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Partnerships for health: expanding the public health nursing role within PCTs

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Since 1997, Labour Governments have championed partnership working as part of a commitment to develop a new public health agenda. Multidisciplinary and multi-agency working have been placed at the heart of attempts to tackle widening health inequalities, with Primary Care Trusts (PCT) being placed at the forefront of a corporate approach to delivering improvements in individual, community and population well-being. However, observed practice in relation to public health collaboration has rarely met the challenge of past policy prescriptions. Furthermore, we have limited understanding of who is best placed to meet the challenge of securing public health partnerships within a primary care led National Health Service (NHS). This paper reviews the need for PCT involvement in partnership working, assesses the potential contribution primary care nurses can make to the co-ordinated delivery of the new public health agenda, and identifies key issues for policy and practice. It concludes that nurses have the opportunity to play a key role in the development of partnerships for improved public health at the PCT level. However, it also notes that the development of such functions will require an expansion of existing nursing roles, a willingness to take on a more overtly political role, and a deeper consideration of the constituents of successful collaborative action for improved public health.

Key words: nursing partnership; collaboration; primary care; public health

Introduction

It is widely recognized that for government to deliver improved public health the support of key stakeholders is required (Glendinning, 1999). Furthermore, their commitment to collaboration is imperative (Baileff, 2000; DoH, 1999; DoH, 2001; Gerrish, 1999; Glendinning, 1999; Plews *et al.,* 2000). Indeed, 'collaborative working for health and social well-being' has recently been identified as a key competency area for those working in a public health capacity (Health Works, 2001).

Historically, however, diverse agencies and professions have failed to form the sustainable working partnerships required to deliver improved population health. Numerous reasons for this failure have been identified. Joint and joined-up working at the level of both organizations and professions has been poor (Rowe *et al.,* 1998; Baileff, 2000; Plews *et al.,* 2000). There has been little agreement or understanding on the definition or scope of public health (Pearson *et al*., 2000; Plews *et al*., 2000; Rowe *et al.,* 1998). The development of population based public health has been hindered by the paucity of research evidence on which to base practice (Baileff, 2000; Gerrish, 1999; Pearson *et al.,* 2000; Plews *et al.,* 2000). Cultural divides, enduring communication problems, poor co-ordination and inadequate planning both within NHS organisations, and between the NHS and other agencies, has hindered attempts to develop a community level focus (Glendinning, 1999). Finally, the dominance of the bio-medical model within public health medicine (Pearson *et al.,* 2000; Plews *et al.,* 2000), combined with the narrow disease and individual patient focus of many medical practitioners within primary care (Pearson *et al.,* 2000), has led to the marginalization of other professions, agencies and approaches within the

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wider public health arena (Gerrish, 1999; Rowe *et al.,* 1998).

In response to these shortcomings policy documents such as *Saving Lives* and *Making a Difference* have suggested that attention to public health be refocused and the role of other nonmedical professions expanded (DoH, 1999; DoH, 1999b). Specifically, it has been suggested that the potential that exists within other professions, such as nursing, to deliver a more holistic, multidisciplinary and population centred public health should be developed. This paper explores that potential with specific reference to primary care and community health care nursing. In particular, it considers how an expanded nursing role relates to the new public health agenda; it reviews how nurses can contribute to the development of partnership working for improved public health, including a description of the antecedents of successful partnership working; and identifies key issues for policy and practice.

Policy Context

The NHS Plan (2000) sets an agenda for far-reaching change across the NHS in the UK. It aspires to a system designed around the patient, delivering improvements in health, while securing levels of service that patients expect and NHS staff want to provide. It heralds a radical redesign of the whole care system (DoH, 2000: 7.3) with a requirement for change at every level of the NHS (DoH, 2000: 16.10).

At the centre of these changes in England are PCTs. Free-standing, legally established, statutory NHS bodies, PCTs are responsible for planning commissioning and delivering health services to local communities. Accountable to strategic health authorities, they offer local stakeholders including general practitioners, nurses, therapists and managers the chance to make decisions about the provision of care close to the point of delivery.

PCTs are not, however, to work in isolation. Documents such as the NHS Plan recognize that if the health of the nation is to be improved, PCT members will have to work collaboratively with local authorities, voluntary agencies and communities if people are not to fall in the cracks between services (DoH, 2000: Executive Summary). Accordingly, as part of their core functions PCTs are charged with 'improving the health of their populations through activities that reach beyond the NHS' (Gillam et al., 2001:89) securing improvements in health and reducing inequalities. Indeed, it is in the reduction of inequalities that the public health role of PCTs and primary care nurses can be most clearly discerned.

Public health is concerned with more than the absence of disease and the provision of medical care. It is premised on recognition of the association between low educational achievement, unemployment, poverty, lifestyles and health inequality (Acheson, 1998; DoH 1999b). Furthermore, socio-economic explanations of inequality broadly define public health activity as the organized efforts of society to prevent disease, prolong life and promote health and well-being (Acheson, 1998). It is in this context of changing systems, new organizational priorities, an emphasis on the reduction of inequalities, promoting improved health and the desire to develop 'integrated care' which is 'based on partnership and driven by performance' (DoH, 1997: para 2.2), that the role of primary and community care nurses (including health visitors, midwives and nurses) is being defined. It suggests an inclusive definition of public health nursing operating at different levels. These range from working with individuals at one extreme (e.g., immunisation, providing one-to-one health promotion advice) to leading programmes at a community level at the other (e.g., health needs assessment, developing and implementing health improvement programmes and commissioning services within a PCT locality). Between these extremes public health nursing may target families (e.g., developing parenting skills and managing children with behavioural difficulties), groups (e.g., smoking cessation and school health) or communities through community development work (e.g., working with disadvantaged communities such as homeless people to improve health and reduce social exclusion). As such, public health nursing can be defined as a complex endeavour intended to tackle inequality and promote community health and well-being through interventions tailored to the needs of individuals, groups, populations and policy communities. It is with this definition in mind that the paper explores the potential role of primary and community health nurses in delivering the public health functions of PCTs.

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History of disappointment and medical dominance

Prior to the publication of the Acheson report into health inequalities in 1998, public health and public health nursing were largely peripheral concerns within the NHS. Three factors contributed to this status. First, public health nursing was poorly understood (Pearson *et al.,* 2000; Plews *et al.,* 2000; Reutter and Ford, 1996). Secondly, the focus of nursing within the primary care sector was being narrowed by workload demands and financial concerns (Caraher and McNab, 1997; Lewis, 1999; Pearson *et al*., 2000; Rowe *et al*., 1998). Finally, public health working was being dominated, even subjugated, at policy and practice levels by the power of the 'bio-medical' model. Indeed, policies such as those surrounding the *Health of the Nation* programme reinforced the disease orientation of public health medicine (Pearson *et al.,* 2000) largely ignoring the socio-economic determinants of health inequality (Caraher and McNab, 1997) and eschewing population approaches to health improvement.

Combining a population with an individual patient approach to care has, therefore, presented substantial challenges for many GPs and other primary and community care practitioners (Gillam *et al.*, 2001). In recent years some Personal Medical Service (PMS) pilots have enthusiastically adopted innovative and integrated approaches to improved public health (Gillam, 1999). Yet, attempts to tackle wide-ranging inequalities within general practice settings are the exception rather than the rule. Primary care tends to be dominated by epidemiological approaches to public health (Plews *et al.,* 2000). It has been preoccupied with screening, infection control and attempts to influence individual patient lifestyles (Pearson *et al.,* 2000; Plews *et al.,* 2000). In brief, it continues to focus on the detection, management and avoidance of ill health (Caraher and McNab, 1996; Tinsley and Luck, 1998) as part of an emphasis which has remained on 'treating or preventing diseases by correcting problems in the mechanical functions of the body' (Labonte quoted by Caraher and McNab, 1996:45).

This narrow focus has been shown to manifest itself in a number of ways. For example, general practice has consistently struggled to engage with team working and interorganisational collaboration as part of effective public health working (Glendinning, 1999; Hudson, 1999; Lewis, 1999; Tinsley and Luck, 1998). Primary care nurses have been shown to feel marginalized – a fear which in its worst manifestation has been expressed in terms of a concern that the profession may become 'subordinated to the role of handmaidens' to GPs (Tinsley and Luck, 1998: 357). A concentration on individual patients and practice lists means that the well-being of vulnerable populations such as the homeless - who may be within a practice area yet never register - has been neglected (Caraher and McNab, 1997; Plews *et al.,* 2000). Similarly, the involvement of users and communities in the development of primary care services has, with some notable exceptions (e.g., Scott and Graham, 1995), borne closer relation to policy rhetoric than public health practice (Milewa and Calnan, 2000; Poulton, 1999). It is this narrow medical and task orientated focus that has done much to limit the expansion of public health nursing in the past. Indeed, it is on meeting the challenge of widening this focus that much of the success of the new public health agenda depends.

The new public health agenda

In 1997, the then Labour Government commissioned the Acheson inquiry into inequalities in health. Its remit was to summarize evidence of inequalities in England and identify priority areas for future policy development. The report found that:

> [A]lthough average mortality has fallen over the past 50 years, unacceptable inequalities persist. For many measures of health, inequalities have either remained the same or have widened in recent decades.
>
> (Acheson, 1998:xi)

The report supports socio-economic explanation of health inequalities and describes a need for policies which targeted ethnic and gender inequalities, as well as distinct health needs at different stages of the life cycle, for example, childhood, adolescence, motherhood, working age and older age. This new public health agenda also implies a need for greater partnership between NHS and other agencies to tackle the prime causes of ill health across different population groups. It requires a reorientation of the NHS role to reflect an emphasis on prevention and

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community enablement, rather than simply the treatment and management of disease. It is for these reasons that the Labour government committed itself to 're-activating a dormant duty of the NHS – to promote good health, not just treat people when they are sick' (DoH, 1999b para 1.7). More precisely, it has determined that:

> In the poorest communities the NHS now has a key role to play. By working in partnership with local people, local government and local organisations the NHS can make a huge contribution to narrowing health inequalities.
> (Milburn, 2001).

This key role has been assigned first and foremost to PCTs and the Care Trusts that will follow. It is they who find themselves with a duty of partnership in pursuit of the new integrated public health agenda.

Duty of Partnership

PCTs are challenged with collaborating with other stakeholders to use their local knowledge and experience in shaping priorities and services to improve the health and well-being of their communities in the 'widest sense' (LAC(98)23). This includes assessing the needs of local populations, identifying inequalities in access to services, devising strategies and financial frameworks for achieving local targets and national standards relating to the prevention of ill health, improving health, reducing health inequalities, treating disease and securing improvements in community well-being. In short, it requires that PCTs and their associated partners develop a more inclusive vision of integrated public health care.

This requirement is reinforced through a 'duty of partnership' enshrined in the 1999 Health Act. This directs PCTs and their members to work in collaboration with key local stakeholders to promote the common good (DoH, 1997). Included within this is a requirement that PCTs, strategic health authorities, hospital and mental health Trusts and social services openly share the information required to develop integrated services through common documents such as the Health Improvement Plan (HImP). Together with Joint Investment Plans (JIPs), the ability to pool resources and the opportunity to access a National Performance Fund, this duty reflects an attempt to use the force of central government finances and mandate to secure partnerships for improved public health.

However, mandatory force is insufficient to ensure that partnership working succeeds (Gray, 1985). Commitment, understanding, adequate resources, sharing, appropriate skill mix, role change, flexibility and adequate capacity are also required. It is our contention that nurses are among the professions best placed to meet these requirements in primary care settings. Indeed, these requirements are indicative of those now being demanded of primary care nursing, where new and expanded models of integrated/collaborative public health working are increasingly desired (DoH, 1999; DoH, 1999b).

The role of nursing in primary care public health

Documents such as *Saving Lives* and *Making A Difference* provide some indication of how government sees the reorientation and expansion of public health nursing in its widest sense. For example, health visiting and school nursing are expected to develop modern family and child-centred public health roles that address the effects of poverty and health inequalities (DoH, 1999b). They are seen as ideally placed to tackle issues such as teenage pregnancy, stress, risk taking behaviours, parenting, health promotion and wider community health (DoH, 1999; DoH, 1999b). Indeed, in a recent report published by the House of Commons Health Committee it was stated that:

> Health visitors and other public health nurses seem to us to be the key to delivering public health through the primary care team
> (House of Commons Health Committee Report, 2001).

However, the new public health agenda does not apply just to health visiting and school nursing. *Saving Lives* and *Making A Difference* identify a need to strengthen the public health roles of nurses and midwives more generally. They point to the need for new forms of, and settings for, nurse-led health promotion, advice and education. Yet, a public health approach to nursing suggests more than just a change of location or role – it requires

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an altered ethos. It requires that a focus on the treatment of individuals be combined with a focus on whole communities. It identifies a need to target deprived populations and, in partnership with voluntary agencies and local authorities, the wider environmental determinants of health. The need to focus on population health and health inequalities is not, of course, new to health visitors and other community practitioners (Webster, 2000). However, historically community nursing, health visiting and midwifery have tended to lack the strategic leadership, management support and infrastructure required to address wider public health issues. A new approach to public health nursing in the UK is therefore required in which primary and community based nursing services adopt new or enhanced models of practice for improved local health.

An expanded model of public health nursing

While current government policy points to the significant contribution nurses, midwives and health visitors can make to improving the health of the public, there appears little consensus or strategic vision (beyond initiatives such as Sure Start) on how it will be translated into practice within PCTs and community/primary care services. There is also the risk that new public health nursing posts are being created across the UK with little understanding of what professionals in these posts should be doing or whether they are meeting local public health work force capacity needs.

The literature offers some useful pointers in helping to articulate public health nursing roles, functions and practices in primary care. For example, Carlson and El-Ansari (2000) reviewed a number of public health nursing models. Among those favoured is the Public Health Nursing Intervention approach that exists in the USA. Carlson and El-Ansari describe the model as being population focused, and underpinned by a desire to understand the health status of local communities, especially those at risk. It prioritizes community needs yet is based on a willingness to target interventions at the individual, community or systems level. It is, in a very real sense, a public health role which is closely allied to political action, (Carlson and El-Ansari, 2000) empowering and facilitating communities to work at all levels for the advancement of their own well-being.

In this context public health nursing suggests a type of 'caring activism' wherein the professional acts as an advocate for health and social policy change, while also promoting community participation in the removal of those local factors which suppress efforts to attain healthy and productive lifestyles (Erickson, 1996). Indeed, this model of public health nursing can be seen to accord with the Chief Medical Officer's support for an extension of community development approaches among nurses and midwives as a means of generating health improvement (DoH, 2001). Furthermore, research recently commissioned by the English National Board for Nursing, Midwifery and Health Visiting has acknowledged that key features of public health nursing in the UK should include collective and collaborative action which engages with the social, organizational and policy aspects of health development as well as medical concerns (Pearson *et al.,* 2000).

If nurses in the UK are to emerge as agents for such powerful change they will need to create empowering links with local communities; forge partnerships across agencies in pursuit of action directed toward individuals, families, communities and systems, and; fulfil roles which include coalition builder, advocate, community organiser, policy developer and health care provider (Carlson and El-Ansari, 2000). Indeed, it is perhaps in a role such as 'partnership champion' – identified as crucial to collaboration in other sectors (Browning *et al*., 1995) – that the public health aspect of primary and community care nursing may finally flourish.

A minority of health visitors and other public health practitioners have worked as partnership champions. Yet, self-assessments of the perceived public health skill needs of the existing UK workforce, including nurses, identify a clear need for training and support in effective partnership working (Harvey-Jordan, 2000; NHSP, 2000; HAD, 2001). It is imperative therefore that nurses working in a public health capacity understand the opportunities, costs and processes associated with effective collaboration (DoH, 2001). To achieve this, the interprofessional and interagency aspects of nurses' knowledge, education, training, skills and practice need to be addressed. The remainder of this paper considers both the nature and antecedents of such successful partnership working in relation to public health nursing. This is achieved through description of the cyclical nature of collab-

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orative working; discussion of the of the complexities of joint working using the process of *stakeholder identification* as an illustration; and finally, summation of a guide to the development of partnership working within primary care nursing.

Partnership cycle

Partnership formation is not a single act or event. Rather, it is a process of interaction between individuals and agencies. By way of illustrating this point, it is worth briefly reviewing a model for this process provided by Gray (1985). Gray describes a cyclical process, similar to that found elsewhere (Ring and Van de Ven, 1994), centred on three overlapping phases: *problem-setting*, *direction-setting* and *structuring* (see figure 1). The problem-setting phase involves an identification of relevant stakeholders within an area. As stakeholders interact they engender a growing awareness of their mutual interdependence. With this growing awareness stakeholders also begin to develop a common identity, in addition to a common appreciation of those issues which bind them.

The identification of stakeholders, and the subsequent growth of a common appreciation of those issues which unite partners, is developed further in the second phase of the cycle: direction-setting. Direction setting involves the articulation of individual values and the development of common purpose. At this point mutual hopes, commitments and expectations for the future are developed. The emergence of commonly held values or goals, which are presumed to reflect the pursuit of mutually beneficial ends, should also be discernible.

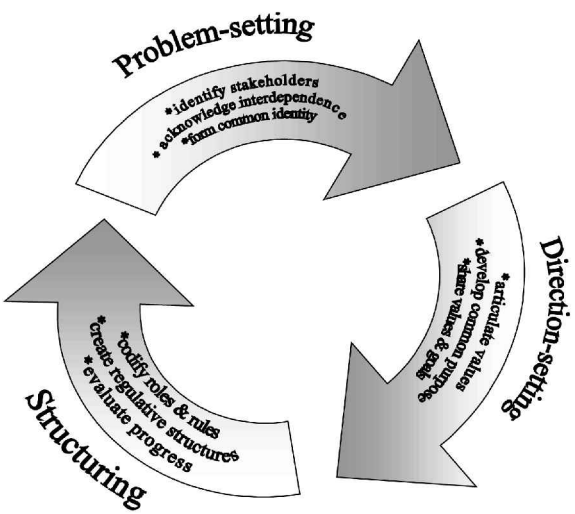

Figure 1 Gray's cyclical process of partnership working.

Structuring, the last stage in the developmental cycle, represents the institutionalization of organizational relationships. Roles, rules and common values begin to be codified and structured to give the domain concrete form. In essence, structuring describes the creation of long term regulative structures 'to support and sustain their [the collaborative partners] collective appreciation and problem-setting activities' (Gray, 1985:917). As such, the potential that existed within an area for collaborative working begins to be recognized and structured. The cycle of interaction then begins again as problems are redefined; direction altered; and structures adapted in the light of stakeholder interaction, external threats or working outcomes. Consequently, the cycle described by Gray is one of continued mutual adjustment. The success of that cycle in areas such as public health is, in turn, dependent on a wide range of factors.

Constituents of partnership success

A wide range of factors has been identified as facilitating partnership working. These include: the incorporation of legitimate stakeholders (Browning *et al.,* 1995; Gray, 1985; Huxham, 1996); commitment to joint enterprise (Browning *et al.,* 1995; Mijis, 1992); geographical proximity (Bond *et al.*, 1985; Gray, 1985; Ovretveit, 1993; Whetten, 1981); adequate resources (Cropper, 1996; Smith, 1988; Whetten, 1981); flexibility to changing needs and environmental turbulence (Sink, 1996; Whetten, 1981); sufficient time for the establishment and maintenance of collaborative relationships (Huxham, 1996; Mijis, 1992; Ovretveit, 1993); stability of personnel (Ring an Van de Ven, 1994); effective intra- and inter-organisational communication for the development of shared cultures and understanding (Bond, 1995; Huxham, 1993; Mijis, 1992; Ovretveit, 1993; Van de Ven and Walker, 1994; Whetten, 1981) and investment in social capital – the ability of people to work together for common purposes in groups and organizations utilising shared norms, values and trust (Browning, 1995; Cropper, 1996; Fukuyama,

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1995; Leathard, 1994; Miller *et al.,* 1995; Ring and Van de Ven, 1994).

The importance of these factors has been observed in a wide range of collaborative settings including community, mental health and acute care (e.g., Ovretveit, 1993; Tausig, 1987; Update, 1998); local government and regional regeneration (e.g., Gray, 1996; Huxham, 1993); industry and commerce (e.g., Browning *et al.,* 1995; Fukuyama, 1995), through studies and reviews undertaken across the USA and Europe (e.g., Oliver, 1990; Ring and Van de Ven, 1994; Whetten, 1981). It should be noted that these lessons are not drawn from, nor provide examples of, effective collaborative working within the newly emerging NHS primary care organizations. To date there has been little rigorous in-depth examination of the collaborative capabilities of these fledgling agencies. Nonetheless, the studies cited offer evidence of effective partnership working taken from public and private organizational contexts that are in their own ways as complex and dynamic as those faced by public health professionals. They provide examples of how to deal with multiple objectives and competing power differentials in the pursuit of a common goal. They identify key components of partnership success, each impinging on different aspects of the collaborative cycle, and central to the development of multiagency partnerships in complex areas such as public health. Yet, each of these concepts also implies a high level of skill and understanding among those charged with organizing and managing interorganisational relationships. A consideration of stakeholder identification – the starting point of most collaborations and a key component of long term success in any sector including public health primary care (Browning *et al.*, 1995; Gray, 1985) will serve to illustrate the point.

Advancing partnership working – the case of stakeholder identification

Identification of legitimate stakeholders is the process through which relevant partners are identified on the basis of their power, their similarity, their expressed interest in the issue under consideration, or mutual recognition of the other's role and function in relation to a given problem (Oliver, 1990; Whetten, 1981). However, the inclusion of all stakeholders is rarely feasible. This is, in part, a logistical issue. The greater the number of organizations involved, the more difficult the reaching of agreement on future action is likely to be and the more unwieldy the management of interactions. Therefore, it is likely that stakeholders will have to be divided into internal (part of the collaborative) and external (interested but outside the collaborative), with such decisions revolving around issues of resource and power possession.

Inherent in this process is the danger that powerful stakeholders may be excluded, and thus seek to thwart the efforts of those who are involved in collaborative action. This exclusion of legitimate players (e.g., GPs, social workers, housing officers) makes them less likely to abide by decisions in which they have played no part (De Jong, 1996; Gray, 1985). They may also seek to thwart the work of the collaborative because they see it as a threat to themselves or their interests. This suggests that there is a need for those who initiate collaboration, such as public health nurses, to manage carefully the process of inclusion.

There is also a need to ensure that relationships within the collaborative are structured to allow some degree of power equalisation (Huxham, 1996). This is because consideration of the relative balance of power among stakeholders in the new collaborative is liable to be a major determinant of future success, as power imbalance within a collaborative will inhibit the participation of weaker players whose valuable contributions could be missed (Gray, 1985), just as the exclusion of powerful players could result in animosity and conflict.

These inclusion and power equalization difficulties are heightened where those who initiate partnerships seek, in line with recent public policy, to move beyond interagency collaboration to include the community at large. Briefly, collaboration at the community level may take two forms: betterment or empowerment. Betterment is described as starting outside communities with public or voluntary agencies (Himmelman, 1996). These agencies design and control change processes upon which the community are consulted. In this traditional top down public health model collaboration is limited to consideration of community advice, with no obligation to be held by its conclusions. On the other hand, empowerment begins with the community who are given the power to set priorities and control resources (Himmelman, 1996). It is aimed at policy change or service improvement and is facilitated by local agencies.

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Within the new models of public health nursing being proposed either of these types of community partnership could be encouraged. Thus, public health nurses and the communities they serve need to clearly agree and articulate whether partnerships working is to be viewed as an overtly political and empowering activity, or in pragmatic terms as a means of improving programme implementation through design consultation and increased ownership at a local level. However, regardless of which approach is adopted, those who champion community–public sector partnerships will have to deal with the complexities which surround issues such as stakeholder identification, inclusion, representativeness and power on an even grander scale. The complexity of facilitating partnerships between different agencies and professionals may in some respects become compounded as public health workers seek to collaborate with those who have very different status, background, power and resources.

The above consideration of stakeholder inclusion at the agency and community level is intended to indicate the inherent complexity of collaborative working for improved public health. Good collaboration, like good management and communication, are not skills inherited as of right and exercised intuitively. Those charged with spanning organizational boundaries and identifying community stakeholders, such as primary care public health nurses, require education, training, support, resources and time. They need permission (from managers and themselves as professionals) to adopt integrated public health working within the context of a move toward targeted and manageable caseloads. They need guidance in terms of how to identify and manage partners, as well as progress their work through each phase of the collaborative cycle. Only then will the NHS and PCTs have succeeded in making a 'huge contribution to narrowing health inequalities' (Milburn, 2001).

A word of caution

Caraher and McNab note that '[p]ublic health at the primary health care level needs to be concerned with broad alliances in tackling the determinants of ill-health' (1994:45). However, acceptance of this statement should not be taken by public health nurses as an indication that partnership working is without either risks or cost.

The securing of mutual, or any benefit, from the collaborative processes described above is not assured. Partnership working is inherently risky and difficult to achieve (Huxham, 1993; Huxham, 1996; Leathard, 1994b). One set of risks falls under the notion of costs that may reveal themselves in terms of the finance, time and other resources required to initiate and maintain relationships between relevant parties. These costs may exceed those experienced in noncollaborative activities (Huxham, 1996b) and are not guaranteed to provide a good return. Costs are incurred despite the fact that the 'potential returns on this [partnership] investment are often unclear or intangible' (Van der Ven & Walker, 1984:601). Indeed, in the short-term, the actual costs of such interaction may exceed any returns.

The resource sharing and degree of linkage involved in partnership working also imply a loss of autonomy for professionals and organizations as they increasingly forgo the freedom to act independently (Huxham, 1996b; Van der Ven & Walker, 1984). Consequently, a second set of risks could be defined as stemming from the potential loss of independence and identity. To this could be added a third group of risks stemming from differences in professional and organizational cultures, and a fourth from the logistical complexities of co-ordinating action. In short, those seeking to advance partnership working in the pursuit of improved public health will have to cope with difficulties stemming from 'differences in aims, language, procedures, culture and perceived power; from the tensions between autonomy and accountability and the lack of authority structures; and from the time needed to manage the logistics' (Huxham, 1996b:4).

Yet despite the potential risks, collaboration is believed to be required within public health because issues such as poverty, urban or rural deprivation, and inequalities in treatment and outcome are all 'meta-issues'. They are problems that span yet go beyond the concerns and influence of any one agency. They represent indivisible problems that are larger than the capacity of any one discipline, organization or sector to solve alone (Browning *et al.,* 1995; Finn, 1996; Gray, 1985; Huxham, 1996b). As a consequence, they require a reciprocal approach to joint working wherein agencies recognize their interdependence and seek

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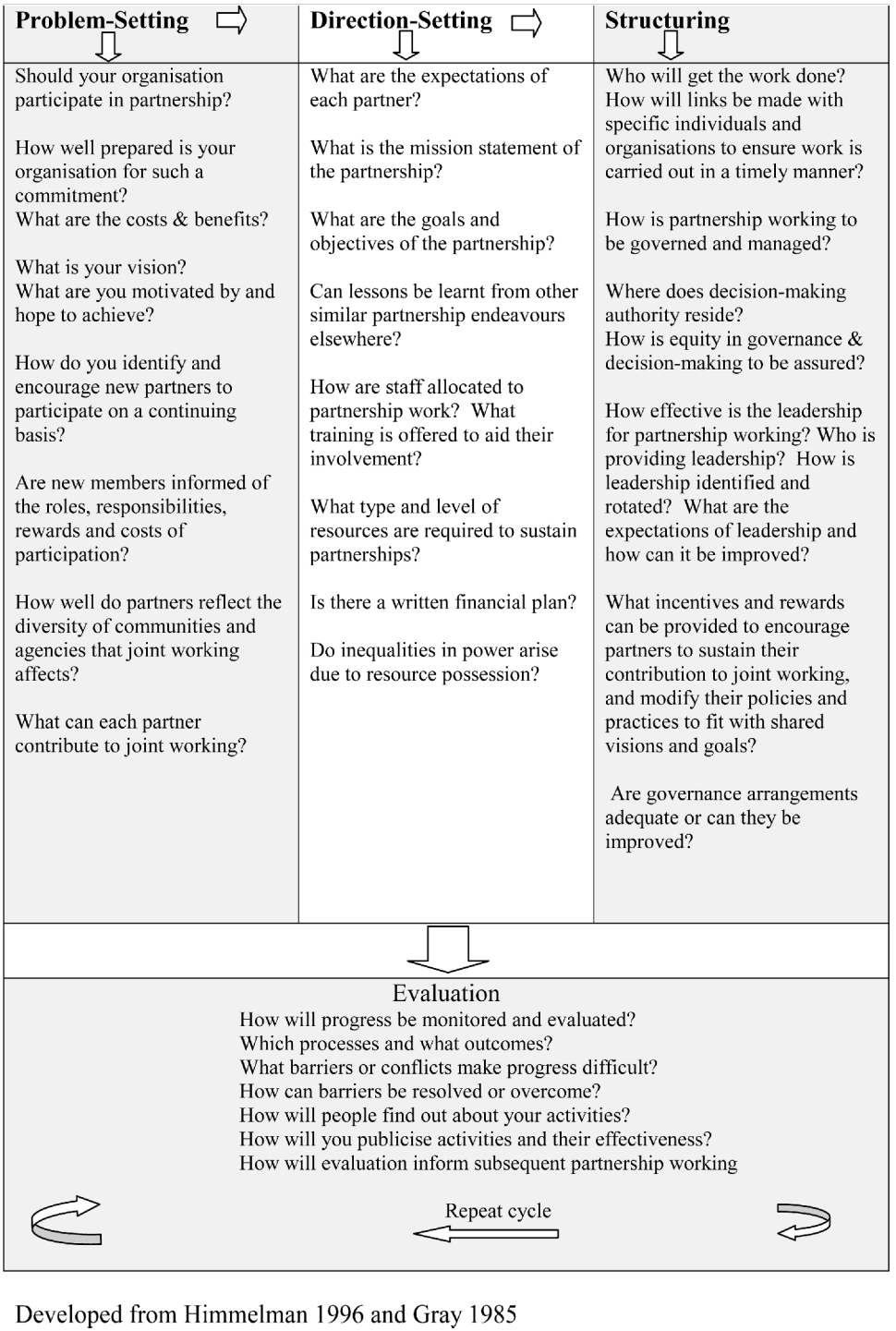

Developed from Himmelman 1996 and Gray 1985

Figure 2 User-friendly guide to partnership processes.

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to take advantage of each other's resources and provide mutual support.

Even so, collaborative action between different professionals from different sectors presents extraordinary challenges to those, such as primary care based nurses, who may seek to champion them (Sink, 1996). To stand any chance of success public health nurses must understand the processes through which interagency collaborations are likely to progress and prosper. To this end, Himmelman offers a user-friendly guide to the collaborative process. Figure 2, presents the steps toward partnership described by Himmelman, but situates them within the phases of collaboration described by Gray (1985).

The guide is based on many of those key constituents of partnership success identified earlier (e.g., stakeholder identification, agreement on aims and adequate resources). As such, it provides a template from which nurses and other primary and community based professionals may begin to organize their thoughts and actions in relation to building partnerships for public health. More importantly, the guide points to the inherent complexity of partnership formation, and indicates the need for a considerable commitment of time and resources at practice, planning and policy levels if integrated public health work is to become a reality for individual patients and entire communities.

Conclusion

Primary and community health care nurses are well placed to adopt roles such as partnership advocate, co-ordinator, facilitator or champion in the pursuit of improved public health. They have the ability to work with and move beyond the traditional strengths and limitations of the 'bio-medical' model. They have been identified by commentators, select committees and government as ideally placed to spearhead the development of population approaches to public health within the primary care team. However, unless they are provided with the knowledge and skills required to build collaborative alliances internally with GPs, other health professionals and patients; externally with agencies such as social services, universities, housing authorities and voluntary agencies; and with the community itself through betterment or empowerment approaches, their ability to contribute to wider partnerships for improved public health is liable to be severely limited.

If public health partnerships are to be advanced, those charged with delivering multiprofessional and multiagency collaboration will require extensive education, training, support, resources and time if they are to develop the co-ordination required to meet the meta-issues presented by the new public health agenda. They require more and better quality evidence of what works. There needs to be recognition among practitioners, managers, planners and policy makers that the success of partnership working is not guaranteed. However, in reviewing, synthesising and disseminating the good sources of knowledge that already exist in relation to partnership working we may increase the possibility that those such as public health nurses may champion and deliver collaborative working with an ever improved degree of success.

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