Partnerships in Health Care

Note

Health care practice and knowledge are constantly changing and developing as new research and treatments, changes in procedures, drugs and equipment become available.

The author and publishers have, as far as is possible, taken care to confirm that the information complies with the latest standards of practice and legislation.

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Foreword

Professor Christine Beasley, Chief Nursing Officer

I was delighted to be invited to provide a foreword for this book because partnerships are such an important aspect of my work as Chief Nursing Officer. The establishment and maintenance of partnerships is a cornerstone of policy, not just in health, but also in all government departments. This book adds to this current policy direction and debates how we can continually improve partnerships at all levels of provider organisations. The importance of partnerships within health care should not be understated, and I am pleased that those who have contributed to this book are exploring best practice. The NHS is a dynamic organisation and the issues raised in the following pages offer many and varied points to be considered as we deliver health care in the next decades.

Good quality nursing, midwifery and health visiting are integral to health care in the UK; and professional development is an important component of delivering this provision. I applaud the efforts of the nurses who have contributed to this book. They have all endeavoured to carry out original work that challenges and expands our understanding of partnerships. This work shows a strong commitment to personal and professional development and these nurses are an example to all health care workers.

The book also demonstrates in itself a form of partnership, between Higher Education Institutions (HEIs) and NHS Trusts. A good quality partnership between these institutions ensures that Trusts have access to the knowledge, skills and resources of HEIs and that HEIs understand the current issues and concerns facing health care providers in the 21st century. This book, as the product of a partnership between the editors at the University of Essex and the authors based in local NHS trusts, demonstrates just what can be achieved by working together.

I hope you will be inspired, motivated and challenged by what you read in this book. You may find that you are inspired to examine how partnerships work in your own organisation. You may also find that you are motivated to examine how partnerships may be improved and how patients and service users might become involved in this process. If you are challenged by what you read then you are engaging with this important debate about how health and social care are delivered now and in the future.

Preface

The papers collected together in this book have been assembled with the intention of demonstrating the importance of partnership in contemporary health care settings. The book examines the principles and practice of partnerships as they are realised by practitioners. In so doing it explores the use of the term 'partnership' as a guiding principle and critically examines its merit. Partnership is not a single and unified concept for which there is common understanding. It is a term that has entered the language and is applied liberally within a range of contexts to express a variety of endeavours. The book explores how the different writers define and apply the term and establishes whether comparable principles are recognisable in each case.

The contributors to the book were all students on an MSc scheme of the University of Essex. They have all since qualified and some have gone on to further academic study. The work that this group of students produced for this scheme was assessed as being of a very high standard by internal and external examination, and it was proposed that the work should be brought to the attention of the wider health care community. The editors identified work around the theme of partnership and invited students to present their work in a suitable form for publication.

The structure of the book grew out of discussion between the researchers and the editors. The editors were responsible for providing the structure, which consists of chapters containing papers that share a common focus: Users and Providers, Mental Health, Information Giving, and Service Partnerships. The editors examine the papers to trace common partnership themes, which are used to construct the concluding chapter. The conclusion examines the implications for partnership working in contemporary practice and shows how partnership is currently understood and practised by health care professionals.

Editing the work of nine authors has necessitated a degree of compromise and order. Each paper is approximately one quarter of its original length; the editors, working with the authors, have attempted to maintain the coherency of each paper. Inevitably, however, some of the detail has been lost. The papers are presented in a systematic manner to aid readability. It should be noted that the original papers might not have used the heading and structure imposed upon the papers during the editing process.

We hope that you will find the contents of this book useful and the structure accessible. The term 'partnership' is widely used throughout the health and

social services. It is applied to different contexts and with different intentions. This book contributes to the debate by expanding our understanding of the term as it is used in contemporary practice settings. It also provides evidence of the enactment of policy through changing practices. The book provides detailed exemplars of 'real' partnerships in health and social care, which readers can explore further with a view to developing their own practice and the practice of others.

Kimmy Eldridge and Peter J. Martin
June 2006

Contributors

Elizabeth Carpenter
Liz is a currently a Consultant Nurse in Critical Care. She has extensive experience working within the field of critical care, within both intensive and acute care. This has involved her working collaboratively across professional and organisational boundaries and within Higher Education to support and develop acute and critical care practice. She obtained an MSc in Advanced Clinical Practice in 2004 and she is currently undertaking a Doctorate in Nursing at the University of Essex.

Susan Eastbrook
Susan qualified as an RGN in 1975 at St Bartholomew's Hospital. She has worked within acute general nursing as a night sister and ward manager before commencing the role of patient care coordinator for medicine. Sue, along with her colleague Debbie Reynolds, was asked to pilot and develop her current role, the first of its kind to be introduced in the UK. The role has improved patient pathways of care during emergency admission. It has also improved the interface between, medicine, nursing and diagnostic departments.

Kimmy Eldridge
Professor Kimmy Eldridge was born in Malaysia and has lived and worked in the UK since 1967. She is responsible, at the University of Essex, for strategic development, interpreting professional and government policies, and advising the University and NHS partners on the education and training of health care professionals. In addition the Eastern Deanery employs Kimmy to organise the Colchester General Practitioner (GP) Vocational Training. In this role she takes part in the recruitment and selection of GP trainees and in approval visits to GPs and their practices to determine their suitability to provide placement-based learning.

Moira Keating
Moira is stroke care coordinator at Colchester General Hospital, a role that entails coordinating multi-agency services for stroke care. She qualified as a SRN in 1979 and attained a BA in 1999. In 2002 she was awarded an MSc from the University of Essex. Moira has maintained a professional interest in reha-

bilitation nursing for much of her nursing career and has worked specifically in stroke care for ten years.

Peter J. Martin
Peter is a senior lecturer at the University of Essex. He leads the Professional Doctorate schemes in health and social care in the Department of Health and Human Sciences. As a mental health nurse, he practices within the local mental health Trust working in groups with people who have enduring mental health problems. He is particularly interested in recovery and the subjective experience of mental illness. Peter completed his doctorate in 1999, which examined influences on the clinical judgement of mental health nurses.

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Debbie qualified as RGN in 1983 at Colchester General Hospital. She worked in acute general nursing as a night sister and managed an acute medical ward for older people before taking up the post of patient care coordinator. Debbie, along with her colleague Sue Eastbrook, was asked to pilot and develop her current role, the first of its kind to be introduced in the UK. The role has improved patient pathways of care during emergency admission. It has also improved the interface between medicine, nursing and diagnostic departments.

Diane Treadwell
Diane currently works as a Nurse Practitioner in a busy South Essex practice. She trained and worked at The Royal London Hospital between 1987 and 1997 where she developed a passion for medicine. Diane became interested in the way Primary Care worked and moved into Practice Nursing whilst doing her first degree. Diane's main interest now is working with people who live with cardiac and respiratory conditions.

Rachel 'Ray' Wilson
Ray is the Deputy Director of Community and Day Services at St Helena Hospice in Colchester. From 1978 to 1981 Ray studied music at Colchester Institute for Higher Education. A career change meant that she qualified as a nurse at the North East Essex School of Nursing in 1986. Ray has 19 years' experience in cancer nursing. In 2004, she completed an MSc in Advanced Clinical Practice (Palliative Care) at the University of Essex.

Nick Wrycraft
Nick is currently employed as a Senior Lecturer in mental health by Anglia Ruskin University and is a student on the Professional Doctoral programme at the University of Essex. On qualifying as a mental health nurse Nick gained wide experience of adult and elderly mental health services before moving on

to work as a research facilitator in primary care. His interests include clinical supervision, mental health in primary care settings and service design.

Jane Young

Jane is currently employed as the Lead Diabetes Nurse Specialist working with a team of Diabetes Specialist Nurses based at Broomfield Hospital, Chelmsford. Jane has a background in acute medicine in varied clinical settings and has worked abroad in Denmark and Hong Kong. Particular areas of interest are the impact of culture on health care delivery and patient education. Outside of work, Jane is driven by a passion for sailing and exploring remote parts of the world.

Introduction

Rosy Stamp, Director, St Helena Hospice, Colchester

I am delighted to introduce a book about partnership, a theme that is dear to the heart of St Helena Hospice. We are most grateful to the authors of the book, all local health practitioners and academics, for donating the proceeds to this Hospice.

Dame Cicely Saunders first began to attend to the need for a holistic, less medicalised, service for patients with incurable disease in 1967, with the establishment of St Christopher's Hospice in Sydenham. The United Kingdom has continued to lead the way in developing appropriate services for those who require palliative care. Partnership working is integral to such organisations and the hospice movement continually strives to achieve better standards for those who use our services. Hospices focus on listening to patients and working in partnership with families; they are role models in patient-centred working.

Most hospices are independent voluntary organisations that emerge like mushrooms within their local communities. They are truly community organisations – held in high regard and with a sense of pride and ownership from their local community. The community provides not only financial support but also the volunteers who give of their time and skills. Most hospices are small organisations that achieve high standards through the immediacy of their management and governance. The involvement of the community throughout the organisation promotes openness and accountability and has given hospice founders and supporters a strong voice in the growth and development of their own organisation. Patients and family members have also felt empowered in a way that is unusual within an NHS organisation. Hospices have, therefore, been partners with local members of the public and patients to an extent that would be unusual in many organisations.

Small, independent organisations working in isolation, no matter how successful and well regarded, must always be self-evaluating. Vulnerable patients need all those caring for them to be communicating effectively. This is especially so in palliative care, where time is of the essence and a day missed or a message not passed on may mean that a patient is denied care or support at the end of life. In recent years, hospices such as St Helena have tried to reach

out into their local health communities and to build relationships, developing services in response to local health needs. The need to work in partnership with the NHS through Primary Care Trusts and Acute Trusts is pragmatic as well as philosophical, especially as we move towards further health care reorganisations and commissioning. We are enthusiastically committed to developing mutually supportive relationships locally and to becoming increasingly responsive to, and collaborative with, others in the local health environment.

For all of us though, our key partnerships must be with patients. We are moving into an era where patient choice is not just good practice, but also government policy. This is an exciting opportunity for all of us working in health care to reflect on our own practice and to learn from our patients how we can move forward into a relationship based on true partnership.

The health care environment has, until recently, been infamous for relationships based on an imbalance of power. In 1660, Samuel Pepys was tied to a table and held down by strong men to have his kidney stone removed; desperate people will put up with desperate measures. Mental health patients have been medicated against their will, parents' and children's rights to have contact with each other have been refused for specious medical reasons, and even bereaved parents' rights to consent over their children's body parts have recently and notoriously been ignored. Doctors throughout the last century were frequently god-like figures, attended by subservient nurses and other staff, with patients viewed as a collection of systems and symptoms rather than sentient beings. It is relatively recently that medical staff have been encouraged to view themselves as team members, working in interdisciplinary teams where each member has an equally valid input. Such a profound revision of self-image takes time and the traditional dominance of medicine still pervades many older hospitals.

As for patients themselves, we talk about patient choice and great efforts are made by some clinical teams to communicate effectively and to look after the psychological and emotional needs of the patient. It is sad that patients, all too often, still feel like an inconvenience, an interruption to the day of a health care worker. Emotional and spiritual needs remain unmet because they are seen as less important than physical health needs. Patients are still flooded with jargon, leaving appointments with questions unanswered and more full of apprehension than when they arrived. Knowledge is power, and too often patients do not have the knowledge that would allow them to be more assertive in their use of health care professionals and systems. It is exciting to see patients becoming empowered through access to good information and through groups where they can support each other. We show our commitment to these principles through our Partnership Group and representation on our Board of Trustees and Clinical Governance Group from users at this Hospice.

So, in conclusion, what does partnership imply? First of all, it indicates equality between people and not a relationship where one person is dominant. Secondly, it implies a cooperative relationship, where people gain from each

other and have investment in effective collaboration and communication. To achieve true partnership there need to be harmony of purpose and true mutual respect.

CHAPTER 1

An overview of health care partnerships in the United Kingdom

This chapter provides an overview of partnership working in the UK health care setting to provide the context for subsequent chapters. It is not a systematic review, rather a review based on selected literature (including commentaries).

Part 1
An overview of partnership in UK general health care

Kimmy Eldridge

Intention

To examine:

- The problematic nature of partnership as a concept
- The drivers and barriers to partnership working in the UK health care setting
- The achievements in partnership working

Definition and purpose

Partnership is a term that is seen as being central to the Government's public services policy. Consistent with its electoral pledges in 1997 to improve the quality of health care, the Labour Government has set out its vision for a new and modern NHS. The competition culture, created by the internal market under the previous government, was to be replaced with partnership (Department of

Health, 1997). This was to be achieved by 'breaking down organisational barriers and forging stronger links with local authorities' (Department of Health, 1997). Openness and public involvement were to become a key feature of all parts of the new NHS; in particular, the Government emphasised that 'the needs of the patient not the needs of institutions will be at the heart of the new NHS' (Department of Health, 1997).

The ten-year NHS Plan (Department of Health, 2000a) made clear that increased funding from the public purse would be tied to service reform and modernisation. The suggestion that these changes were necessary to modernise the NHS and put patients at its centre is highly emotive; by implication, those questioning change are at risk of being seen as working against patients' interests.

While these policy statements proved effective tools to motivate and energise NHS staff, the language used and the speed with which the policies were introduced did not encourage national debate. Managers continue to concentrate on waiting time and other performance targets which, it could be argued, preclude patient-centredness and longer consultation. Moreover, the policy drive towards partnership working in health and social care is not new. Successive governments have attempted to bring health and social services together since the early 1960s, but without success (Hudson and Henwood, 2002).

Conservative as well as Labour governments encouraged purchaser–provider relationships (later commissioner and provider) based on trust and collaboration. However, this policy objective is inconsistent with the requirement of organisations to drive down the cost of health and social care with competitive tendering (Hudson and Henwood, 2002). At an organisational level, one of the barriers to inter-agency collaboration is the absence of a single health and social care budget. The health and social care division thus prevents access to a seamless service designed to meet the needs of the individual.

The 1999 Health Act made partnership a statutory duty of all NHS organisations (Department of Health, 1997) in an effort to break down the 'Berlin Wall' between health and social care. However, the term 'partnership' was not defined (Hudson and Henwood, 2002; McLaughlin, 2004; Tomlinson, 2005). Furthermore, it was used interchangeably with 'collaborative approach' (Department of Health, 1997). This ambiguity allows for local interpretation and implementation and makes systematic evaluation of partnership development difficult.

The literature suggests that there is no universally accepted definition of partnership (McLaughlin, 2004; Wildridge *et al*., 2004; Tomlinson, 2005). Nonetheless, the literature suggests that partnership includes the following elements (McLaughlin, 2004; Wildridge *et al*., 2004):

- Shared aims, goals or vision between individuals, groups and organisations
- Joint rights, resources and responsibilities
- Autonomy and interdependence