevant personal circumstances:
This patient has an ACP please see Harrogate future care planning template. Sever frailty, Guillian Barre syndrome, ankylosing spondylitis, Rheumatoid arthritis, Previuos CVA. Lives in a care home. Assistance with all ADL's with 2 carers, PEG, CPAP, Catheter. PPD care home. Full CHC funding.
Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer):

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8	Has appointed person with personal welfare LPA (MCA 2005)

3. What matters to me in decisions about my treatment and care in an emergency

Living as long as possible matters most to me / Quality of life and comfort matters most to me

What I most value:	What I most fear / wish to avoid:
To be cared for well and have my symptoms well managed. My family and friends and my dogs Ruby and Amber	I do not want to talk about prognosis and I would not like to know if I was dying. I am absolutely petrified of dying and what will happen at the end of my life,

4. Clinical recommendations for emergency care and treatment

Prioritise extending life	or	Balance extending life with comfort and valued outcomes	or	Prioritise comfort
				Fiona Derham

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:
Treatment Escalation Plan: Home for Treatment of reversible conditions as appropriate. Stephen stated that he does not want to be admitted into hospital unless it is absolutely necessary. This patient is known to the Harrogate Palliative Care Team. If advice needed Monday-Friday 08.30-17.00 contact the team on 01423 553464. Outside these hours contact Saint Michael's Hospice (Harrogate) on 01423 872658. This patient has been referred to the Goldline for 24/7 advice and support for patients, carers and health care professionals. The telephone number is 01535 292768.

CPR attempts recommended Adult or child	or	For modified CPR Child only, as detailed above	or	CPR attempts **NOT** recommended Adult or child
				Not for attempted CPR Fiona Derham

Case Study: Advance care planning review process

SITUATION

Patients in the LYOL who have documented their wishes and care preferences in an advance care plan, may need to make changes if their condition has progressed or their personal situation has changed.

Opportunities to make changes could be highlighted by HCP if a patient's condition has progressed. However, the opportunity to have dedicated time to check in with each patient (who has made a plan) and give them the option to make changes may not always be possible.

ACTION

All patients who have completed an advance care plan with the St Michael's ACP team are offered a review after 6 months.

Patients are sent a letter inviting them to review their advance care plan (should they wish to) This gives patients the opportunity to discuss and document any changes to their original plan, ensuring the document it up to date and relevant. However, planning for this additional potential activity is challenging, so the team are exploring the option of providing telephone reviews rather than face to face appointments.

OUTCOME

Since January 2025, 4 patients have accepted the invitation to review their advance care plan. The team has taken a flexible approach to the format of the appointments based on patient need, with a clinical triage taking place for each appointment.

Patient A *wanted to add some additional details to the plan. The team was able to arrange a call with the ACP nurse who originally saw this patient, and the changes were made during a phone appointment.*

Patient B *has a diagnosis of MND and is non-verbal but able to communicate through a computer. The team arranged a face to face appointment to enable the patient to be involved in making the changes to the care plan.*

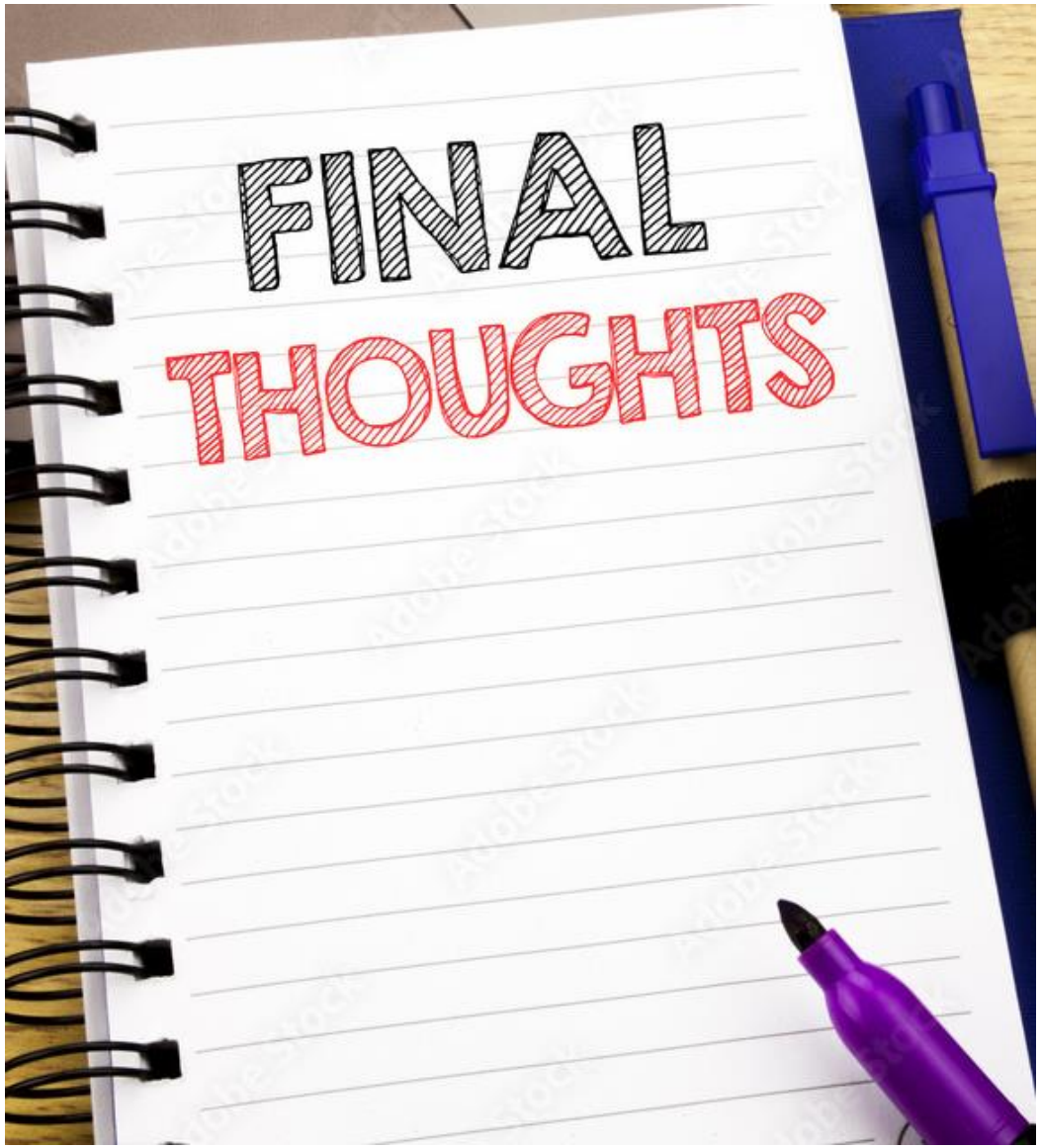
LEARNING

Advance care plan reviews can be carried out via telephone appointment to support efficient capacity management. However, it is important to assess need to ensure patients and careers are supported in the most appropriate way to input into changes to the advance care plan reviews.

A simple triage when a patient or career contacts the team to review the advance care plan is effective in ensuring the right appointment format takes place. This could be developed into a simple algorithm to enable the administrative team to assess and book the most appropriate appointment format.

Further Information

- **Visit** Harrogate End of Life Planning and Support Service (HELPSS) - Harrogate and District NHS Foundation Trust
- **Watch** the HELPSS video
- **Email us**: hdft.helpss@nhs.net we would be happy to arrange to talk to your team about the project/service.



What is your reason for forming a partnership?

Don’t assume you will be a good or bad partner – keep an open mind!

Do you know what you need to be a good partner?

Are you clear about the skills, behaviours, mindset and values that you can bring?

Are you confident you can commit time and resources?

Discussion/Q&A

Useful Links & Resources

What is Appreciative Inquiry (AI)? - The Center For Appreciative Inquiry
Nesta - Partnership-Toolkit-Feb-2019.pdf
The Partnership Cycle | NCCPE
Partnership cycle infographic - webpage version | NCCPE
Addressing Barriers - Actions To Support Partnership | The King's Fund
Place-based Partnerships: Challenges And Opportunities | The King's Fund
Home - The Partnering Initiative
TPI - Partnership-health-check.pdf
Lottery - Good Practice Guide-Assessing partnership working-2014