



Building partnerships for the improvement of public health

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The UK has seen an increase in initiatives to encourage partnership working with the aim of improving services to patients and communities. This article looks at inter-organisational and interprofessional relationships for the improvement of public health. It highlights the importance of collaborative working and looks at how to identify possible partners and ensure coordination.

In the UK, the drive towards interprofessional working is changing the healthcare system. Nurses have long held the view that failure to implement collaborative working has led to the fragmentation of care, patient dissatisfaction and poor outcomes.

Background

The first wave of policies that advocated interprofessional working as a means of achieving the new agenda in the NHS came out in the late 1990s (Kenny, 2002). The documents were: *The New NHS: Modern, Dependable* (DH, 1997); *A First Class Service: Quality in the New NHS* (DH, 1998) and *Clinical Governance: Quality in the New NHS* (NHSE, 1999). There are many examples of individual nurses working across the health and social care sectors – Parkinson’s disease nurse specialists for example (Parkinson’s Disease Society, 2004), or those providing integrated continence services (Thomas, 2004). In addition the new General Medical Services contracts promote teamwork in order to use the skills of different nursing groups in effective ways – for example, school nurses collaborating with GP practices (National Primary and Care Trust Development Programme (NatPaCT), 2004).

Now partnerships are a significant feature of public service delivery. Around 5,500 partnerships exist in the UK, accounting for some £4bn of public expenditure (Audit Commission, 2005).

A major emphasis for working in partnership has been seen at the local level. Securing healthy communities depends on PCTs working closely with local authorities and other partners through local strategic partnerships. The best local strategic partnerships have been very effective in bringing about real improvements in the health of their

communities by facilitating joined-up planning and delivery. Many health partnerships that sit within local strategic partnerships structures have built upon the work of already established healthy cities programmes, health action zones (HAZs) and health improvement plans (DH, 2004a).

The *NHS Improvement Plan* (2004b) set out the way the NHS needed to change to be patient-led. This has been followed up by *Creating a Patient-led NHS – Delivering the NHS Improvement Plan* (2005), which looks at how some of the major changes in the NHS will take place to ensure the service is patient-led. In securing services for its patients a major emphasis is on strengthening existing networks for emergency, urgent and specialist services with PCTs and strategic health authorities (StHAs) having explicit responsibility to review and develop them and to build on current practice in shared commissioning (DH, 2005).

A recent review of partnerships in the UK found that they can bring significant benefits by responding to the multifaceted problems that face society. This is often achieved by partnerships being flexible, innovative and by pooling financial and human capital resources. The review also found that partnerships can bring risks. Working across organisational boundaries brings complexity and ambiguity that can generate confusion and weaken accountability (Audit Commission, 2005).

There are many configurations of inter-organisational relationships commonly referred to as ‘cooperation’. These include partnership, collaboration, coalition, alliance and network (Dolny, 2000). Working with widespread and varied partnerships reflects the shift from a medical to a more inclusive model that incorporates socioeconomic factors in health (Henderson and Torn, 2003).

In developing countries the health services are often provided by agencies outside of the government due to the poorly resourced health sector and limited government capacity. Non-governmental organisations are one of these agencies. They are regarded as being distinguished by their decision-making mechanisms, independence from governments and concern with broad social ends (Green and Matthias, 1996). Weaknesses have been cited such as their isolated operation, often with little regard to the wider health system and with little or no participation in national and district planning; reluctance to adopt national policy

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guidelines where they conflict with other concerns (for example, family planning); poor information systems and sometimes weak management capacities (Gilson et al, 1994). Fortunately in recent years NGOs are beginning to see that working in isolation will make no significant contribution to the growth and development of poor countries (Stefanini, 1995). Basch (2000) identified a number of internal factors that led to the need for aid coordination in the health sector:

- Increasing the number and the diversity of external agencies;
- Increasing the volume and importance of health aid;
- Project proliferation and recipient institutional weakening;
- Shift from project aid to sector aid;
- Policy conditionality associated with sector reform and the need for leverage;
- Focus on efficiency, effectiveness and equity goals.

The author has worked for a number of NGOs in Africa and found that despite the realisation that coordination is important it often does not receive the priority it deserves and is not done well.

As a strong advocate for the partnership approach, I hope this article will assist primary health care practitioners and policymakers in the UK in turning the various new policies that advocate partnering into action to improve public health. In particular, overlaps can be seen with UK initiatives such as the HAZ initiative. HAZs are partnerships between the NHS, local authorities, the voluntary and private sectors, and local communities. Launched by the government in 1997, the HAZ initiative was concerned with new ways of tackling health inequalities in some of the most deprived areas of England (HAZnet, 2003). Overcoming the challenges presented by such a complex policy problem required interventions that cut across the conventional boundaries of national and local governance (Barnes et al, 2003). The following section of the article will look at coordination.

The importance of coordination

A number of reasons can be cited as to why coordination is important in partnership working.

To improve advocacy

Development of a critical mass of organisations in networks for lobbying government on pertinent issues can be an important part of coordination. A common voice can be more effective than taking on an issue single-handedly. Building up national networks with donors, agencies and NGOs and negotiating integrated planning, reporting, monitoring and evaluation can be effective. There is also a need for linking services at local and national level to ensure that practice can inform policy. For this to happen, nurses must have a clear

understanding of changes in the NHS or social care sector. By being aware of the gulf between the utopian rhetoric of the policy and the reality of healthcare organisations, nurses can engage in debate and discussion with greater clarity and effectiveness, and challenge the conflicts in this dynamic (Basford, 1999).

To reduce duplication and ensure better use of resources

Coordination between agencies helps to reduce duplication of effort. It is important to undertake coordination with other bodies to facilitate the sharing of information on needs, lessons learnt and resources (Ritchie et al, 1995). Vertical and parallel service approaches have tended to exacerbate management problems for government staff because programme resources given direct to NGOs are often managed separately from government resources. It is then difficult for the government district health teams to plan and deliver services in an integrated and efficient way (Conn et al, 1996).

Integration of activities can lead to more efficient use of health service resources. Better organisation of tasks and scheduling of services and treatment uses staff time more effectively. In the UK the Audit Commission study (1999) into district nursing services found that one in ten referrals to the service was inappropriate, a reflection on the lack of knowledge that other healthcare providers had of the service. This wastes staff time and resources.

To address health holistically

In order to improve health outcomes and reduce inequalities, there is a need to tackle the various dimensions of poverty that impact on health. An example of where coordination is essential is in HIV/Aids work in Africa.

Dealing with the comprehensive needs of people with HIV/Aids can be categorised into four domains: medical needs, such as information and treatment; psychological needs, such as emotional support; socioeconomic needs, such as welfare provisions, help in the household and orphan support; and human rights and legal needs, including access, care and protection against violence, and discrimination. Over the years relevant responses have been developed in these domains. Effective referral systems ensure that people affected by HIV can benefit from the variety of services at the community and institutional levels throughout the course of infection and disease (Family Health International, 2000). This is often known as a continuum of care.

To have a full picture of what is happening

For the relevant Ministry of Health to understand the principal challenges to better performance it must have a full picture of what is happening. Ensuring

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regular contact with NGOs and submission of relevant health information is critical for health sector managers at the national or district level. NGO leaders have useful information for managers if a suitable forum for dialogue can be arranged. The identity of all health actors should be known to the Ministry of Health and regular lines of communication established.

Coordination is one of the top ten priorities in a refugee situation but is also one of the most neglected. Over 200 agencies were involved in the emergency and rehabilitation work following the genocide in Rwanda. The main goal of refugee programme coordination is to achieve the greatest possible impact on the situation through the integration of relief activities (Médecins Sans Frontières, 1997).

To encourage sustainability of services

Building broader coalitions and promoting a wider range of services can enhance sustainability. When comprehensive care and support services for HIV/Aids interventions are built on existing structures, such services have proven effective and sustainable if the various providers link with and complement each other. In addition, if larger organisations build the capacity of those which are non-mainstream, they can encourage sustainability.

To improve commissioning

The focus on commissioning is a relatively new concept in the NHS and one that is being given a high priority. Partnering in the NHS is about helping to improve PCT and acute trusts in a practical way. It is about proactively working together to innovate and improve the quality of health services for patients in a collaborative way (NatPaCT, 2004). For example, in order to improve commissioning the UK National Strategy for Sexual Health and HIV recommends inclusive partnership models involving all key stakeholders, particularly local authorities and the voluntary sector (DH, 2002).

Identifying partnerships

Care must be taken to identify partners who are suitable for collaborative working. A solid needs assessment can identify all the organisations that can implement the required services and identify their strengths and weaknesses. It should take place with any number of stakeholders, in particular the relevant client group or community. In addition, collaborative needs assessments can create opportunities for multiple points of view, as well as increasing the credibility of the assessment.

How to coordinate

Different agencies have different mandates, aims and objectives, and a way has to be found where partnerships for coordination can still be formed

despite different agendas. Various initiatives from both the UK and developing countries, described below, demonstrate how to improve coordination.

Develop partnership models

Better ways of agencies working together need to be found. Tennyson (1998) provides some useful guidelines on practical steps for planning and resourcing a relationship, particularly for cooperative strategies or partnerships:

- Decide what you want to do. It seems obvious but it is important that the relationship has a purpose;
- Identify partners who will best fit that purpose and establish a clear leadership;
- Agree core principles;
- Formalise the relationships, for example with a memorandum of understanding;
- Set objectives and ensure that priorities are shared by all organisations. Prevent service duplication and ensure that all needs are met as far as possible;
- Engage with stakeholders;
- Mobilise resources.

Establishing working groups to draft guiding principles for work in certain areas can assist with standardising the work and improve communication. This will help with recognising how agencies can effectively complement each other. Working groups should consist of practitioners and policymakers. Determining lead organisations or deciding what roles different groups will play is an important strategic decision. Clear lines of responsibility enable everyone to focus on the objectives.

In addition, the UK National Primary and Care Trust Development Programme (NatPaCT) recommends honesty, trust and integrity as some of the key ingredients to partnering success (NatPaCT, 2004).

Incorporate into training

A study in The Gambia found that district health teams did not give a high priority to increased intersectoral collaboration because these approaches had not been included in their training (Conn et al, 1996). As policies change then these should be incorporated into the continuing education of health workers. Staff buy-in is critical to success and can be managed by partnering workshops (NatPaCT, 2004). Multidisciplinary training can inculcate a team ethos such as the development of integrated team nursing with fortnightly seminars for all practice staff (Mahaffey, 1998).

Dissemination of good practice and information sharing

The identification of good practice is part of clinical governance. Efforts must be made to improve research and documentation. Task groups can be formed to improve knowledge about pertinent issues. There are websites with compendiums of

good practices and for discussion groups on various topics. A systematic approach to identifying, collecting and disseminating information on proven, effective, evidence-based practices is likely to help managers strengthen and expand their services. Better dissemination of information can be regarded as a capacity building strategy for partner organisations. Effective communication strategies need to be found to suit the circumstances.

Establishing a newsletter to link partners can assist with dissemination of good practice. Monthly sectoral meetings can be helpful where information is shared and new policies or reporting requirements discussed. In addition dissemination of good practice is an effective advocacy strategy as it raises awareness of pertinent issues.

Following an assessment of district nursing referrals in Dudley South and Dudley Beacon and Castle PCTs, marketing strategies such as the development of a community nursing resource pack were disseminated to provide a clear understanding of community nursing team roles and responsibilities to reduce inappropriate referrals, enhance information sharing and improve communication between all agencies for patient care. Workshops between the acute and community sectors have improved referrals ensuring enhanced continuity of patient care and improved working relationships (Hollingworth et al, 2003–2004).

An example of partnership working

The author's recent work with an international NGO in Uganda has used a partnership approach in all its activities to work towards achieving common goals. The NGO seeks to base its partnerships on principles of shared goals, mutual respect, openness and a belief in learning from experience (including our mistakes). Different parties to the relationship have different skills, resources, capacities, and weaknesses. We recognise the value of these different resources (material and non-material, financial and non-financial) and seek to treat all with the respect they are due.

Development practice over the last 50 years has demonstrated that long-term, sustainable change must be based on the needs and capacities of the people themselves. We should work in partnership with local organisations, communities and individuals, rather than seek to implement projects directly ourselves.

By working in partnership we help to build capacity and experience, contributing to the longer-term and broader development of individuals, communities and societies. By seeking out the poor and marginalised we help to encourage equity and reduce exclusion. In addition many local organisations have particular strengths that they can bring to partnerships that help to maximise our joint efforts.

Examples of such strengths include the following:

- Excellent knowledge of and access to communities;
- Continuity of personnel and long-term programming potential;
- The ability to involve intended beneficiaries directly in project planning and implementation;
- Through promoting locally owned initiatives the chances for appropriate and sustainable interventions are improved.

In addition to these benefits, there are also other advantages:

- Supporting partners has the potential to build the capacity of local organisations to care for disadvantaged groups in a very effective manner;
- Local organisations often have lower costs than international NGOs;
- Funding from the international NGO may generate further funds;
- Collaborating with local organisations provides an entry point into communities for identifying new sectors and vulnerable populations.

Lessons learnt

Ensuring a partnership approach when providing services is not always straightforward. Competition for limited resources among organisations can reduce the effort put into coordination. When organisations are writing proposals for funding from the same source there can be reluctance to share information. Building trust between organisations takes time and effort. It can be difficult to create an environment of complete openness where organisations are comfortable to acknowledge their mistakes. In addition, different organisations may have different mandates and objectives. This can make it difficult to develop an effective relationship.

Sustained funding of non-mainstream services is rarely guaranteed and some services may be stopped at short notice leading to a gap in service provision. It can also be time consuming to work collaboratively as it requires attending meetings of the relevant stakeholders. Ensuring meetings are time limited and focused will mean they remain efficient (NatPaCT, 2004). As can be seen from the evaluation of HAZs, no single strategy for partnership working is likely to be or remain the 'right approach' (Barnes et al, 2003). Commitment to the strategy remains key.

Conclusion

No one agency can hope to do everything nor can agencies afford to work in isolation. Agencies need to supplement their own area of expertise with that of other groups where necessary. Such a multisectoral approach calls for collaboration between all the key groups (Smith, 2002). Coordination in many health programmes is an important area that can still be improved in order for programmes to have maximum impact. ■

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