

Evaluating partnership working: lessons for palliative care

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Partnership working in palliative care is being increasingly promoted as the solution to poorly coordinated health and social care services. A key example is the UK National Institute for Clinical Excellence (NICE) guidance on supportive and palliative care. However, partnerships have costs in negotiating, developing and maintaining working relationships and translating these into successful outcomes, so may not always be the best or most effective method of service improvement. This article explores structural, procedural, financial, professional and legitimacy barriers to partnership working. We conclude that these five barriers could be sufficient to destroy emerging partnerships. Nowhere in the NICE guidance on supportive and palliative care are such barriers acknowledged. We suggest that current and projected palliative care partnerships should be critically evaluated against both process and outcome success criteria. Such evaluations must be integral to partnerships, to learn about what makes an effective palliative care partnership, and what affects partnerships have on patient care and outcomes. Partnerships may not be the panacea for issues of fragmentation, and should not be the only solution considered. Lessons should be learnt from the UK's promulgation of partnerships to ensure that these are used appropriately and only where patient benefit can be anticipated.

Keywords: palliative care, policy, evaluation.

INTRODUCTION

Partnership is the new political imperative and is widely promoted as a solution to problems of fragmentation and poor coordination in health and social care (El Ansari *et al.* 2001; Glendinning *et al.* 2001). Partnership working is widely encouraged within UK government legislation such as the Health Act 1999 section 31 flexibilities (House

of Commons 1999), by new National Health Service (NHS) bodies such as care trusts, and by guidelines such as the National Institute for Clinical Excellence (NICE) supportive and palliative care guidance (2004).

An emphasis on partnership as a key component of service improvement in palliative care is not new (NCHSPCS 1998). However, the drive towards partnership as a mandated element of successful palliative care is increasing. An inter- or multidisciplinary team approach to coordinating palliative care is routinely accepted now as good practice through its promotion in the World Health Organization definition of palliative care (Sepúlveda *et al.* 2002) and European documents such as the Council of Europe's recommendations (2003) on the organization of palliative care. In England, guidance on how palliative and

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Box 1. Overview of key elements of the NICE supportive and palliative care guidance

Guidance on Cancer Services. Improving supportive and palliative care for adults with cancer

Aim of guidance:

- To define service models likely to ensure that support and care is received to help patients, families and carers cope with cancer and its treatment at all stages.

Guidance development:

- Evidence-based guidance developed through extensive literature searching and consultation with key stakeholders.

Guidance implementation:

- Guidance sets out key recommendations to be taken forward nationally, by cancer networks, commissioners, providers, multidisciplinary teams and individual practitioners.

Service model:

- Involves cancer networks as a vehicle for delivery of the cancer plan. It recognizes a range of patient, family and carer needs for general and specialist services. It recognizes the value of partnerships between patients and professionals to achieve best outcomes. It recognizes the value of partnership in achieving effective multiagency and multidisciplinary team working.

Topic areas:

- Coordination of care, user involvement, face-to-face communication, information. Psychological, social, spiritual support, general palliative care, specialist palliative care, rehabilitation, complementary therapy and family and career services. Research in supportive and palliative care.

National Institute for Clinical Excellence (2004)

supportive care services should be both provided (NICE 2004) and funded (DOH 2003) requires partnerships to be in place to successfully deliver services and provide local funding plans. The new supportive and palliative care guidance places particular emphasis on partnership working as a vehicle for change and improvement at the level of the cancer network, service provider and patient (NICE 2004, pp. 5–6). Within this article, the NICE guidance will be used as an exemplar of a document promoting partnership working, but the issues discussed should be relevant to those from all countries providing palliative care. A summary of the key elements of the guidance is shown in Box 1.

This increasing momentum towards using partnerships in palliative care to meet key directives makes an understanding of partnerships and how they work essential. In addition, effective partnerships in health, social and voluntary care may not be easy to achieve. Ineffective partnerships could potentially be costly and complex to administer, with unclear lines of accountability for individuals involved. This article will explore the meaning of partnership, and identify some of the potential barriers and facilitators to partnership working in palliative care. It will then consider what criteria are used in identifying

successful partnerships, to provoke thought about the effectiveness of current and planned partnerships.

DEFINING PARTNERSHIP

Glendinning (2002) defines partnership in a minimal way:

Partnerships between organisations, groups or agencies denote a particular type of relationship in which one or more common goals, interests and/or dependencies are identified, acknowledged and acted upon, but in which the autonomy and separate accountabilities of the partner organisations can remain untouched. (p. 118)

There are wide variations in the type of partnerships formed. Partnerships can range from limited and loosely formed collaborations to complete organizational integration (Hudson *et al.* 1999). Glendinning's (2002) definition hints at some areas of partnership which can be either constructive or destructive, for example, whether goals are mutually agreed and acted upon. The definition implies that partnerships require work – to identify suitable partnership organizations, to discuss aims and objectives, and to work together to meet these. Guidance, such

as that in supportive and palliative care, often advises partnership without fully acknowledging both barriers and benefits.

ENABLING PARTNERSHIP

The problems of achieving effective partnerships are well documented outside the palliative care field. Perhaps most notably, given the clear recommendation within the NICE guidelines to develop explicit partnership arrangements between health and social services and voluntary agencies, it is such partnerships that have a problematic history (Rummery & Glendinning 2000). Partnership working not only creates opportunities for cooperation and service improvement, but also raises the potential for significant clashes of professional interests and organizational culture (Holtom 2001). Holtom (2001) identifies five types of obstacle to partnership working: structural, procedural, financial, professional, and status and legitimacy. These will be discussed in turn with reference to partnerships in palliative care.

Structural and procedural

Structural obstacles relate to the way in which potential partners construct their current organizations and services. Examples of issues that might hinder partnerships include where the organizations have different geographical boundaries, where partners differ in size, complexity and capacity, and where the partners work within different statutory frameworks and have different statutory powers (Ashcroft 2001; Holtom 2001). Procedural issues relate to the way in which different organizations work. Procedural issues may include making allowances for different operational systems and planning cycles, for different organizational cultures and policy agendas (Holtom 2001). Key to the success of any partnership therefore is the recognition of these differences and the development of agreed and shared values, roles, responsibilities, objectives and outcomes (Kemshall & Ross 2000).

Palliative care in many countries is provided by a range of services. For example, in England, potential partners may include organizations such as the cancer network (with a strategic and planning role for a large area), primary care trust (with responsibility for providing general and possibly specialist palliative care to a defined local population), hospital services, and hospice (which may have charitable status, and be funded mainly by fundraising). Each will bring their own agenda to any potential partnership, and are likely to have different criteria for the evaluation of the success of any partnership. Historically,

many specialist palliative care services may have developed outside mainstream health services. In these circumstances, working together in partnership will require acknowledgement of these historical issues.

Financial

Financial issues can include different funding streams and budget cycles, different financial accountabilities and perceived inequalities in budgets (Holtom 2001).

Specialist palliative care services are often distinctive because of their origins outside mainstream health services. Some partners may have a charitable status, with a different ethos and financial outlook from those funded within mainstream health or social care budgets. Effective partnership working not only needs to recognize common aims and objectives relating to patient care structures and processes, but needs to acknowledge and address such fundamental financial issues.

Professional

Professional barriers to partnership concern issues around potentially different professional values and roles that individuals within partnerships or partner organizations can have (Holtom 2001).

Within palliative care, the use of multidisciplinary or inter-professional teams has always been highlighted as a cornerstone of care (Sepúlveda *et al.* 2002). The importance of working with patients, carers and families is also emphasized (Council of Europe 2003). This emphasis is continued in the NICE guidance (2004), which recommends partnerships and collaboration between professional groups and between professionals and service users.

However, such partnerships in palliative care may not always operate smoothly. Research with primary care professionals, such as general practitioners and district nurses, consistently identifies tensions over issues such as professional autonomy, a sense of patient ownership, and reluctance to involve other professionals in patient care (Griffiths 1997; Austin *et al.* 2000; Bliss *et al.* 2000; Mitchell 2002; Fellowes *et al.* 2003). In particular, referral to and work with specialist palliative care services can be constrained by beliefs that non-referral would maintain patient hope, and that patients would refuse referral to such services (Karim *et al.* 2000; Schim *et al.* 2000). Many inter-professional partnerships in palliative care are constrained by communication difficulties. Communication issues that affect partnership working include problems networking with colleagues, difficulties in transmitting relevant practice knowledge, lack of consensus about care

coordination responsibilities, and lack of standardized documentation (Street & Blackford 2001). Specific communication issues around transfer of patients between services (e.g. at discharge) have also been noted (Austin *et al.* 2000).

Such communication issues and the underlying values that influence them can be significant professional barriers to working in partnership. Simply providing evidence of inter-organizational working does not necessarily equate with successful inter-professional partnership (Hudson 2002).

Status and legitimacy

Partner organizations and partnership representatives construct their status and legitimacy in different ways.

Palliative care partnerships could, for example, involve healthcare professionals (deriving their legitimacy by their professional position), local authorities (deriving legitimacy by electoral mandate), voluntary hospices (deriving legitimacy by experience of palliative care and local fundraising support) and users (deriving legitimacy from their illness experience) (Holtom 2001). Such differences could be a source of tension within the partnership. In addition, if the partnership work requires changes within the partner organizations, those representing the partnership within the organization need to have sufficient power and influence to broker such change.

These five barriers to partnership working could potentially be sufficient to destroy embryonic partnerships. Nowhere in the NICE guidance (2004) on supportive and palliative care are such barriers acknowledged. Promulgating partnership without explicitly recognizing the problems that those entering partnerships may face is misleading. Those entering partnerships at any level are likely to expend significant amounts of time and effort to ensure a successful partnership, and it is only fair that the barriers to as well as the benefits of partnership are expounded.

However, the picture is not entirely negative. Partnership is endorsed precisely because there are examples of successful partnerships delivering improved services (Audit Commission 1998). Understanding what makes a partnership successful, and how to emulate its success elsewhere are therefore essential. Partnership evaluations can examine both the process of how the partnership works and the outcomes of the partnership. Such evaluations can tell us a lot about existing partnerships, but they can also inform how we develop new partnerships and ensure their success. Partnership evaluation will now be discussed in more detail.

EVALUATING PARTNERSHIPS

There is a broad literature discussing the merits of different approaches to evaluation (Pawson & Tilley 1997; Rossi *et al.* 1999). Here, specific criteria used in partnership evaluations will be discussed, rather than debating evaluation approaches *per se*. Such success criteria may be useful to those working towards positive partnerships in palliative care in enabling them to critically examine their partnerships and identify areas of strength and weakness.

Process criteria

Hudson and Hardy (2002) identify six principles of partnership that can be used to guide a process evaluation: acknowledging the need for partnership; clarity and realism of purpose; commitment and ownership; development and maintenance of trust; establishment of clear and robust partnership arrangements; monitoring, review and organizational learning. These are outlined within Box 2.

While adhering to these principles does not guarantee a successful partnership, ignoring them is likely to hinder partnership working (Hudson & Hardy 2002). It is clear that some of these principles mirror the barriers to partnership working discussed earlier, emphasizing the core nature of these criteria.

Implicit in any discussion of process criteria is an assumption that the way partnerships work is crucial to what they achieve. Furthermore, Pawson and Tilley (1997) argue that setting or context is critical to outcomes. It would therefore be unwise to assume that a successful palliative care partnership in one context can be easily replicated elsewhere. Local problems need local solutions based on the particular strengths, weaknesses and tensions of local partners.

Outcome criteria

It is insufficient to concentrate solely on how partnerships work for guidance on developing effective palliative care partnerships. Partnerships also should make an impact on the issues that they were created to address. The NICE guidance (2004), for example, expects partnerships to have an impact on the way in which services are coordinated, on inter-professional communication, and on patient outcomes. However, it is important to recognize that different partners may not concur on what constitutes success (Thomas & Palfrey 1996). Clear success criteria should be agreed for the partnership. The most commonly considered success criteria are within the domains of: effectiveness, efficiency, equity, acceptability, accessibility,

Box 2. Six success criteria for partnership processes

Criteria for successful partnership processes

- *Acknowledging the need for partnership*: the extent of partnership history and the recognition of need to work in partnership (Hudson & Hardy 2002).
- *Clarity and realism of purpose*: commonality and shared objectives (Ashcroft 2001); the values and goals of partnership (Smith & Beazley 2000). Service users often have a different vision to those addressing a corporate, organizational or professional perspective (Smith & Beazley 2000).
- *Commitment and ownership*: commitment by senior members of stakeholder organizations is critical (Hudson & Hardy 2002). For those representing more nebulous and less organized groups such as 'the community' or 'patients', their legitimacy to those they represent is critical (Smith & Beazley 2000)
- *Developing and maintaining trust* is both the most distinctive marker of partnership, and perhaps the most elusive (Hudson & Hardy 2002). Trust is often gained by recognizing the equal participation and value of each stakeholder.
- *Clear and robust partnership arrangements* should be unambiguous and straightforward. They should not abuse power, represent a fair distribution of risk and reward, and treat people with respect and integrity (Ashcroft 2001). Resources should be widely recognized, not only financial, but also the less tangible resources of expertise, time and knowledge.
- *Engage in monitoring, review and organizational learning*: The success of a partnership is often measured by the process itself – the development of trust and shared vision – rather than changes in service. While service users may recognize potential benefits in such success criteria, it is unlikely that they will focus exclusively on process issues. Organizational stakeholders may prize process issues highly.

appropriateness, accountability, ethics, responsiveness and choice (Thomas & Palfrey 1996; Glendinning 2002). These criteria are considered in Box 3.

Perhaps a key message to consider in these outcome criteria is that each partner is likely to value or understand outcomes differently. For example, the NICE guidance (2004) specifies that services need to work together to ensure that patients' and carers' needs are addressed with no loss of continuity (p. 35). Meeting such an objective would demonstrate effectiveness of a partnership. However, local partners would need to develop their understanding of continuity by debating, for example, the role of a service model that introduces specialist palliative care services only when there are specific unmet needs, and how this might be integrated with general palliative care services. In addition, a professional's view of continuity of care may differ from patients – for example, they may view telephone-based services in different ways (Payne *et al.* 2001).

DISCUSSION

Partnerships are complex and multifaceted. Simply recommending partnership working in palliative care as a means of meeting key objectives both masks the complexities and realities of achieving effective partnerships and assumes that partnership working is the best way of

achieving such objectives (McLaughlin 2004). Documents promoting greater communication, collaboration and partnership between individuals, teams and organizations rarely recognize the costs or skills involved in negotiating, developing and maintaining thriving working relationships and translating these into successful outcomes. Indeed, despite a plethora of partnership evaluation guides, it appears rare that partnerships are commenced with evaluation of either processes or benefits in mind (Markwell 2003). To learn whether partnership working is an appropriate way of providing palliative care services, such evaluations should be integral to the planning and conduct of any partnership.

This article has discussed barriers to partnership working, and criteria for success of both the process of partnership and its outcome. This discussion reveals both costs and benefits from partnership. Working in partnership may not be the only or best way to deal with a particular issue (McLaughlin 2004). Where a partnership is not essential, then a clear judgement needs to be made by all potential partners that the assumed benefits of the partnership outweigh the likely costs. A recent review of health and social care partnerships considers it a sign of progress that people are no longer questioning whether partnerships are important, but rather how best to make them work (Banks 2002). Perhaps a more questioning attitude is required. Partnerships are often important solutions to particular

Box 3. Criteria for successful partnership outcomes

Criteria for successful partnership outcomes

- *Effectiveness* is the achievement of stated objectives, and depends on clear objectives being set by the partnership (Thomas & Palfrey 1996).
- *Efficiency* is the ratio of benefits (outputs or outcomes) to costs. This is a difficult issue to measure accurately as both costs and benefits of a partnership may be difficult to discern, and not immediately apparent. The timescale of evaluation is important, in the real world of constant organizational change (Charlesworth 2001).
- *Equity* is treating people with equal needs equally. The outcomes of treatments may not be equitable, but the process should be transparently equitable and defensible (Thomas & Palfrey 1996). Equity also involves considering the impact of a partnership on others (Glendinning 2002). Stakeholders in a partnership may view needs differently, with professional and patient stakeholders concerned with meeting individual needs and organizational stakeholders concerned with equity in type of service offered across an area (Glendinning 2002).
- *Acceptability* implies acceptance of partnerships and the services they deliver by all stakeholders. The processes of care may be as important as the outcomes in determining acceptability (Kemshall & Ross 2000).
- *Accessibility* is an eclectic criterion, which may refer to access to information about services, distance to services, and processes of assessment and waiting for services (Glendinning 2002). Stakeholders who are users of services are likely to value this issue highly, as it impacts significantly on their ability to use services appropriately.
- The *appropriateness* of a partnership depends on its relevance to needs. Defining need is a fraught area, divided by the potential for divisions between user and professional definitions of need (Thomas & Palfrey 1996).
- *Accountability* encompasses both the accountability of professionals and their organizations to external stakeholders and the adequacy of the governance arrangements within the partnership (Glendinning 2002). Users should have a mechanism for holding those commissioning and providing services to account (Thomas & Palfrey 1996).
- *Ethical* considerations relate principally to the conduct of the evaluation: whether the evaluation design discriminates against certain stakeholders; who guides the evaluation agenda; and whether change will follow an evaluation (Thomas & Palfrey 1996). Particularly given the strong policy focus on partnership, there may be considerable pressure to demonstrate success (Glendinning 2002).
- *Responsiveness* refers to the speed and accuracy with which a service provider reacts to a request for action or information (Thomas & Palfrey 1996). Service users are likely to value responsiveness very highly in any evaluation as it is of direct relevance to their experience of the service. Glendinning (2002) connects responsiveness to choice – noting that faster responses may be because a service redesign has reduced choice of interventions.

problems, but they are not always the only or best solution for the individual or the organization.

Many of the issues discussed are also attitudinal in nature, placing emphasis on the different and individual values that people have towards partnership issues, such as commitment, trust, ownership and power. Naively, many of the palliative care documents recommending partnership do not recognize the influence of attitudes on behaviour. In the NICE guidance (2004), the recommended solutions to problems focus exclusively on developing new knowledge and skills such as in assessment. The guidance does not explicitly recognize that the motivation to use and acquire new knowledge and skills, and to use these collaboratively can be intimately related to attitudes and beliefs (Ajzen 2001). These could include beliefs about how they work as a professional, or how their organization functions.

A blanket recommendation of partnership working as a solution to problems in palliative care provision also ignores possibly the most important factor of all: context. Local issues, local histories, local organizations, all of these contextual factors will have a significant influence on the success of any partnership (Glendinning 2002). We must be careful not to promote a particular 'one size fits all' approach to partnership working in palliative care. Each partnership solution will need to be unique.

Here, the NICE guidance (2004) on supportive and palliative care has been used as an example of a document promoting partnership without either consideration of whether partnerships are the best solution to problems or acknowledging the costs and barriers to partnership. While this discussion has focused on a UK setting, it should have relevance to those working throughout Europe and beyond. Certainly, the recommendations from

the Council of Europe (2003) on how palliative care should be organized appear to be moving towards recommending the kinds of inter-professional working that readers of the NICE guidance would recognize. While healthcare delivery systems may differ across Europe, we should still take the opportunity to learn about what is both good and bad about working in partnership. Then the lessons learnt from both the UK and European experiences can be used to maximize patient benefit.

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