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Interorganisational partnership arrangements: A new model for nursing and midwifery education

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SUMMARY

Introduction: This paper describes a framework to facilitate collaboration between hospitals and third level universities and colleges in Ireland. The move to higher education for nurses and midwives in Europe heralded the development of partnership between organisations that provide nursing education. There is an increased risk of exacerbation of the 'theory–practice gap' phenomenon. Hence the need for greater unity between education and practice is paramount.
Methods: The study included five organisations involved in nursing and midwifery education. An action research case study approach was used. This paper reports on the cooperative inquiry element of the study.
Results: Seven key elements of a framework for interorganisatinal partnership emerged; Context, Environment, Inputs, Processes, Skills, Outcomes, Role of Coordinator. The framework was found to have a key role to integrating nursing education.
Discussion: Leading and managing nursing education for the future requires support from clinical and academic partners. These knowledge domains need to move forward together to ensure success.
Conclusions: Responsibility for leading and managing nursing education requires a framework to engage the support of the clinical and academic partners. Implementation of partnership frameworks is critical to ensuring responsiveness of nursing and midwifery education to students' learning and patient care.

Background

There is much variation in the nursing education pathways within the EU (Zabalegui et al., 2006) with no uniform approach to the education of nurses (Wells and Norman, 2009). Ireland has fully adopted degree entry to the profession and the UK is set to follow. France and Germany continue with the hospital based non degree system and Hungry has taken a more vocational college approach (Jackson et al., 2009), and the new European Union countries have adopted the traditional hospital-based apprenticeship model with medical staff acting as clinical teachers for both medical and nursing students (Kalnins et al., 2001; Saarikoski et al., 2007). However most countries that have undertaken reform, have combined hospital based clinical practice with higher education. Implementing these reforms across Western Europe was concordant (Spitzer and Perrenoud, 2006b) and upgrading nursing education into higher scholarly levels has taken place in most countries (Zabalegui et al., 2006).

In Ireland, as elsewhere in Europe, there were no major structural changes and few additional resources provided to support these new developments. It was not surprising therefore that nurse lecturers involved in the transition felt isolated, insecure, underconfident and without role clarity (Dempsey, 2007). The transition to third level education lacked leadership and an implementation strategy on ways to harmonise developments, and the current multitude of preregistration programmes across Europe is indicative of the difficulties in linking nursing programmes to higher education. Issues in relation to responsibility, governance, accountability and integration were largely ignored. While The European Commission (2007) demands the Bologna agreement integrative development in all fields of education, the current lack of a formal collaborative working framework increases the risk of practical knowledge becoming delegitimised in the ensuing relationship particularly, if the universities draw their cultural authority from the institutional separation from the immediate motives of practical life (Winter, 1998). In this context, academia would do well to remember that it is not self serving and must relate meaningfully to the services of its discipline (Bishop, 2009).

Implementation of the Bologna agreement has impacted on education in Europe (Davies, 2008) and efforts have been directed towards the adoption of the European Credit Transfer and Accumulation System with emphasis on evaluating European nurse education (Marrow, 2009). Although combining theoretical and practical learning and developing strategies to ensure the competency of nurses is crucial (Talyor et al., 2010), without a strategic partnership framework efforts are as likely to fail as to succeed, as implementing and managing a partnership relationship is harder than deciding to collaborate. Bespoke partnership frameworks can incorporate mechanisms for responsibility,

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accountability and governance while also ensuring that education is current, responsive and meeting the needs of students' and positively impacting on patient health and safety.

Literature

Partnership frameworks and nursing and midwifery

The concept of partnership is popular because it "evinces a warm glow…it emphasises mutual self help…shared information, shared evaluation, shared decision-making and shared responsibilities" (Coulter, 1999 p. 719). The term relates to a wide variety of contexts such as teacher–student relationships (Paterson, 1998); professional nursing practice relationships (Keatinge et al., 2002; Brown et al., 2006; Salminen et al., 2010); professional medical relationships (Cribb, 2000); implementation of clinical supervision (Spence et al., 2002); a symbiotic business relationship (Hauenstein and Grupe, 1994); an interorganisational relationship (Kernaghan, 1993) and a strategy for change and improvement (Health Services National Partnership Forum (HSNPF), 2003). Successful partnerships are non-hierarchical and the partners share decision-making and common ownership of the resolution of challenges (Coulter, 1999; Department of Health and Children, 2001; HSNPF, 2003). Nevertheless, there is agreement in the literature that partnership is a relationship (Gallant et al., 2002), involves commitment to improvement, efficiency and consideration of employers' rights in the context of major decisions (HSNPF, 2003).

In 1977, European Directives enabled licensure reciprocity to facilitate work migration of nurses across Europe. Further reforms in the 1990s focused on promoting the status of the nursing profession, enriching the clinical settings with highly qualified nurses and elaborating the scientific knowledge base of the discipline (Spitzer and Perrenoud, 2006a). These reforms heralded the integration of nursing programmes within higher education institutions and the predominant approach for these changes was the "big bang approach" (Spitzer and Perrenoud, 2006a p.167). However, the current multitude of pre-registration programmes is testimony of difficulties in linking nursing programmes to higher educational institutes (Spitzer and Perrenoud, 2006b).

The preferred model for implementation and continued governance of nursing education is ostensibly that of partnership; yet there is no visible framework in use. Anecdotal evidence suggests these partnerships are not functioning well (Casey, 2008) and are fraught with difficulty due in part to unclear roles, internal power struggles and few internal regulatory mechanisms. They struggle to move beyond their immediate organisational context and constraints into the realm of interorganisational partnership. To add further complexity, the advancement of nursing practice is progressively redefining the parameters for practice between nursing, medicine and other professions on the health care team and consultation, communication and collaboration are required to ensure successful implementation of the advanced practitioner role (Dunn, 1998; Della, 2004). Most research to date has viewed partnerships in their formative stages and has not followed the process through its life cycle. Moreover, this diverse literature mostly deals with examples from the business sector and the focus is on lateral or horizontal patterns of exchange, interdependent flows of resources and reciprocal lines of communication, which offers little by way of understanding the particular issues inherent in partnership between academic and health care institutions.

Methods

Aim of this study

The purpose of this study was to support and inquire into a partnership to find solutions to issues as they arose. This learning could then be transferred into the development of a framework for partnership between the organisations that provide nursing and midwifery education.

Research approach

The study spanned a 9 year period and an insider action research case study design (Coghlan and Casey, 2001) was successfully deployed. There were four phases: archival, grounded theory, clinical inquiry and cooperative inquiry. This paper reports on the cooperative inquiry phase which is a form of action research concerned with revisioning understanding of the participants' world, as well as transforming it (Reason and Heron, 1999). Action research incorporates fact-finding, planning, execution, and evaluation. It is a cyclical process of collaboration and mutual dependence between the researcher and the participants, finding a solution(s) to practical problems, development of theory and proceeding systematically through the spirals of planning, acting, observing and reflecting (Coghlan and Brannick, 2010). Action research involves observation, elicitation and reporting of data to help manage change or solve problems (Waterman et al., 2001) and must involve those responsible for practice in all of the activities (Sanford, 1970; Grundy, 1982; Holter and Schwartz-Barcott, 1993). Cooperative inquiry is "a form of participative, person-centred inquiry which does research with people not on them or about them" (Heron, 1996 p.19).

Participants and procedure

Five organisations participated in the study and ethical approval was obtained on the basis of a research proposal, from the Local Ethics Research Board of each of the hospitals and the third level college of education. Informed consent to participate in the cooperative inquiry groups was obtained on the basis of full disclosure of the purpose and aims of the study to each participant with particular emphasis on maintenance of confidentiality. The participants included four hospital tutors from nursing and midwifery education and two senior nurse and midwifery managers and three representatives from the third level college which included the researcher. As informed consent in action research is a negotiated process, each participant was asked to reconfirm agreement to participate at the beginning of each cooperative inquiry meeting. The length of the cooperative inquiry meetings was 3–4 h and 13 cooperative inquiry meetings were held.

Data collection

Data collection was achieved by engaging, as a collective group involved in the experience of partnership, to research the partnership using action research cycles of planning, taking action, evaluating the action leading to further action. This resulted in narrative accounts of the partnership and critical reflection at each stage of the action cycles was a central feature of the design.

Data analysis and making sense of the data

As "the starting point for meaning-making is typically the stories of experiences of the participants" (Bray et al., 2000 p. 93), the cooperative inquiry meetings provide a forum for reflection-on-action and therefore provide the basis for both individual and collective learning. The narrative accounts were audio taped, transcribed verbatim and thematically analysed using reflective action research cycles.

Results

Components of a conceptual framework for partnership

Seven key concepts relating to issues to do with the 'context', 'environment', 'inputs', 'processes', 'skills' 'outcomes' and the 'role of coordinator' emerged as cornerstones of a framework. To highlight the

relationship between these seven components, a model for partnership for nursing and midwifery education is presented in Fig. 1. Global summaries are used explain the nature of each of these seven components and cumulative exemplars, as derived from the results of the final phase of the study (the cooperative inquiry phase of 13 meetings over a year), are provided as supportive evidence in table format for ease of presentation.

Context as a core concept of a framework of partnership

Context refers to the purpose of the partnership and contextual analysis indicated the partnership is influenced by time and changing circumstances. Context can include multiple contexts depending on the partnership circumstances and stage of development. An example of the narrative content of context of the partnership framework is provided in Table 1.

Environment as a core concept of a framework of partnership

This takes cognisance of the immediate influences on the partnership and were divided these into internal which relates to the interactions between the curriculum and steering groups. External factors relate to outside influences such as the number of organisations or national registration changes. The environment is interactive with other components of the framework. Table 2 indicates an example of the content of the construct environment based on the data.

Input as a core concept of a framework of partnership

Inputs refer to resources such as structural, financial and human and include developing procedures for dealing with conflict and monitoring progress. Inputs also relate to the formulation of an implementation strategy to assist measurement of the partnership progress. Thematic content which contributed to this concept are identified in Table 3.

Processes as a core concept of a framework of partnership

This refers to such activities as decision-making, planning, and managing conflict. This element provides a link between the internal and external environment. Examples of the narrative content of this concept are provided in Table 4.

Skills as a core concept of a framework of partnership

Skills are essential to translate the knowledge of partnership into action through the application of a framework. Skills enable collaborative interaction between the partners and application of skills requires the use of power to make change happen. Elements which contributed to this concept are identified in Table 5.

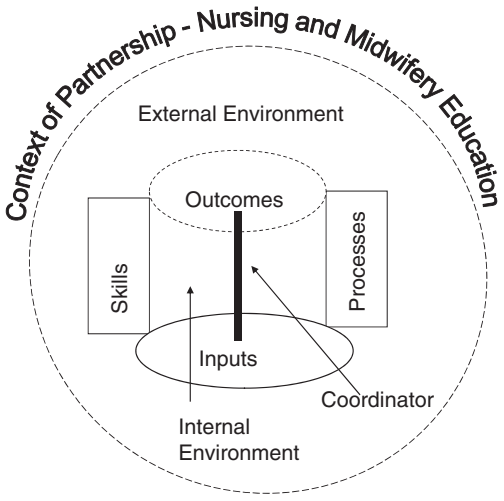

Fig. 1. A new model for nursing and midwifery education (Casey, 2006).

Table 1
Example of items which suggests context is central to framework.

National changes to the registration examinations and standards for programmes heralded the need to work closer to ensure that the standards were maintained. In the beginning, more effort was made by the third level institute to get on with the hospitals, then, as the level of expertise grew in the third level institute, less effort was made and the partnership became stunted.

Outcomes as a core concept of a framework of partnership

This refers to the various interactions or non interactions which result from being involved in a partnership. Outcomes can be attributed to the synergic action of input, skills and processes. Outcomes can be planned and unplanned and provide the evidence of success /failure of the partnership process and can provide a source of evaluation. It is important to agree to shared goals prior to committing to partnership. Table 6 indicates thematic content which contributed to this concept.

The role of the coordinator a core concept of a framework of partnership

The role of coordinator was in addition to the role of lecturer. Maintaining contact with the students and the teaching staff was a key part of this role. Building strategic alliances in one's own organisations is vital to success. Table 7 provides an indication of the content of this element.

Discussion

Moss-Kanter (1994) suggests that productive partnerships involve strategic, tactical, operational, interpersonal and cultural integration. This study appears to support this, for example in relation to the strategic element, there was regular planned contact between the partners in relation to securing third level accreditation. From a tactical aspect, the involvement of the other staff in each of the organisations was not a planned activity in the beginning. The third level educational organisation resourced operational integration by choice, which became seen as a way of controlling the partnership. On the interpersonal and cultural aspect, the partners openly expressed that they had a good working relationship with each other on a personal level and as they shared a similar type of apprenticeship training there was some cultural integration. However, both the tutors and newly appointed coordinators had little understanding on how the third level colleges or centres of education functioned. Gillies (1998) suggests that effective planning such as undertaking a needs assessment, setting up various committees to cross professional and lay boundaries to guide, steer and implement the partnership activities provides the foundation for effective partnership development. In the current context, there was a deficit in planning at strategic and operational levels.

Partnership arrangements linking hospitals to third level institutes and centres of third level education hold the key to the future of nursing and midwifery education in Ireland (Government of Ireland, 1998); however, there is an absence of bespoke frameworks for nursing education. Spekman et al. (1998) developed a seven-stage life cycle model of an alliance consisting of stages of anticipating, engaging, valuing, coordinating, investing, stabilising and decision-making. This is similar to Ring and Van De Ven's (1994) negotiation stage of cooperative interorganisational relationships which involves identification of shared goals and expectations and discussions about uncertainties and involves bargaining activities. The developmental nature of the relationship is also emphasized by Good (2001) and Ring and Van De Ven (1994). The

Table 2
Example of items which suggests environment is central to the framework.

Additional appointments by the third level institute to the curriculum group appeared as further bureaucracy. Developing good working relationships with the medical staff ensured support for programme changes. Gaining political support helps sustain the partnership and assists policy development and implementation.

Table 3
Example of items which suggests input is central to the framework.

Partnership requires stability of membership and trust. Recognising the key players and valuing their expertise and opinions is important and promotes a good working relationship. Job descriptions and specific induction programmes for all programme coordinators are necessary prior to implementing partnership. The content and context of the partnership is important. Partnership incorporates roles, ownership and credibility.

current framework supports this dynamic nature of partnership which can be uniquely modified through the role of coordinator.

Weiner et al. (2000) suggest the partnership development process is related to the willingness and capability of the individual partners to promote shared decision-making activities and collective responsibility for outcomes. This relates to the commitment stage identified by Ring and Van De Ven (1994) where the partners agree on rules for action. The participants in the current study indicated that the partnership was a forced relationship without regard given to the time needed for development of a relationship. There were also frequent changes in personnel which had a disruptive effect and therefore participation in decision-making activities was compromised. This relates to the emergence stage of the life cycle model (Weiner et al., 2000) which emphasises that getting to know the partners and clarifying interests and expectations provides the basis for building initial working relationships. Courtney et al. (1996) also support this viewpoint and Spekman et al. (1998) describe a valuing stage in their model which enables the partners to bring their skills and resources to the alliance and to negotiate the terms and conditions of the alliance. These authors suggest the alliance then moves to a coordinating phase where the work gets done and partnership structures become more fixed. This relates to the execution stage described by Ring and Van De Ven's (1994) where action takes place through a series of role interactions and the interpersonal aspect of the relationship may become more supportive than relying on role function.

Good (2001) suggests that a framework should include a shared vision and principles such as interdependence, recognition and respect for the autonomy and self-governance of the partners, recognition of the distinct role played by the partners, dialogue, collaboration and public accountability are required to guide the actions of the partners (Good, 2001). He also suggests a framework agreement must include the legitimate differences between the partners and emphasises that process issues are more important than the content of the agreement. Kernaghan (1993) suggests that the more formalised a partnership is, the more likely it is to be maintained. In the current study there was no framework.

Spekman et al. (1998) suggests the role of the manager within the alliance in the investing stage is viewed as a facilitator and in the current study, the coordinator was required to act as facilitator of change, however this did not materialise in any consistent manner due to issues such as role confusion and the frequent changes in personnel. Partnership maturity develops as the partners form a tighter bond and institutionalise the benefits of collaboration (Weiner et al., 2000), this corresponds with Spekman et al.'s (1998) decision-making stage where the alliance is evaluated in terms of future directions and plans. This maturity stage was not an obvious development in the current study. The frequent changes in coordinators and key personnel also accounts for some hindrance to partnership maturity.

Table 4
Example of items which suggests processes are central to the framework.

Not circulating minutes/agenda at meeting prevents proactive planning. Partnership is unequal because some (the tutors) had more experience than others (the lecturers) in teaching and in the clinical area but this did not appear to be valued. Equality also related to the organisation with the power to make the educational award and collect fees. Decision-making impeded by status and position of the partnership representative.

Table 5
Example of item which suggests skills are central to the framework.

The partnership coordinator requires solid interpersonal and social skills to facilitate a good working relationship. Use of power and effective social skills are important to make change happen. Partnership involves leading the change and managing relationships with external bodies and managing politics.

Weiner et al. (2000) critical crossroads stage of the partnership development cycle relates to struggles between autonomy and authority and participants are required to balance the pressure between maintaining organisational independence and the interorganisational interdependence of the partnership. This stage has some similarity to Spekman et al.'s (1998) decision-making stage about engaging in evaluation to determine future directions. There was evidence of a critical crossroads stage in the current study, particularly in relation to the expressed need of the participants to remain independent and to maintain the reputation of their own teaching hospitals.

The framework by the Institute of Public Health (IPA) (2001) reveals some similarities to the current study, however, there is no designated coordinator and it suggests that reshuffling the members keeps the partnership invigorated and prevents people becoming entrenched. The IPA (2001) highlighted research and evaluation which were not distinct elements in the current study. However the need for evaluation was highlighted in relation to the purpose of the partnership, evaluating the new system of education and measuring outcomes in terms of competent practitioners.

Conclusion

Little research has been undertaken in relation to frameworks for the provision of nursing and midwifery education. While there is an absence of evidence of the benefits of partnership arrangements, this is not to say that there is evidence of framework absence in use as most likely there was some mental model guiding the relationship. Nevertheless, the absence of an appropriate framework for nursing and midwifery education is further compounded by the fact that most research has viewed partnership in its formative stages and has not followed the process through its life cycle. As a result, there is a paucity of literature on how the relationship between the partners can be managed and implemented which limits comprehension of the extent of participation, consultation and shared decision-making required for successful partnership.

Without framework and a coordinator, there is a risk of return to 'education for service' and the higher education institutes becoming more removed from practice and less able to respond to change. It is difficult therefore for leaders in nursing and midwifery to develop and implement successful partnerships or to employ evidenced based management practice to guide the partnership process. The challenge therefore is on how to maintain a perspective that combines both the lofty goals of strategy formulation of partnership development for the future of nursing education and the minutiae associated with day-to-day operational activity and managing that partnership. A bespoke framework for partnership, such as this current model, provides a suitable and applicable theoretical framework. Further research to test this framework is necessary to meet the challenges posed in these new

Table 6
Example of item which suggests outcomes is central to the framework.

Development of a new educational programme and competent safe practitioners were two outcomes. Resolving the dual examination system for registration and academic award were crucial outcomes. Development of progress indicators such as student pass/failure rates. The reputation of organisation is important to successful partnership and the reputation of hospitals gives status and a sense of superiority.

Table 7
Example of item which suggests the role of coordinator is central to the framework.

Role of coordinator to liaise between the organisations. Clinical credibility gives status to the coordinator. Management, negotiation and diplomatic skills are more important for coordinator than knowledge of the discipline. Role of coordinator to facilitate the tutors to develop educational content based on their area of expertise. The role of coordinator is to enable others to contribute to the partnership development.

collaborative interorganisational relationships between organisations that provide nursing and midwifery education.

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