

The Partnership Initiative in Nursing and Social Services: Practical Collaboration in Services for Older People

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Abstract

This paper reports on the Partnership Initiative in Nursing and Social Services (PINSS), a project that placed community nurses within social services Assessment and Care Management Teams (ACMTs) within two Social Services Departments (SSDs) within the East Midlands. The project aimed to assess the impact of the nurses on the social services environment and the parallel effects on the nurses of working in such contexts. The paper observes that the nurses had a positive impact within the ACMTs and they reported having found the experience both stimulating and valuable for their own development. Although the project was felt to have been highly successful, questions remain about the extent to which the location of community nurses within social services assessment and care management teams represents the best way forward for inter-professional working in social and health care for older people.

Keywords

Community nurses, social services, inter-professional work, organisational structure

Introduction

The Partnership Initiative in Nursing and Social Services (PINSS) located community nurses in Assessment and Care Management Teams (ACMTs) in two east midlands social services departments (SSDs). These teams have the primary responsibility, within community and hospital settings, for assessing the social care needs of (predominantly) older people, and in establishing services to meet those needs. Within British social welfare, health and social care needs are the responsibility of different agencies, each with its own systems for assessing and meeting those needs. As the government has indicated, it is believed that this organisational separation leads to a fragmented approach to services, a problem that the emphasis on improved partnership working between health and social care agencies is intended to address. Certainly, there has been renewed interest in concepts of partnership and collaboration since the accession of the Labour government in 1997

(Glendinning *et al.*, 2002). As Hudson *et al.*, (1999) indicate, the terms ‘partnership’ and ‘collaboration’ have been “conceptually elusive”. In this paper, ‘partnership’ is used to describe the working together of agencies at the organisational level, whereas ‘collaboration’ refers to the working relationships of professionals within those agencies.

The project was established on the hypothesis that locating qualified nurses within ACMTs would improve the quality of social care assessments in respect of health and nursing needs. There has been considerable literature on the interface between primary health care and social services (see Levin *et al.*, 2002), but relatively little that examines the role of nurses within the context of assessment and care management (but see Bergen, 1997; Weiner *et al.*, 2003); more research has been undertaken on the role of social workers within primary health care (see Lymbery and Millward, 2000). In general, the PINSS

project fitted within the priorities of government regarding the need for closer working between health and social care, as well as within a tradition of literature that focuses on the quality of inter-professional practice.

The paper begins by outlining the context within which the project was developed, moving on to consider issues concerning its origins, organisation, and purpose. It then introduces the evaluation approaches that were deployed before highlighting the project's key findings, focusing on two areas:

- The impact of the nurses on the teams within which they were located.
- The impact of the project on the nurses themselves.

The paper concludes by suggesting that understanding the mechanics of joint working will assist in the development of the single assessment process for older people (DoH, 2001; 2002a; 2002b), both in illustrating how professionals can work together effectively and how organisations can co-operate to facilitate joint working. In considering the most effective way of implementing the National Service Framework for Older People (DoH, 2001), the paper suggests that full multi-disciplinary teams would allow for the establishment of integrated assessment processes, a core requirement of the single assessment process that is a key feature of the Framework.

The multi-disciplinary context

This section identifies policy issues that formed the background to the PINSS project, focusing particularly on partnership and assessment. It moves from a general consideration of the 'new' Labour government's attitudes to partnership and collaboration to a discussion of the specific policy developments that are intended to encourage partnership working between health and social care organisations. The section then moves on to consider various options for collaborative working to make

improved partnership a realistic and achievable goal.

It has long been recognised that organisational differences between health and social care agencies work against the interests of people who require health and social care services (Lewis, 2001). Indeed, this has led the government to suggest that there is a 'Berlin wall' between health and social care agencies (DoH, 1998b). The way in which the term is used implies that the responsibility for this barrier rests in the organisations themselves; this is an over-simplification of a complex structural problem (Lewis, 2001; Means *et al.*, 2002). Means and Smith (1998) suggest that the barriers between health and social care organisations are long-standing, dating back to the National Assistance Act 1948. This Act created a category of people deemed in need of 'care and attention' who became the responsibility of social care agencies. However, the definition was fundamentally ambiguous, allowing an increasing proportion of frail older people (who would hitherto have been the responsibility of health services) to become defined as the responsibility of social care services without sufficient resources being allocated to meet their needs effectively.

Much of the recent emphasis on partnership working has been on the need for improved inter-professional collaboration as opposed to engaging with the structural problems that created and perpetuated the 'Berlin wall' (see, for example, DoH, 1998a). The publication of the NHS Plan appeared to change this, declaring that there "will be a new relationship between health and social care", which "will bring about a radical redesign of the whole care system" (DoH, 2000, p. 71). This has been seen as an attempt to introduce an element of compulsion into the previous exhortations to achieve improved partnerships (see Hudson and Henwood, 2002). However, the core weakness of this drive towards greater structural integration is simple: that in itself it

will not be a guarantee of improved, better co-ordinated services (Hudson and Henwood, 2002).

In an implicit recognition of this, the *National Service Framework for Older People* (DoH, 2001) contained several further proposals for the development of collaborative working that would not depend upon structural change. It proposed the introduction of a single assessment process for older people, its purpose being “to ensure that older people receive appropriate, effective and timely responses to their health and social care needs, and that professional resources are used effectively” (DoH, 2002a, p.1). The guidance emphasised that assessments should be kept in proportion to older people’s needs, that agencies should not duplicate each other’s assessments and that a range of professionals would need to contribute according to the nature and extent of need (DoH, 2002a). In the view of the Department of Health – supported by considerable research evidence (Nolan and Caldock, 1996; Stewart *et al.*, 1999) – good quality holistic assessments of older people require the involvement of different professional groups; in the absence of this, the overall quality of assessment practice would suffer. Therefore, it is important to establish effective arrangements for inter-agency, multi-disciplinary and inter-professional collaboration in order to facilitate improved assessment practice; the PINSS project can be seen in this context.

Origins, organisation and purpose of the project

The PINSS project can be seen as complementary to the Bridging the Gap project that located social workers within primary health care settings within the same general locality (Lymbery and Millward, 2000). This project found that the placement of social workers in such settings “would be a move in line with government thinking on the development of partnership between health and social care”, and also that “it

enhances the level of professional satisfaction experienced by social workers, and that it provides an opportunity for excellent multi-disciplinary practice” (Lymbery and Millward, 2000, p.39). Having pursued one direction for the enhancement of inter-professional working – which has resulted in the location of 6 social workers within primary health care settings in one of the departments – the PINSS project provided an opportunity to assess whether alternative approaches to the same problem could have equally beneficial results. At the same time, another project which had an inter-professional focus was also under way. This focused on the location of some Occupational Therapists within ACMTs, away from their normal location in specialist teams; this project has not been subjected to any external evaluation.

This continuity with other related projects was highly significant; the majority of middle managers from both social services and health who were responsible for creating and directing the project had worked together on previous projects, as had the evaluator. The original plan for PINSS was that three qualified District Nurses would be placed in different work settings across two SSDs, and would be seconded to these posts from their normal roles within District Nursing teams. Two of these were full-time in ACMTs, one based in a hospital with the other in an area-based team. The third worked on a half time basis from a location in a different area-based ACMT.

As originally defined, the nurses had two core functions; 1) to be directly involved in the assessment of need, and 2) to contribute to the process of quality control by taking part in the panels that approved recommendations arising from completed assessments. The full-time placements were initially for 6 months, with the part-time placement being for 12 months. There was continued oversight of the project through a Steering Group, which met regularly to review progress. Membership of this

Steering Group included middle managers from the various health and social services agencies along with the project's evaluator. The project commenced in the autumn of 1999; although the formal evaluation was completed in 2002, the project is ongoing, with nursing staff continuing to be deployed in social services teams.

At the outset, the aims of the initiative were defined as follows:

1. To improve the quality of social services assessments, on the assumption that a qualified district nurse would add an important dimension to the assessment process.
2. By improving the quality and appropriateness of assessment, to improve the quality of service offered, and the appropriateness of service outcomes.
3. To improve links between social services and community health.
4. To improve the quality of inter-professional working between social services and community health.
5. To test out alternative models of service organisation.

The purpose of this paper is to explore the extent to which objectives 3-5 were met. The reasons for this choice are discussed in the following section.

While the broad intentions of the project remained unchanged, it went through several changes in its structure and organisation. Within a few months, the part-time District Nurse opted to return to a mainstream post. It proved difficult to replace her with another District Nurse; at the same time, consideration was given to the viability of the role as it had been constructed. It was subsequently decided to change the nature of the project by recruiting a community-based Registered General Nurse to replace the

District Nurse. It was accepted that the role the District Nurse had been asked to fill was problematic, particularly given her part-time hours. It was therefore decided that the Registered General Nurse would be full-time and carry out a more limited and clearly defined role within a single team (the District Nurse had been working across 3 different teams). This carried the added advantage of placing the nurse in a team that was already familiar with the concept of inter-professional working, an Occupational Therapist having been based there for some months. This nurse was also seconded from an existing District Nursing team.

Due to the perceived success of the project in its initial stages, the Steering Group decided that it should be increased in scope and duration to provide an opportunity to evaluate it over a longer period. This decision had various knock-on effects. For example, the District Nurse placed at the hospital ACMT retired during 2001. In addition, it was decided to fund a similar post based at the other large hospital within the locality; here, an RGN started work in late 2000. The final evaluation sought to encompass these changes.

Evaluation criteria and approach

The topicality of the subject matter emphasised the importance of evaluation, as "the dual demands of collaboration and evidence are ... an integral part of many health and social care programmes" (El Ansari *et al.*, 2001, p. 216). This section will outline the evaluation strategy that was adopted while also highlighting factors that informed and impeded its progress and development. The evaluation started from the location of the project in its policy and organisational context (outlined above), gauging the extent to which these factors influenced the project's findings. Therefore, it focused both on the extent to which the project fulfilled its objectives and on the context-specific issues that affected this. While the evaluation did attempt to link

directly to all the project's objectives, its main focus was on inputs (the contribution of community nurses to assessments and to the team setting) and processes.

A number of specific problems were encountered in the evaluation process. One of the critical limitations was in the funding of the evaluation and the way in which this limited the scope of what could realistically be attempted and achieved. For example, it was not feasible to seek to engage with services users or their carers, even though this would have produced useful and relevant detail. Another particular difficulty was encountered in seeking to establish improved assessment quality and better outcomes for service users, which was more complex than had been envisaged at the start of the project. Although steps were taken to establish a quality baseline, through an examination of 27 completed assessments, it became clear that there was no necessary connecting relationship between subsequent changes in assessment quality and the project. While all practitioners and managers who were interviewed insisted both that there had been improvements, and that there was a causal link between these improvements and the project, this belief could neither be confirmed nor denied by the evidence generated through the evaluation. As a result, this paper does not comment on the extent to which objectives 1 and 2 were met, other than reporting workers' perceptions of success in this area.

Similarly, it was difficult to identify the extent to which any changes in the processes that characterise collaborative practice helped to bring about improved outcomes. This reflects an ongoing debate in the evaluation literature. There are a number of studies (see, for example, Lymbery and Millward, 2000; Ross *et al.*, 2000) that assume that improved outcomes will stem from improved processes. However, as Brown *et al.* (2003) have demonstrated, it is not always easy to define the relationship between process and outcome; a focus on

processes alone constitutes a relatively weak form of evidence of improved collaborative working. (This issue is explored in more depth by Hughes and Traynor, 2000.)

The role that evaluation played in the management and development of the PINSS project was also of interest. Broadly speaking, evaluation can either be predominantly 'summative' or 'formative' (El Ansari *et al.*, 2001). In the early stages, the 'formative' elements of evaluation were particularly strong, with a direct feedback loop between the evaluation and the management of the project. The changes to the project (noted above) were a product of this 'formative' element in the evaluation. Martin and Sanderson (1999) have emphasised that public policy evaluations can legitimately focus on either the measurement of outcomes, the monitoring of processes or the management of pilot projects. In the case of the PINSS project, the evaluation became more concerned with the monitoring of processes and the management of the pilot project than the measurement of outcomes, for the reasons outlined above.

Two main areas of activity are emphasised here. The first concerns the impact of the project on the ACMTs, particularly on social work staff. The second focuses on the impact of the project on the community nurses, where it was assumed that the unfamiliar role would present specific challenges and problems. Evidence relating to these areas of activity was accumulated from a range of sources. Group and individual interviews provided the basis for evidence regarding the impact of the community nurses on ACMTs. Meetings were held with each of these teams near the beginning and again towards the end of the project. There were also individual interviews with Team Managers, which allowed for some comparison between the managerial and practitioner perspectives. In total, 6 group interviews with teams and 4

individual interviews with managers contributed to this part of the research.

The impact of the project on the community nurses was also a key variable. Since nurses are unaccustomed to working within the organisational environment of SSDs, it was instructive to analyse how well they adapted to different requirements. There were two main ways of securing the nurses' perspectives. First and foremost, semi-structured interviews were carried out with all the nurses at the start of their secondments; a second interview was convened with the original nurses once they were well into their work. In total, 8 individual interviews were held with nursing staff. In addition, the nurses provided a breakdown of their work over a defined 6-month period towards the end of the project, when it was working at its operational peak. This generated data on which the following section draws.

The themes that emerged through the process of interviews were confirmed by reference to an operational group – of nurses and their social services managers – that met quarterly throughout the project. This group fulfilled a useful function, particularly in the 'formative' aspects of the evaluation, as well as providing a useful means of support for the staff. In addition, it was an invaluable aid to the smooth running of the project. The evaluator made quarterly presentations of the data to the Steering Group, with particular attention given to the generation of information that could affect the development of the project.

Impact on Social Services Teams

Interpersonal issues

There was a pattern to the responses from staff and managers in relation to this theme. Early in the project, team members tended to report that they felt some "resentment and suspicion" about the presence of a nurse in the team. As the projects progressed, most staff saw this differently, with the nurses

perceived as providing something important and valuable. Positive general attitudes of ACMT staff towards the nurses were widely expressed; for example, one person stated that: "I don't know how we managed without her". The source of this approval is consistent: a belief in the improved quality and credibility of assessments, specifically as regards health and nursing issues.

Impact on assessment quality

There is evidence that suggests that nurse involvement in assessment changed the outcomes for significant numbers of people assessed. However, the figures also reveal considerable duplication of assessment effort. The experiences of one nurse illustrate both sides of this subject. She was involved in 141 assessments over a 6-month period; the movement in those referrals can be seen in Table 1.

While there is a general trend towards a reduced level of assessment outcome here, this does need to be qualified. The group of people who were recommended for nursing home care illustrates this point. In the majority of cases, the nurse acted more to confirm than to overturn the judgements of others. Three hypotheses are suggested by this outcome:

- That most referrals included appropriate recommendations.
- That the work of the nurse was particularly useful in giving credibility to prior judgements.
- That there was some unnecessary duplication within the assessment task.

In addition, substantial numbers either died or were admitted to hospital from this sample, thereby limiting the impact of the nurse intervention. The implications of these points will be discussed later in the paper.

Table 1: Movement from referral through assessment to outcome

	<i>Original referral/ recommendation</i>	<i>Recommendation following nurse input</i>	<i>Outcome</i>
Home	0	5	5
Residential care	11	19	18
Residential care with very dependent needs	15	17	15
Nursing home care	112	97	81
Health care		3	3
Hospital	0	0	6
Died	0	0	13
Total <i>n</i>	141	141	141

Challenges to residential and nursing homes

In addition, staff in ACMTs felt that a nurse’s presence enabled private sector residential and nursing homes to be more effectively challenged. A significant part of the work of the district-based community nurses was in making determinations of the level of care for people already living in residential or nursing home care. In one specific case, 85 out of a total of 135 assessments related to people in these categories and involved requests to change the level of financial support to which they were entitled. Of these 85 assessments, 13 resulted in a decrease in the level of service provided (usually in the case of people who had been self-funding but who now required state support). There was no change in 46 of the cases, whereas there was an increase in the level of care provided to 26. (A higher level of service had been requested in 60 of the above cases.) While it is uncertain whether or not a qualified social worker would have had the same impact, most ACMT staff stated that this was unlikely. This example illustrates a key benefit for social services; it is probable that the intervention of the nurse saved substantial money from the social services budget. Given the centrality of budgetary management to community care (Lewis and Glennerster, 1996) this is a significant factor.

Impact on nurses

The impact of the project on the nurses was possibly the most important of all the various indicators. This is based on a straightforward proposition: if the working conditions were experienced as unpleasant and/or unproductive it would matter little if the project demonstrated benefits in other respects, for it would subsequently prove impossible to recruit nurses to function in this role. Although one of the original nurses found the overall experience unsatisfactory, the general sense was that the experience had been both enjoyable and valuable for the nurses concerned. There was also an interesting contrast between the experiences of specialised District Nurses as opposed to the lower qualified Registered General Nurses.

Working styles

The project identified several points that highlight differences between styles of working within social services and primary health care. For example, each nurse recognised the contrast between the speed of work in community nursing with the slower tempo within social services. This was not necessarily a critical observation; for example, one nurse pointed out that the slower pace of work allowed scope for more reflection. All the nurses felt that, through their participation in the project, they understood the functioning of social services better than they had in their previous roles. They did experience the gap between social

services' eligibility criteria and their recognition of what people actually needed as very frustrating. This fostered a clearer comprehension of the delicate balancing acts between needs and resources that are commonplace within social services – and which are perhaps less explicit within primary health care.

All the nurses acknowledged the impact of working in a different environment. At the start of the project, there was concern that the nature of the work required of the nurses might remove them from their professional strengths and interests. However, as one nurse commented, the work had been “more fulfilling than I expected”. Another asserted that she felt that “the focus is still on what I was trained to do”, while a third reflected that she didn't miss the “horrible things” about the nursing job! Although there was a sense that ‘hands-on’ patient contact was missed, one nurse welcomed the fact that work required within social services was less physically demanding than in her community nursing role.

The pull of the ‘new’

For each nurse a core attraction of the project lay in the challenge of doing something new. There was a strong sense of commitment to the goals of the project. As an example of this, one nurse spoke of the need to create links between the different services and that this was “very much at the forefront of my mind when I took this role on”. However, there were critical observations of the relationship between community nurses and social workers; one spoke of a level of structural mistrust between the two groups, although this was felt less as the project proceeded. Another nurse spoke of the inherent conflicts between social services, health services and independent sector providers under current funding arrangements, an observation given weight by the fact much of the nurses' work was on the interface between the three.

District nurses or Registered General Nurses?

The contrast between the District Nurses and Registered General Nurses was interesting. Originally, it was felt that the project should recruit District Nurses; it was argued that their levels of experience and qualification would render them more capable of working in the unfamiliar, inter-professional environment. This was a comment that related more to their occupational status and authority than their professional skills. As originally envisaged, their role combined direct involvement in assessment as well as making judgements about the assessment decisions of others. However, the role as devised did not attract the interest of many District Nurses, which compelled the Steering Group to think again about how it could be defined. It was decided, initially as a pragmatic response, to narrow the scope of the role by focussing exclusively on direct involvement in assessments. It was felt that this would render the work manageable by a Registered General Nurse with community experience. Indeed, this was the case, with a renewed level of interest from less experienced staff who saw the role as being both interesting in itself and potentially useful for career development. There was no scope to compare the work of the different levels of nurse involved in the project; however, there was no discernible difference in the response of social services staff to the nurse presence in the team, irrespective of the occupational status of the nurse. The implications of this will be discussed in the following section.

Discussion

The purpose of this section is to introduce themes that may be of value to organisations seeking to improve the quality of multi-disciplinary working. For example, although some practitioners commented that there had been mutual learning, the balance of opinion is more accurately expressed by the following statement: “we have learned a lot

from her". However, there were limitations in the scope of these improvements. For example, the increased level of knowledge did not extend beyond the boundaries of the individuals/teams concerned and therefore did not significantly permeate the wider organisation. This reflects a more general concern about the impact of pilot projects: "... while small-scale projects may well have a value ... they will remain peripheral as long as they are not incorporated into the mainstream ..." (Cook *et al.*, 2001, p. 190).

In addition, it was widely argued that the social services role, however satisfying, could not easily be taken on by nurses for longer than 1-2 years. The main element of this relates to the professional identity of the nurse; it was suggested that this needed to be reinforced by regular updates on what is happening within community nursing and that too long an absence from formal nursing environments might compromise this identity. Interestingly, it was not suggested that the project role was deskilling, another fear that had been raised at the outset. When questioned on this typical comments included "I can't say that I feel deskilled" and "I feel that I can go back to the job at any time". The wish to move back into community nursing seemed to represent a desire not to stray too far from the mainstream of nursing practice. It also reflected an awareness of the need to keep abreast of the rapid pace of change within primary care.

The question of whether the project required the secondment of a District Nurse or a Registered General Nurse was unresolved. Both models applied at different points, with both forms of secondment appearing to be successful. In all of the work settings, the centrality of good interpersonal relations was emphasised, arguing that other factors were more important on a day-to-day basis than the qualifications and experience of the participants. This reflects the applicability of Beattie's (1994) model of inter-professional working, which emphasises that good

'interpersonal' relations are equally as important as structural/professional issues.

Although there were reported improvements in the assessment process and outcome, these have to be carefully analysed and balanced. For example, as reported by ACMT staff, one factor was that the involvement of a nurse in the assessment process strengthened the credibility of the assessment recommendation. However, it was observed by one nurse that "on the whole, social workers have a very good idea of who needs what", suggesting that the nurse involvement in assessment, while useful, was not essential. Indeed, there was a clear element of duplication within work processes; the nurses carried out much work that confirmed rather than changed prior assessment recommendations. While this was perceived as useful by social services, it may not represent the best use of scarce professional time.

Conclusion

The evaluation revealed considerable unanimity about the success of the PINSS project, although it must be noted that the enthusiasm of participants does not necessarily mean that the project was actually effective. While there was a strong "culture of success" (Smith and Cantley, 1985) surrounding the project, with participants believing that the involvement of a qualified nurse had improved the quality of assessments, there was little hard evidence to support their contentions.

Participants also believed that the project facilitated improved collaborative working. Many people spoke warmly of the supportive working relationships that derived from co-location, with ACMT staff praising the personal qualities of the nurses that contributed to this. It was often observed how well the nurse had "fitted in" to the team, for example. However, it is unclear whether this model represents the most effective way of organising multi-disciplinary work. A central weakness is that

the nursing role in such arrangements only focused on an element of her/his role – assessment as opposed to treatment. This differs from the placement of social workers within primary health care where the social workers were required to deploy all elements of their professional role (Lybery and Millward, 2000). However, the nurses fulfilled an important function for the social services department, gained substantially as far as their own development is concerned and improved the quality of assessments; the benefits of the model are therefore evident.

It was generally accepted by all people who contributed to the evaluation that full multi-disciplinary teams represented the future for services to older people, although there are numerous practical problems – concerning membership, management, funding, etc. – that have first to be resolved. Such a structural arrangement is implied strongly in the development of the single assessment process and intermediate care (DoH, 2001; 2002a; 2002b). If multi-disciplinary teams build on the core attributes of all occupations, nurses could be enabled to retain the hands-on element of their role, thus addressing the core weakness of this model, while building upon its other strengths. In this way, the PINSS project is best analysed as a useful staging post along the path to the establishment of more comprehensive multi-disciplinary teams.

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