Working in Partnership.

By Professor Steve Campbell. Head, School of Health, University of New England

Given that this journal was born of partnership and epitomises the same, I thought that I would take this as my theme. I have long been a big believer in partnership working, indeed there have been times when I have been embarrassed by being credited as the lead in a partnership project when outcomes could not have been achieved without the work of so many others. Since my recent arrival in Australia my belief in the value of partnerships has been further enhanced by the clear need within health services and social care to get serious about forming collaborative partnerships with the aim of providing the highest quality care and support.

I have been impressed by the way in which Hunter New England Health has worked to form partnerships across New South Wales and Australia and particularly in the formation of the Nursing and Midwifery Leadership Council, a high level collaborative group with members from HNEH, TAFE, the University of Newcastle and the University of New England. There is now the need to build on this partnership as a beacon to narrow the separation between higher education and health services and social care still further. Other countries have similar operating models to Australia, but the separation is made less by having formal partnership structures that deliver good patient, clinician and student outcomes.

My first example of the potential of close partnerships is joint accountability for ensuring that student nurses are fit for purpose and can be registered. Here I see the three institutions, the universities, health services, and the new national registration board, as needing to have proper partnership arrangements. This should involve a stronger input from health services, who provide the clinical environment for student practise and the services of clinical staff to support, supervise and assess the competence of students during their clinical placements. This involvement should go beyond course advisory committees and empower the health services to participate more overtly in developing the competence of nurses, and the range of skills expected of new graduate nurses. If health services were to develop a list or “Pen Portrait” of the new graduate, this could then be debated with the universities in relation to such influences as the recent recommendations of the Garling Report. The role of the new national registration board must include the two broad functions of facilitation and governance, being roughly translated as support and protection. The current state and territory boards rightly have a role in public protection, but need to be increasingly facilitative to respond to the rapidly changing health care context.

My second example of the need for collaborative partnerships involves research and related teaching. Health service practitioners and managers have a glut of health care questions that need answers, but are resource poor to solve them. The inverse is the case for academics. They are not exposed on a daily basis to the health issues requiring examination, but have the research and analytical expertise to explore them. It is clear that academics can solve problems for practitioners and managers, but there is a need for a process that facilitates closer research partnerships. To allow this to happen a clear framework for research partnerships, including funding streams, needs to be developed to ensure that research projects and their outcomes are timely and relevant and avoid expectations being unfulfilled. The funding of such processes is crucial, thereby releasing clinical and academic staff, who are already working to their full capacity, to be able to become proper partners in these endeavours.

Partnership cannot go ahead without a shared vision. This is obvious in the current health care climate. It is about working together to improve the quality of health care provided to patients and their families or carers.