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 interorganisational 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.

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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 (Taloyer 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,
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); imple-
mentation of clinical supervision (Spence et al., 2002); a symbiotic
business relationship (Hauenstein and Grupe, 1994); an interorganisa-
tional 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 profes-
sions 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,
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 reflexive 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.

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 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.
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.

**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 minuteness 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

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**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. |

**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. |

**Table 6**

Example of item which suggests outcomes are 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. |
collaborative interorganisational relationships between organisations that provide nursing and midwifery education.

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References


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 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.

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