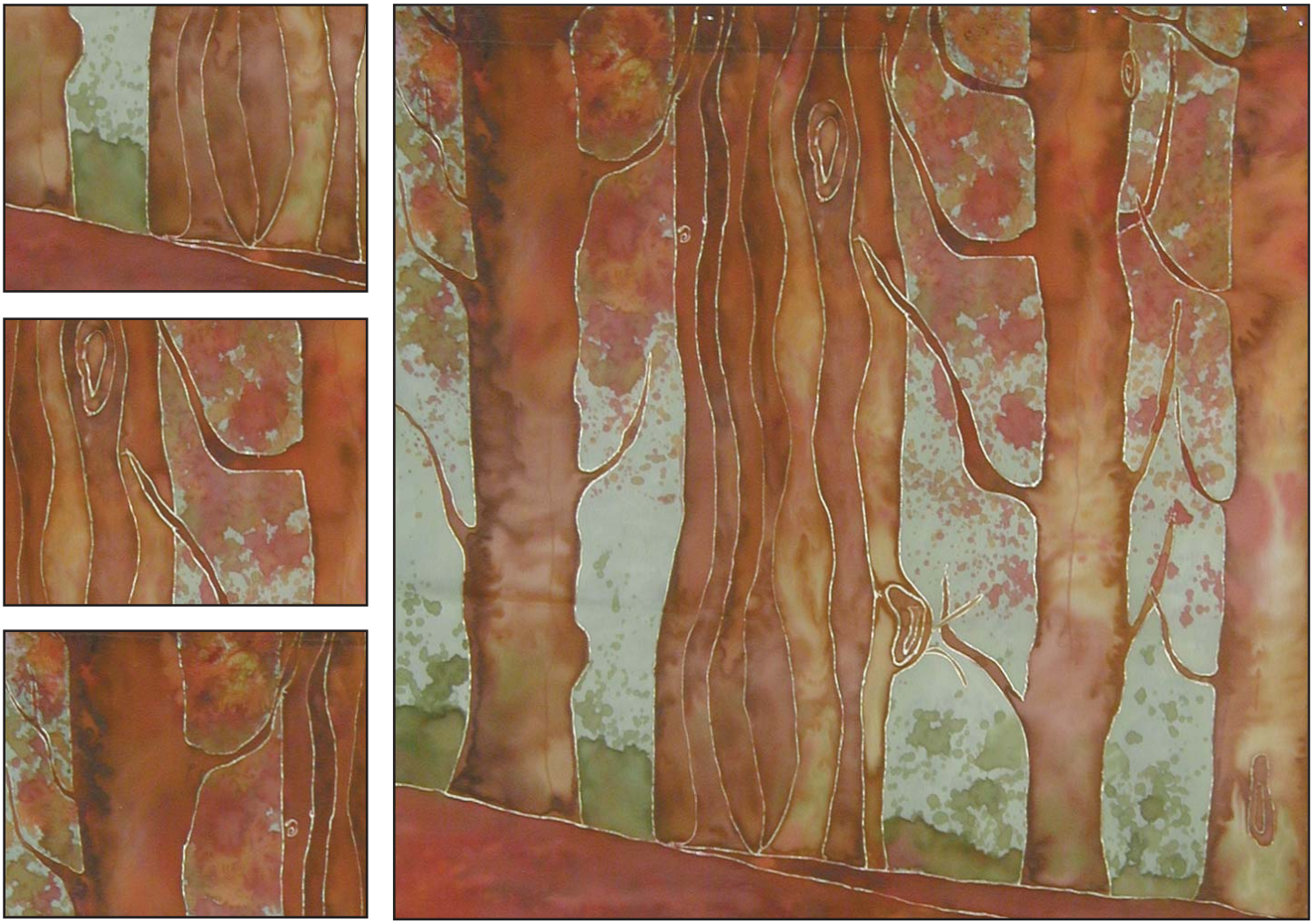
NHS

National Institute for
Mental Health in England

Cases for Change

Partnership Working Across Health & Social Care



mental health questions? **ask NIMHE**

Cases for Change

Mental health services in England are experiencing a period of unprecedented change. The pace of this change is potentially matched only by the pace at which information about both effective and less effective practice in mental health care is emerging. Over the past five years an incredible wealth of published literature has continued to remind all those engaged in developing mental health services of the reasons why fundamental change is necessary and of how services might be improved to better meet the needs of service users.

In addition to the evidence emerging from the research literature, it is important to recognise the role that publications appearing beyond the peer-reviewed journals have also had in informing the many cases for change that exist in adult mental health care today. These include publications reporting non-research based service reviews and the expert opinion of groups and organisations representing the interests of mental health service users, carers and professionals.

For those engaged daily in supporting change in local mental health services it can be difficult to feel well informed of the context of evidence and opinion within which current mental health policy has been established. With this in mind, in late 2001 the National Institute for Mental Health in England (NIMHE) commissioned a review of recent literature on adult mental health services with a view to producing an accessible summary of the emerging cases for change.

Cases for Change comprises ten booklets.

- **Introduction:** describes the background and methodology of the review and also summarises the findings and suggests areas for future research/policy development.
- **Policy Context:** describes the context of the review with an overview of recent mental health policy.

The following seven booklets each consider a different aspect of mental health service provision:

- **Primary Care**
- **Community Services**
- **Hospital Services**
- **Forensic Mental Health Services**
- **Partnership Working Across Health & Social Care**
- **User Involvement**
- **Anti-discriminatory Practice**
- **Emerging Areas of Service Provision:** reviews the literature that does not fit neatly into any of the previous topics.

The review collates evidence from over 650 documents published between January 1997 and February 2002 concerning adult mental health service delivery and/or policy in England. With the information collected synthesised into a number of key themes or issues, the review aims to describe how we got to where we are today and sets out the cases for change from the evidence base.

The articles highlighted at the beginning of each booklet as The Nature of the Evidence are those that are particularly relevant to the cases for change cited in the booklet concerned. Each document within the review has been classified using the "hierarchy of evidence" adopted in the *National Service Framework for Mental Health (NSF)* (Department of Health, 1999a):

- Type 1 evidence represents at least one good systematic review, including at least one randomised controlled trial.
- Type 2 evidence represents at least one good randomised controlled trial.
- Type 3 evidence represents at least one well-designed intervention study without randomisation.
- Type 4 evidence represents at least one well-designed observational study.
- Type 5 evidence represents expert opinion, including the opinion of services users and carers.

At the end of each of the main booklets, there are critical commentaries by service users and practitioners/managers/policy analysts from across England. These commentaries are intended to emphasise that different groups of people have different priorities and identify different cases for change. All contributors have been encouraged to be as challenging as possible and, where they disagree with interpretations, to say so.

Each booklet can be read independently or alongside one another to bring together a full picture of the development of mental health services. We hope this will be helpful in enhancing our understanding of the history as well as emphasising the need to develop future individual services within the context of an integrated system of care and support.

Cases for Change should be seen as a starting point and as a means to an end rather than an end in itself. By summarising the key issues that have emerged from the literature and by emphasising the diversity of opinion that exists within mental health services, Cases for Change may help to encourage debate about the best way forward and the way in which different view points can be balanced to achieve mutually beneficial outcomes.

Cases for Change has been written by a multi-disciplinary research team based at the University of Birmingham with the active support and encouragement of Susannah Rix at NIMHE Eastern, the guidance of the Expert Panel, and service users and practitioners who have provided written commentaries for the main sections of the review. Our thanks also to colleagues in the mental health group at the Department of Health for their editorial input to help finalise the publication.

The research team comprised:

- Jon Glasby, a qualified social worker and a lecturer at the Health Services Management Centre.
- Helen Lester, a GP, national primary care career scientist and Co-Director of the University of Birmingham's Interdisciplinary Centre for Mental Health.
- James Briscoe, a consultant psychiatrist and senior lecturer in the University of Birmingham's Department of Primary Care.
- Marion Clark, a former teacher who worked on this study as a user consultant.
- Steve Rose, Library and Information Services Manager at the Health Services Management Centre at the time of this review and now Health Care Libraries Manager, University of Oxford.
- Liz England, a clinical research fellow in the University of Birmingham's Department of Primary Care.

Four Seasons

These original artworks were designed and painted by a team at The Hollies in Ipswich, Suffolk. Working together the group generates ideas, energy and input. The community spirit engendered provides a platform that allows creativity to shine through. The group experience builds confidence and develops a sense of esteem. *"This kind of work may not cure our problems, but this is the first year I have not been admitted to hospital".*

The Hollies is a Social Enterprise developing meaningful work opportunities for people who have used mental health services. Social Enterprise can and does create real jobs. The pictures illustrate a theme of constant change and renewal in nature. They reflect the changes that can evolve through Social Enterprise and working together.

For more information, contact Jeremy Beckett, Local Health Partnerships NHS Trust on 01473 329093 or email jeremy.beckett@lhp.nhs.uk

Partnership Working

The Nature of the Evidence

	Number of Articles
Type I	0
Type II	0
Type III	0
Type IV	18
Type V	25

Background

Partnership working is a central feature of health and social care provision, both at a local and a national level. Following the election of New Labour in 1997, there has been an increased recognition of the need for 'joined-up government' and 'joined-up solutions to joined-up problems.' This can range from complex and overarching social issues such as crime, substance misuse and social exclusion to the experiences of specific user groups (such as older people, people with learning difficulties or people with physical impairments), whose needs often call for a co-ordinated response from a range of agencies. Partnerships can also exist at a range of different levels – between front-line workers at an operational level as well as between senior managers and elected members at a strategic level.

From the wider literature, we know that working in partnership can be more effective than a single agency working in isolation. According to the Audit Commission (1998), partnerships can help individual agencies to:

- Deliver co-ordinated packages of services to individuals.
- Tackle so-called 'wicked issues' (that is, complex problems which cross traditional agency boundaries).
- Reduce the impact of organisational fragmentation and minimise the impact of any perverse incentives that result from it.
- Bid for, or gain access to, new resources.
- Meet a statutory requirement.
- Align services provided by all partners with the needs of users.
- Make better use of resources.
- Stimulate more creative approaches to problems.
- Influence the behaviour of the partners or of third parties in ways that none of the partners acting alone could achieve.

An additional list of benefits is provided by Payne (2000, p.41), who suggests that partnership working can help with bringing together skills, sharing information, achieving continuity of care, apportioning and ensuring responsibility/accountability, co-ordinating the planning of resources and co-ordinating the delivery of resources for professionals to apply for the benefit of service users.

Although partnership working is recognised as a valuable activity, there are a series of well-documented barriers to greater inter-agency collaboration (see figure 1).

In seeking to promote more effective partnership working, New Labour has introduced a number of key policy measures. In 1998, for example, a Department of Health consultation document provided a scathing critique of the current state of partnership working in health and social care (Department of Health, 1998e, p.3):

"All too often when people have complex needs spanning both health and social care good quality services are sacrificed for sterile arguments about boundaries. When this happens people, often the most vulnerable in our society… and those who care for them find themselves in the no man's land between health and social services. This is not what people want or need. It places the needs of the organisation above the needs of the people they are there to serve. It is poor organisation, poor practice, poor use of taxpayers' money – it is unacceptable."

In response to this state of affairs, the document proposed three new powers or 'flexibilities' whereby those agencies that wished to work more closely together could begin to do so by pooling parts of their budgets, integrating their service provision and/or nominating a lead agency to

Figure 1 Barriers to Inter-agency Collaboration

Barriers to partnership working include:

- Structural (fragmentation of service responsibilities across agency boundaries, within and between sectors).
- Procedural (differences in planning horizons and cycles; differences in budgetary cycles and procedures; differences in information systems and protocols regarding confidentiality and access).
- Financial (differences in funding mechanisms and bases; differences in the stocks and flows of financial resources).
- Professional (professional self-interest and autonomy and inter-professional competition for domains; threats to job security; conflicting views about clients/consumers interests and roles).
- Status and legitimacy (organisational self-interest and autonomy and inter-organisational competition for domains; differences in legitimacy between elected and appointed agencies).

To overcome these barriers, there are four broad principles for strengthening strategic approaches to collaboration:

- Shared Vision: Specifying what is to be achieved in terms of user-centred goals; clarifying the purpose of collaboration as a mechanism for achieving such goals, and mobilising commitment around goals, outcomes and mechanisms.
- Clarity of Roles and Responsibilities: Specifying and agreeing 'who does what', and designing organisational arrangements by which roles and responsibilities are to be fulfilled.
- Appropriate Incentives and Rewards: Promoting organisational behaviour consistent with agreed goals and responsibilities, and harnessing organisational self-interest to collective goals.
- Accountability for Joint Working: Monitoring achievements in relation to the stated vision; holding individuals and agencies to account for the fulfilment of pre-determined roles and responsibilities, and providing feedback and review of vision, responsibilities, incentives, and their inter-relationship.

(Hudson et al., 1997, pp.11-13)

Partnership Working

commission all health and social care services for particular user groups. These proposals were subsequently enacted under the *Health Act* 1999 and participating agencies are listed on a Department of Health website (www.doh.gov.uk/jointunit). More recently, the government's *NHS Plan* (Department of Health, 2000d) announced the introduction of new type of organisation – the Care Trust – to commission and provide both health and social care. At the time of writing, there are four 'demonstrator' projects in operation, with three of the four focusing on services for people with mental health problems.

Cases for Change

Against this background, many of the documents in the Cases for Change review re-inforce a number of key messages from the wider literature about:

- The importance of working in partnership in mental health services.
- Barriers to successful partnerships.
- Possible solutions.

Unfortunately, much of this literature tends to be descriptive (simply describing good practice examples) or heavily prescriptive (stating that partnerships are a 'good thing' and urging agencies and practitioners to work more effectively together), without always citing the evidence for such claims. This is an issue to which we return below. Although this chapter focuses primarily on partnership working between health and social care, moreover, it is important to note that partnerships can also include a number of other participants. Examples include:

- The criminal justice system (see the booklet on Forensic Services).
- The independent sector (see the booklets on Hospital and Forensic Services).
- Partnerships between service users and mental health workers (see the User Involvement booklet).

The importance of working in partnership in mental health:

Although most documents reviewed in this chapter acknowledge barriers to successful inter-agency collaboration, they are almost unanimous in identifying a range of potential benefits associated with partnership working. In North-East England, for example, an evaluation of a Community Mental Health Team found that an integrated team approach improved the transfer of information, encouraged a pooling of expertise, led to enhanced creativity in problem solving and resulted in more responsive services (Cook et al., 2001). In Somerset and Northumberland, service reviews have emphasised the importance of a service with a single point of contact (Gulliver, 1999), while staff in Leeds feel that multi-disciplinary working leads to pooled knowledge and to the opportunities to experience areas of work outside individuals' normal professional roles (Millar, 2000). At the same time, work undertaken by the Sainsbury Centre for Mental Health (2000b, pp.12-14) suggests that partnership working is a "must do" for mental health services for a range of political, financial and practical reasons:

- Mental health is complex with a range of different agencies involved (including health care, social care, housing, welfare advice and the employment services).
- Many mental health service users are vulnerable and have limited capacity to negotiate complex bureaucracies. They therefore need services that are well integrated at the point of contact, are easy to negotiate and are focused on their needs.
- Resources are scarce, but the task is broad. It therefore makes sense for agencies to work together to achieve the vision for mental health set out in official policy documents.
- There are strong perverse incentives in mental health, with evidence of, for example, bed blocking due to the lack of community alternatives.
- Integrating the Care Programme Approach and care management is a high priority and is simpler and more effective when joint working arrangements are sound.
- Partnership working can help to minimise bureaucracy and duplication as well as maximising integration for service users and staff.

Above all, partnership working is deemed to be beneficial for service users and their carers, who can often experience fragmented services, a lack of continuity and conflicting information in situations where local agencies fail to collaborate effectively. This has been described by Preston et al (1999) in terms of being "left in limbo", with users and carers feeling that they are failing to make progress through the mental health system:

"*Separate clinics don't talk to each other or ring each other. I find the whole thing incredible the length of time it takes; it's just been horrendous, waiting weeks to see a consultant to be told 'I don't know why you've been referred to me'… It can make you feel very insignificant.*" (Service user, quoted in Preston et al., 1999, p.19)

Barriers to successful partnerships:

In addition to the barriers identified in figure 1, the literature contained in this review identifies a number of specific difficulties in developing effective partnerships within mental health services. Thus, Norman and Peck's (1999) study of the views of leading members of professional organisations highlights issues such as a loss of faith by mental health professionals in the system within which they work, strong adherence to uni-professional cultures, the absence of a shared philosophy for community mental health services and mistrust of managerial solutions. For Nolan et al (1998), key obstacles to collaboration include individual practitioners' lack of knowledge of other professionals, a tendency to stereotype other workers, defensive attitudes and a lack of certainty over one's own role. For others, government policy may inadvertently serve to hinder attempts to work in partnership (e.g. by introducing separate performance reporting requirements for health and social services) (Hayward, 2000). Engaging members of particular professions can also be problematic, as can looking beyond health and social care to include a wider range of partners (see figure 2).

Possible solutions:

In order to overcome the barriers to inter-agency collaboration and maximise the potential benefits of partnership working, the literature contained in this review proposes a wide range of possible solutions (see figure 3). Sometimes, the existence of a key power broker (often a consultant psychiatrist) can facilitate greater collaboration in a local area, although the resultant partnership is very vulnerable if this person leaves (Norman and Peck, 1999). Personal and leadership styles can also be important, with partnerships dependent on the attitude of senior managers and a willingness to pioneer new approaches (Sainsbury Centre for Mental Health, 2000b). In contrast to this emphasis on key individuals or on personal characteristics, other commentators emphasise the need for more formal

Figure 2 Engaging 'Hard to Reach' Groups

Sometimes, it can be difficult to engage members from particular professionals in partnership working:

- General practitioners may not necessarily see mental health issues as a priority and are independent practitioners with very different contractual arrangements to other health and social care services (Cook et al., 2000; Hancock and Villeneau, 1997; Poxton, 1999).
- Psychiatrists sometimes see themselves as being responsible for the work of the whole multi-disciplinary team and may not support the view that team membership implies peer equality of status and some form of democratic decision-making. This can lead to high levels of psychological stress, generate conflict amongst team members and inhibit team relationships (Norman and Peck, 1999; Peck and Norman, 1999).
- Practice nurses have different employment arrangements than other groups and can feel isolated from other professional colleagues (Nolan et al., 1998).
- Psychologists may sometimes perceive themselves as relatively autonomous, high status practitioners and may be ambivalent about being too closely identified with multi-disciplinary teams (Peck and Norman, 1999).
- Non-executive board members and local authority councillors are key decision-makers, but are felt by some mental health practitioners to have a poor understanding of mental health issues (Hancock et al., 1997).

In addition to these groups, partnerships may sometimes fail to reach out to services beyond health and social care (such as housing) or to keep other partners (such as services users or voluntary agencies) fully informed of what is happening (Hancock et al., 1997).

Figure 3 Improving Partnership Working

Work undertaken by the Sainsbury Centre for Mental Health (2000b, pp.6-9) suggests that successful partnerships may depend upon:

- Avoiding organisationally defensive routines.
- Taking into account the user movement.
- Understanding changing organisational cultures.
- Understanding the key components of effective dialogue.
- Taking account of well understood success factors such as having a clear strategic purpose for the partnership.
- Creating alliances which form part of the everyday functioning of organisations.
- Developing a supportive internal infrastructure.
- Looking at external factors when planning and acting.
- Taking specific account of key issues such as governance arrangements, performance management, information systems, workforce issues, charging policies, complaints procedures and user involvement.

For Norman and Peck (1999, p.224), the way forward is to:

- Draw upon users' aspirations as an explicit philosophy for guiding the development of the partnership.
- Clarifying accountability and responsibility of staff.
- Clarifying staff roles.
- Developing a framework to explore the relationships between multi-disciplinary groups.
- Drawing upon existing theories for understanding team effectiveness.

approaches to partnership working such as inter-professional education (Roberts and Priest, 1997) or inter-agency agreements about how to prioritise and allocate referrals (Maunder et al., 2001; McDermott and Reid, 1999). For Gulliver (1999), the focus should be on more strategic issues such as securing senior management commitment, developing a shared vision, investing time in staff, owning each other's difficulties and recognising that partnerships are a means to an end rather than an end in themselves. Elsewhere, progress towards more effective partnerships seems to have been made by adopting a more developmental approach which seeks to explore the perceptions which different practitioners have of colleagues from other disciplines and working through these preconceptions in multi-agency settings (see, for example, Nolan et al., 1998; Peck and Norman, 1999).

For others, one way forward may lie in structural change and service redesign. Examples of this may include shared offices (Cook et al., 2001), multi-disciplinary records (Yates and Deakes, 1998), integrated service provision (McMillan, 2000) or integrated information technology systems (Hayward, 2000). Despite this, a cautionary note is sounded by Peck et al (2001) in their study of the meaning of 'culture' within an integrated mental health trust. Although many local stakeholders felt that creating an new health and social care organisation would lead to a shared organisational culture, more detailed research found that the creation of a combined trust, by itself, was not sufficient to do this. On the contrary, one of the outcomes of the project, at least in the short-term, may have been a strengthening of attachments to existing professional cultures, with workers feeling threatened by the changes and troubled by a perceived lack of identity. Structural solutions, in short, may not necessarily provide a panacea to the thorny issue of partnership working (see also Sainsbury Centre for Mental Health, 2000b).

A further solution proposed by a range of commentators is the development of specialist liaison services to support staff in more generic roles in settings such as general hospitals or A&E departments. Although there is a lack of a clear definition, typical features of a liaison service include the use of specialist skills and knowledge to educate

and support staff and/or to assess and respond to the needs of people with mental health problems in non-specialist health settings (see figure 4). Traditionally, liaison services have originated in A&E and have tended to focus on self-harm (see, for example, Crawford and Kohen, 1997; Roberts and Taylor, 1997), but have since spread to other areas such as diabetes clinics, services for people with HIV/AIDS, burns trauma or obstetrics (Callaghan et al., 2000; Mitchell et al., 2000; Smith, 1999). Key positives of this model appear to include the harnessing of specialist skills in settings where staff are unaccustomed to working with people with mental health problems, ensuring that services respond not only to physical problems but also to psychological issues as well. As Roberts (1998, pp.51-52) notes:

"Health professionals have become more aware in the past decade of the impact of psychosocial problems on physically ill people… It is important for general nurses to have access to specialist knowledge and skills in order to manage these aspects of care. Mental health liaison is a means of making mental health expertise available to patients and staff in non-psychiatric settings, particularly in general hospitals. Liaison mental health nurses frequently provide such a service to general nurses. The number of liaison posts is increasing and there is considerable potential for this to develop further… Meeting health needs effectively requires integration of physical and psychosocial aspects of care and treatment. This is best achieved through close working relationships between mental health and non-mental health care staff, based on mutual respect and clarity of role, with a clear focus on the patient as the centre of collaborative effort."

Figure 4 Mental Health Liaison

"My role as a mental health nurse practitioner in the A&E department of St James' Hospital, Leeds, was created as an experiment… The project has been positively received by many groups of professionals and the service users themselves. For the service users and carers it means that the [mental health nurse practitioner] can see patients much more quickly than can a casualty officer. Our specialised knowledge of mental health problems, services and experience in assessment ensure that a better service is delivered. The availability of a variety of interventions which can be offered on site ensures that problems are identified and responded to appropriately and the need for follow-up services can be assessed accurately…

A&E staff find it difficult to respond to mental health problems. By having us working as part of the team, care can be delivered to a vulnerable group and staff can learn effective interventions, develop confidence and widen their skill base to the benefit of all their patients."

(Greenwood, 2000, pp.14-15)

Overall, the diverse range of solutions offered in the literature would seem to support an assertion by Sainsbury Centre for Mental Health (2000b, p.27) that "there are no 'quick fixes', and no magic solutions to complex health and social problems." While there may be a range of approaches that can help to promote greater inter-agency collaboration, it would appear that there are no easy answers. Ultimately, therefore, it seems as though the way forward may lie in an incremental approach, whereby individual partners make use of whatever avenue they think may be beneficial and locally appropriate to travel closer to the overall goal of more effective partnership working.

Unfortunately, though, our understanding of the issues at stake is restricted by four main limitations in the partnership literature. First and foremost, the vast majority of documents cited in this booklet focus on the needs and perspectives of policy makers, managers and front-line workers without adequately exploring the views and experiences of service users and their carers. Given that much of the available literature seeks to justify partnership working in terms of more responsive services for users, this failure to include a significant user/carer perspective must be seen as a major oversight.

Secondly, almost by definition many of the articles cited draw on good practice examples from areas which seem to have a strong history of joint working and a commitment amongst local agencies to working in partnership. While these documents are able to highlight the factors that helped or hindered partnership working, they may not necessarily be representative of the country as a whole. Indeed, the very fact that they have commissioned external evaluations or been cited in print as good practice examples suggests that they may not be typical. As a result, little is known about how to promote partnership working in areas which have a poor history of collaboration or where local partners are hostile to each other.

Third, few of the documents in this booklet explore whether or not partnership working may have negative consequences. That this can sometimes be the case is suggested by preliminary findings from Somerset where the creation of an integrated mental health trust led initially to a reduction in user satisfaction as a result of changes in key workers, uncertainty about the re-organisation of buildings and a perceived reduction in personnel (Gulliver et al., 2001). For staff, there was evidence of a reduction in job satisfaction and morale due to confusion over organisational identity, concerns about changes in professional roles and a lack of management role clarity. In the future, therefore, it would be a useful addition to the literature to see a more balanced consideration of the disadvantages of partnership working alongside more traditional, positive accounts.

Finally, it is disappointing to note that many of the documents reviewed in this booklet are essentially journalistic accounts of apparently successful schemes, emphasising the virtues of partnership working without necessarily citing evidence for the claims made. Thus, as Gulliver et al (2000b, p.13) observe:

"Recent government policy documents have underlined the importance of evidence-based practice. However, the implementation of evidence-based practice has well-documented difficulties, even when the evidence is readily available. In some areas, such as the creation of partnerships in the commissioning and provision of health and social services, that evidence is lacking. There have been a number of joint commissioning or joint provision initiatives between health and social services described in the literature. In addition, there have been a number of papers written on the requirements for joint initiatives to work. But there are no detailed published studies that monitor the impact of joint commissioning and/or integrated provision on a range of stakeholders over time."

This is also a criticism which some may wish to level at national policy, as the evidence base for some of the measures currently being implemented sometimes lacks clarity. Thus, the use of the Health Act flexibilities is being actively promoted by the government prior to the completion of the national

evaluation of this initiative, while legislation has given the Secretary of State powers to impose the flexibilities on organisations in certain situations without any indication that 'forced' partnerships can be effective. At the same time, the concept of the Care Trust is very much a leap of faith, and was introduced in a single page of a much larger 144-page document (Department of Health, 2000d, p.73). Not only was no evidence cited for this new model, but the announcement came at a time when the success of previous developments in health care (such as PCTs) had been insufficiently researched. As a result, the government laid itself open to criticism that it was introducing a new model of care when there was very little evidence about the effectiveness or otherwise of the current way of working. As Hudson (forthcoming, pp.9-10) observes:

"[In the case of Care Trusts], there remains a strong political commitment to an untried model. In the light of the emphasis normally placed by the Department of Health on evidence-based approaches to policy and practice, this is perhaps a surprising turn of events."

Again, this is not dismiss the concept of the Health Act flexibilities or Care Trusts - in time, these policies may well prove to be an effective means of promoting greater partnership working. However, the key issue is that both initiatives appear to be based more on faith than on a firm evidence-base and their potential impact is uncertain.

Further Information

For those seeking to find out more about partnership working, there are a number of key sources:

- The Sainsbury Centre for Mental Health (1998d) has produced a briefing paper on the Partnership in Action consultation paper and the potential implications of the Health Act flexibilities.
- The Sainsbury Centre for Mental Health and the Social Services Inspectorate have collaborated to produce a series of key indicators which can be used to assess the effectiveness of joint working in mental health in a particular locality (Hancock and Villeneau, 1997; Hancock et al., 1997).
- Peck and Norman's (1999) study of inter-professional role relations provides an insight into the way in which different types of mental health practitioners view colleagues from different professional backgrounds. While the data collected is interesting in itself, the process of examining professionals' perceptions of their own and other mental health disciplines may also offer a useful means of beginning to explore stereotypes and attitudes at a local level prior to an attempt to promote greater partnership working.
- Additional information on liaison psychiatry is provided by Peveler et al (2000) in an edited collection produced by the Royal College of Psychiatrists, while Roberts (1997) explores the literature to date on liaison mental health nursing.
- In the wider literature, researchers at the Nuffield Institute for Health have produced an evidence-based partnership tool designed to assist organisations in assessing and improving partnership working (see www.leeds.ac.uk/nuffield/ for further details).

Above all, however, the recent evaluation of partnership working in Somerset (Peck et al., 2002) is a seminal document and one of the most detailed studies to date of the issues which partnership working can raise in mental health services. Cited in government documents such as the *NHS Plan* (Department of Health, 2000d), the joint commissioning and integrated health and social care provision initiative taking place in this area of the country is the first of its kind outside Northern Ireland (where the health and social care system is very different). For further information, see Gulliver et al (2000a, 2000b, 2001) or the critical commentary included at the end of this booklet.

Partnership Working

Critical Commentary

In my experience as a service user, a former non-executive director of Somerset Partnership NHS and Social Care Trust and now working within the voluntary sector in mental health, I do believe in partnership working as a way forward. Bringing together a richness of experience and expertise from varied perspectives should bring about more holistic care for service users. The example in Somerset with the integration of health and social care I feel has been to a large extent successful. As a service user, benefits such as having a single point of contact especially when you are in a crisis and cannot cope with making numerous calls are important. Also, integrating the Care Programme Approach makes so much sense with everyone supposedly going in the same direction.

However for the staff initially many of the barriers identified by Hudson et al (1997) [see introduction to this chapter] were experienced around procedures, professional insecurities and an uncertain vision. Suddenly sharing office space does not necessarily initiate immediate positive working relationships and good teamwork. Ironically, strong teamwork can prove problematic and disempowering to services users, as in a quest to avoid conflict between team members, this can potentially militate against patient choice (Finlay, 2000).

Service user views in the final Somerset Report focus on the fact that integration does not necessarily change the care people receive as inpatients. Service users staring 'waiting around with nothing to do' and 'not given support I needed by staff' (Peck et al., 2002) shows therefore that whilst it may be important to develop joint working it is also important not to neglect other areas of service. Ironically now with so much change occurring within mental health and trying to meet the NSF targets and financial pressures, the issues of integration are less noticeable as other threats become perhaps more disconcerting to staff, users and carers so perhaps leading more towards a need to unite.

Partnership is not optional under the current government agenda and whilst service users may benefit from a 'seamless service' the issues of partnership need to be wider than just merging two organisations together. Service users, carers, the voluntary sector, housing, education etc need to be involved also. However differences in values and priorities will need to be addressed allowing the dissenting viewpoints to be heard, otherwise dominant professional perspectives will remain unchallenged. Certainly, in my experience as a board member of the Trust, it is very difficult to be the lone voice of opposition – especially when many professionals are used to position of power. However, I feel my position was a fascinating encounter of a service user tackling the thorny issue of partnership.

For me, genuine partnership is not for everyone to just agree on everything and use commonality as a tool. It is more about maintaining each perspective and drawing together constructively to bring about better care and support for each individual service user.

Diane Brodie, Service User and Former Non-Executive Director,
Somerset Partnership NHS and Social Care Trust

Critical Commentary

Having occupied "partnership" roles in service delivery and in commissioning for a number of years now, there is much in this chapter that rings true for me. I have seen at first hand the sharing of skills, ideas and information that can go on in a multi-agency mental health team, the outcome appearing to be a more holistic service for service users. I have also seen the development of services in Sandwell benefiting from a joint approach to the deployment of mental health budgets/resources. My own experience would also reinforce the importance of clarity on roles, responsibilities and management arrangements from the outset – don't leave these and think you'll sort it out later!

However, I think sometimes we look at partnerships through our rose-tinted glasses. I'm sure partnerships 'make better use of resources' in many ways, but I don't think that sufficient attention is paid to the resources (in terms of staff time) partnerships consume - the effect of partnerships is not always to reduce duplication. I agree that developing a shared vision and sense of purpose is crucial, but these are not easy things to embed at all levels of the partner organisations, and we shouldn't just assume a shared understanding. Organisational development may be resourced at the early stages, but my view is that it needs to be ongoing, otherwise years later when you scratch the surface you can still find quite frustrating differences in views on the roles of the team/service, evidence of stereotyping and a fairly poor understanding of each other's roles and responsibilities, but particularly of each other's pressures. Perhaps one test of a good partnership is how it behaves when the pressure is on in some way – has anyone looked at this?

A number of other issues about partnership interest me, and I'd like to see these explored. Is there a ceiling on the number of partnerships we can realistically maintain? Will the increasingly close relationship between health and social care partners merely leave others outside an even higher fence (as I know some in the voluntary sector fear), and has anyone looked at the impact on other partners of close (and more formal) relationships between health and social care? What about the impact of a shared organisational culture on service users – could this lead to reduced choice for service users in some ways and have we had this discussion/debate?

Finally, while I am a supporter of partnership working, I also reserve the right to maintain a healthy scepticism: as this chapter points out, the evidence base is fairly weak and we can easily lose sight of the outcomes for the end user. I wonder if partnership working can become so much of an end in itself that we're sometimes in danger of adopting a partnership approach where it is unnecessary or even inappropriate to the achievement of desired outcomes. I would therefore welcome a more critical appraisal of partnership working before it becomes the new religion with associated heresies!

Lesley Brougham, Strategic Partnership Manager for Mental Health, Sandwell

References

Audit Commission (1998) *A fruitful partnership: effective partnership working.* London, Audit Commission

Callaghan, P., Eales, S., Leigh, L., Smith, A. and Nicholas, J. (2001) Characteristics of an accident and emergency liaison mental health service in East London, *Journal of Advanced Nursing,* 35(6), 812-818

Cook, G., Gerrish, K. and Clarke, C. (2001) Decision-making in teams: issues arising from two UK evaluations, *Journal of Interprofessional Care,* 15(2), 141-151

Crawford, M.J. and Kohen, D. (1997) Urgent psychiatric assessment in an inner-city A&E department, *Psychiatric Bulletin,* 21(10), 625-626

Department of Health (1998e) *Partnership in action: new opportunities for joint working between health and social services – a discussion document.* London, Department of Health

Department of Health (1999a) *National service framework for mental health: modern standards and service models.* London, Department of Health

Department of Health (2000d) *The NHS plan: a plan for investment, a plan for reform.* London, Department of Health

Greenwood, A. (2000) Mental health emergency, *Nursing Standard,* 14(37), 14-15

Gulliver, P. (1999) Two approaches to the joint commissioning of mental health services, *Mental Health Review,* 4(3), 21-23

Gulliver, P., Peck, E., Ramsay, R. and Towell, D. (2000a) Evaluation of the implementation of the Mental Health Review in Somerset: results from the baseline data collection, *Managing Community Care,* Brighton, 8(4), 16-23

Gulliver, P., Peck, E. and Towell, D. (2000b) Evaluation of the implementation of the Mental Health Review in Somerset: methodology, *Managing Community Care,* 8(3), 13-19

Gulliver, P., Peck, E. and Towell, D. (2001) Evaluation of the implementation of the mental health review in Somerset: results after fifteen months of data collection, *Managing Community Care,* 9(1), 14-21

Hancock, M. and Villeneau, L. (1997) *Effective partnerships: developing key indicators for joint working in mental health.* London, Sainsbury Centre for Mental Health

Hancock, M., Villeneau, L. and Hill, R. (1997) *Together we stand: effective partnerships: key indicators for joint working in mental health.* London, Sainsbury Centre for Mental Health

Hayward, R. (2000) Somerset's development of an integrated information system for mental health services: organisational foundations, *British Journal of Healthcare Computing and Information Management,* 17(1), 18-19

Hudson, B. (forthcoming) *Integrated care and structural change in England: the case of Care Trusts,* paper presented to Policy Studies

Hudson, B., Hardy, B., Henwood, M. and Wistow, G. (1997) *Inter-agency collaboration: final report.* Leeds, Nuffield Institute for Health Community Care Division

Maunder, L., Cameron, L. and Liddon, A. (2001) Targeting services to meet need: a tiered approach to mental health care, *Mental Health and Learning Disabilities Care,* 4(11), 366-369

McDermott, G. and Reid, L. (1999) Model for integrated mental health care measures up, *Nursing Times,* 95(13), 46-47

McMillan, I. (2000) One-stop service, *Nursing Standard,* 13(33), 16-17

Millar, B. (2000) All in a day's work, *Therapy Weekly,* 27(10), 48

Mitchell, C., Catalan, J., McIntosh, C. and Feher, M.D. (2000) Joint liaison psychiatry-diabetes clinic: a new specialist service, *Diabetic Medicine,* 17(6), 481-483

Nolan, P., Dunn, L. and Badger, F. (1998) Getting to know you, *Nursing Times,* 94(39), 34-36

Norman, I.J. and Peck, E. (1999) Working together in adult community mental health services: an inter-professional dialogue, *Journal of Mental Health,* 8(3), 217-230

Payne, M. (2000) *Teamwork in mutliprofessional care.* Basingstoke, Macmillan

Peck, E., Gulliver, P. and Towell, D. (2002) *Modernising partnerships: an evaluation of Somerset's innovations in the commissioning and organisation of mental health services – final report.* London, Institute of Applied Health and Social Policy, King's College

Peck, E. and Norman, I.J. (1999) Working together in adult community mental health services: exploring inter-professional role relations, *Journal of Mental Health,* 8(3), 231-242

Peck, E., Towell, D. and Gulliver, P. (2001) The meanings of 'culture' in health and social care: a case study of the combined trust in Somerset, *Journal of Interprofessional Care,* 15(4), 319-327

Peveler, R., Feldman, E. and Friedman, T. (eds) (2000) *Liaison psychiatry: planning services for specialist settings.* London, Gaskell

Poxton, R. (1999) Primary and community mental health and social care: making a difference at the interface, *Mental Health Review,* 4(3), 24-27

Preston, C., Cheater, F., Baker, R. and Hearnshaw, H. (1999) Left in limbo: patients' views on care across the primary/secondary interface, *Quality in Health Care,* 8(1), 16-21

Roberts, D. (1997) Liaison mental health nursing: origins, definition and prospects, *Journal of Advanced Nursing,* 25(1), 101-108

Roberts, D. (1998) Making the connections to aid mental health, *Nursing Times,* 94(15), 50-52

Roberts, P. and Priest, H. (1997) Achieving interprofessional working in mental health, *Nursing Standard,* 12(2), 39-41

Roberts, M. and Taylor, B. (1997) Emergency action, *Nursing Times,* 93(30), 30-32

Sainsbury Centre for Mental Health (1998d) *An executive briefing on the implications for mental health services of the consultation paper Partnership in Action (Briefing 3).* London, Sainsbury Centre for Mental Health

Sainsbury Centre for Mental Health (2000b) *Taking your partners: using opportunities for inter-agency partnership in mental health.* London, Sainsbury Centre for Mental Health

Smith, S. (1999) Solo obstetric liaison service, *Psychiatric Bulletin,* 23(1), 37-40

Yates, M. and Deakes, C. (1998) Introducing multidisciplinary record keeping in a forensic setting, *Psychiatric Care,* 5(6), 204-207

For further information about this review please contact:

Dr Helen Lester
Department of Primary Care
Clinical Sciences Building
University of Birmingham
Edgbaston
Birmingham B15 2TT

E-mail: H.E.Lester@bham.ac.uk

Susannah Rix
NIMHE Eastern
654 The Crescent
Colchester Business Park
Colchester
Essex CO4 9YQ

E-mail: susannah.rix@doh.gsi.gov.uk

National Institute for Mental Health in England (NIMHE)
Blenheim House
West One
Duncombe Street
Leeds
LS1 4PL

Web Address: www.nimhe.org.uk

NIMHE is part of the Modernisation Agency at the Department of Health

DH Department of Health