Effective interagency and interprofessional working: facilitators and barriers

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Abstract

In the UK the provision of palliative care is not the sole responsibility of the National Health Service (NHS); there is an overlap with continuing care, which falls within the remit of local authority social services departments. In addition, hospice and palliative care services are often considerably dependent on charities. Interagency and interdisciplinary working are, therefore, central to the successful delivery of palliative care. A multiple (four case) case study design was used to explore the provision of palliative and continuing care. The analysis identified the antecedents, structures and processes involved in the delivery of interprofessional working, along with the consequences of these in either a good model or one where problems were likely to prevail. Individual activities, roles and specific service configurations seemed far less significant than the overall culture, stability and long-term commitment to a service in a given area. Time is required for new service configurations to stabilize so that staff are able to overcome barriers and develop the necessary facilitators for quality care provision.

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The importance of palliative care in the UK is recognized and promoted in government policy such as *The Cancer Plan* (Department of Health (DoH), 2000a) and the new national service frameworks concerning heart disease and older people (DoH, 2001a,b). The current delivery of palliative care comes from several professionals working in a range of statutory and non-statutory organizations. Because of this diversity of services it is inevitable that the quality and adequacy of care delivered will depend on the extent to which the various professionals and agencies are able or willing to interact (Bliss et al, 2000).

Palliative care has been defined by the World Health Organization (WHO) as:

> **'the active total care of patients and their families by a multiprofessional team where the patient's disease is no longer responsive to curative treatment'**
> **(WHO Expert Committee, 1990)**

Despite this internationally-accepted definition, research has demonstrated that not all those involved in providing palliative care share a common interpretation of the term (Newall and Matthew, 1997). This apparent lack of a common language – a key antecedent for collaboration (Caldock, 1994) – is compounded by a lack of clarity regarding the role of different professionals. Research with district nurses and social workers has identified confusion regarding the contribution each could make to palliative care (Newall and Matthew, 1997; Bliss, 1998).

The National Health Service (NHS) is not solely responsible for the provision of palliative and continuing care; providing such care is the also the responsibility of local authority social services departments and should be negotiated to meet local need (DoH, 1995). Hospice and palliative care services have been considerably dependent on charities (DoH, 2000a) with 75% of inpatient hospices funded by non-statutory provision (Jackson and Eve, 1999). As a result of the involvement of multiple agencies, interagency working plays an important role in effective palliative care. Professionals cannot work independently to meet individuals' needs but must work within organizational policies and legislation as well as professional codes of practice. This may add to the challenge of providing quality care for individuals and their families (Bliss et al, 2000).

This article describes a study carried out in the London region between 1998 and 2000 to identify good models of shared care. Multiple sources of data were collected, including a series of semi-structured interviews, in which the opinions of the many stakeholders involved were acknowledged and the barriers and facilitators to quality care were identified.

Study design

Following Yin's (1994) approach to case study, we used an evaluative model developed by Cowley et al (2000) to guide us in

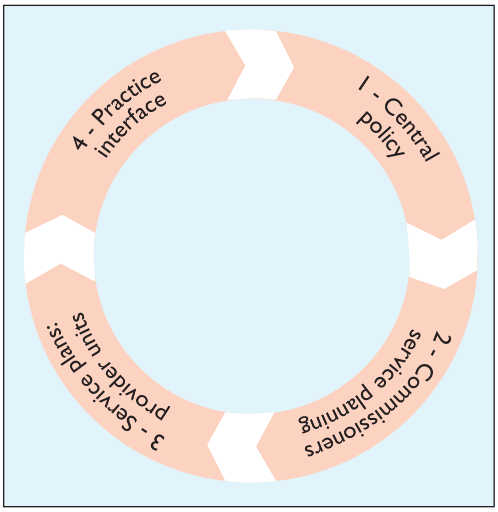

Figure 1. Service planning and delivery cycle.

our data collection and analysis (*Figure 1*). The model considers four levels of service provision:

- It assumes that plans are made in a policy-setting arena such as in central government or other significant authority (1)
- These plans are transmitted to commissioners – the agencies charged with turning these abstract 'ideals' into concrete service level agreements (2)
- The service level agreements are set between the commissioners and senior managers or persons in authority within the units that will provide the services (3)
- Services are then supposed to be delivered at the 'practice interface' (4), which is where the plans turn into practical action, hopefully still encapsulating the positive intentions planned at the policy-setting stage.

The cycle is only complete when some feedback occurs from the practice interface to the policy-makers.

Approval was obtained from the local research ethics committee to set up four case sites. These were neither geographically discrete nor specific to one service or sector. Instead the cases were constructed to emulate the experience of palliative care that would be encountered by a person in need of it, who had somehow obtained services through one of three known routes of access: primary care, social services or specialist palliative care. Each case included a specialist palliative care service, social services and primary care providers along with the major health commissioners for the area. Each site provided different service configurations, including different combinations of:

- Two health authorities (responsible for planning and commissioning palliative care)
- Four local authorities (responsible for planning, commissioning and delivering palliative care)
- Two NHS community trusts (responsible for employing/delivering district nursing services; one was additionally responsible for a specialist palliative care service)
- Four dedicated/specialist palliative care services, each with different funding, accountability and service links.

An initial analysis of 52 central government policy documents and expert reports was carried out to identify expectations

Box 1. Facilitators and barriers to interprofessional working

Facilitators

- Good communication network between service providers, patient and family, which requires good administrative support and up-to-date equipment
- Having a 'keyworker' to facilitate continuity of care
- Using a 'nurse coordinator' within specialist teams to reduce fragmentation
- Specific mechanisms need to be in place to get the kind of close coordination between primary health care, specialist team, secondary and tertiary care, voluntary agencies and social services that creates a 'seamless' service
- Multidisciplinary teams working to protocols can help deliver seamless services

(NHS Executive, 1996; 1997a,b,c; 1998a,b)

Barriers

- Lack of an effective relationship between health and social services contribute to less effective services (DoH, 1998)
- High numbers of local service providers in different service configurations also inhibit joint working (National Council for Hospice and Specialist Palliative Care Services (NCHSPCS), 1997)
- The separation of the purchasing and providing role creates a situation where the voluntary organizations and health trusts are in competition with each other to provide services, which creates a disincentive for joint working (NCHSPCS, 1997)
- Health authorities not taking a lead in needs assessment and the production of a strategy for palliative care services can lead to uncoordinated service development (NCHSPCS, 1997)
- Lack of a comprehensive representative forum at commissioning level for multiple agencies to communicate with

Source: Cowley et al (2001)

and known barriers and facilitators to joint working. This analysis is reported in full elsewhere (Cowley et al, 2001), but aspects relevant to this article are summarized in *Box 1*.

Multiple sources of data were sought from each case study to reflect the four levels of service provision. Organizational arrangements and terminology for the different levels of the service planning and delivery cycle (*Figure 1*) varied within and across the three sectors (social services, specialist palliative care services and primary care), but individuals in roughly equivalent positions were sought for interview. Also, one caseload holder in each of the three sectors was asked to identify two patients/service users with palliative care needs, who could be approached to participate. Each named patient was asked to identify his/her main carer and key worker, who were also to be interviewed where available. Some caseload holders held a ‘dual role’ as both keyworker and caseload holder. The interviews were loosely structured, ranging from 10 minutes to 2 hours; they focused on the process of planning, delivery or receipt of services, along with perceptions of palliative care and joint working.

Table 1 summarizes the anticipated interviews and the varied success in recruiting and completing them in each of the four case studies. Other data included field notes, diary sheets and local policy documents or reports relevant to one case site only. The interviews were all transcribed and coded in the individual case studies using NUD*IST software. Yin (1994) warned that pattern matching is not a precise art, but it was sufficient to yield a description, as planned, of a ‘good model’ of shared palliative care from the viewpoint of patients, carers, health and social care agency practitioners, their managers and purchasers. Finally, barriers and facilitators to implementing this kind of model were identified through analytical replication and pattern-matching within and between the cases.

Findings

None of the four case studies was free of difficulties and some adverse comments. Encouragingly, Case 1 featured many positive aspects that indicated a good model of shared care.

Of the four, Case 1 was the most complete in terms of data collection, which may be significant in itself; the difficulties in accessing some forms of data from the other three case studies may have mirrored difficulties that patients, clients and carers could encounter in seeking suitable palliative care when they needed it.

Good palliative care

Antecedents

In Case 1 the palliative care services were coordinated within a large local health centre. General practitioners (GPs) and other primary care practitioners such as district nurses were based there, with a pharmacy service adjacent to the building. This was considered extremely beneficial:

> **‘There is also the advantage of working in the same building as the nurses. So there is lots of informal contact and none of us are averse to picking up the phone and speaking to anyone else if we need to.’**
> (*GP/Keyworker 2, Case 2*)

The health centre was geographically close to the base used by the local social services area team. The main voluntary

Table 1. Interviews planned and undertaken

		Interviews undertaken			
Interviews planned		**Case 1**	**Case 2**	**Case 3**	**Case 4**
Commissioners (local authority and health authority) (2)		2[*]	2[§]	2[*§]	1[*]
Provider service managers and team leaders (3–6)		3	6	3	3
Practitioners:	Caseload holders in primary health care team, social services and palliative care teams (3)	3	3	3	3
	Key workers (up to 6, where identified)	6	3	3	5
Patients/clients (6)		6	4	3	5
Main carers (up to 6, where identified)		3	0	2	2

[*] One health authority commissioner, responsible for Cases 1, 3 and 4, was interviewed once but appears in each case

[§] One local authority commissioner, responsible for Cases 2 and 3, was interviewed once but appears in each case sector hospice was more distant, but a specialist palliative care team was based in a trust building near to the health centre. The data conveyed an impression of a history of stability and commitment to both palliative care and interprofessional working within the team. The area was also generally considered to have been well resourced, which was not the situation in the other case studies:

> **'The other thing is it's got more money than other boroughs which are totally strapped for cash… it's relatively well off.'**
> (*Social services manager, Case 1*)

Therefore, in Case 1 there was a solid base of service provision and skills which could be built on.

Structures

Although the geographical proximity was clearly widely appreciated, it was also apparent that some of the structures in place in Case 1 had been arranged purposefully. Workers from each of the sectors commented on the efforts and commitment that had gone into thinking about service configurations and putting them into practice:

> **'…we have the service level agreement with the palliative care team and they have two specialist nurses sited… in this building that provide services and work in conjunction with the district nurses.'**
> (*Primary care manager, Case 1*)

The historically good resource base had not only helped to cushion and maintain services in the past, it had also embedded an expectation of good services and good collaboration. Perhaps more significantly, it had shielded workers from the acrimonious disagreements that, elsewhere, had marred working relationships and contributed to a cynicism and defensiveness among staff members.

Processes

Some of the processes involved in developing good palliative care needed to move beyond a single practice base. A commitment at all levels of the service delivery cycle was important. For example, the commissioners planning services in both health and social services in Case 1 demonstrated a particular interest in developing palliative care services. The community trust employing district nurses in Case 1 has a long-standing commitment to developing palliative care skills in all its district nurses, rather than encouraging more specialization. This was also the trust responsible for district nursing services in Case 2. The trust employed a full-time palliative care coordinator to liaise between the specialist service and district nurses and coordinate personal development and skills within the community trust, thereby encouraging strong links between the two services. This appeared successful, particularly from the perspective of the specialist palliative care manager:

> **'…if you compare [another area], for instance, district nurses and GPs need more support than [our] district nurses and GPs… [we] are much better resourced than [another area], and we had to work much harder in [another area] than we do in [this trust].'**
> (*Specialist palliative care manager, Case 1*)

The processes of joint working appeared to be well developed in Case 1, with numerous strategic planning documents referring to palliative care. For example, the local health authority's document on continuing care responsibilities has a chapter about palliative care. This document clearly set a positive tone for collaboration between the different sectors; it stressed that most people with a terminal illness wish to remain at home and services should be able to respond to this. The levels of care required are described in terms of symptoms and the corresponding responsibilities of health and social services (*Table 2*).

The document provides considerable detail on a number of areas that proved contentious in the other three case studies,

Table 2. Levels of care and corresponding responsibilities

Level of care required	Responsibilities
Pre-terminal/ symptom-free	Social services providing support following a joint assessment with a district nurse. District nurse delivering general nursing support to social services
Symptom control	Social services may provide assistance with shopping, cleaning, meals-on-wheels etc with district nurse/ specialist team providing advice regarding symptom control
Terminal care	As for symptom control with social services. District nurse coordinates care. Keyworker, usually specialist nurse is responsible for who provides what care with specialist nurses and district nurses working closely together to assess patients' needs, communicate with the specialist team and support patients and relatives

Source: Internal health authority document on continuing care responsibilities

'A service that is supportive of multidisciplinary palliative care and promotes flexible, timely, needs-led and responsive working is likely to be innovative in a number of ways.'

such as who is responsible for funding particular needs, policy and eligibility criteria, contracted expenditure and interagency arbitration. Eligibility criteria were viewed as guidelines – although not prescriptive, their clarity appeared to enable practitioners to practice flexibly with a degree of confidence.

Encouraging good practice

One of the GPs at the health centre in Case 1 had clearly contributed to the development of good practice by promoting multidisciplinary working. Regular multidisciplinary meetings within the health centre helped health workers to understand each other's individual roles and get to know each other. This facilitated communication and interprofessional planning of care for individuals and families:

> **'…here we have multidisciplinary meetings every other Friday with… different professionals coming in. We discuss patients that have got particular needs that are generally known to most of the professionals there, so that is another avenue where we would discuss any problems or review people's care.'**
> (*Primary care caseload holder, Case 1*)

As well as enhancing working relationships and communication, the meetings ensured that care provision was focused, well-planned and timely. They contributed to a sense of helpfulness, flexibility and commitment to providing a responsive, needs-led service.

Consequences

It was consistently apparent in Case 1 that there were strong links between all the services, including regular joint visits and some joint assessments. Sharing information, both in the multidisciplinary meetings and outside them, was encouraged as was communication across the services.

The benefits of staying in close touch were described as going far beyond support and guidance for junior members of the team. There was a need for clarity about who would take responsibility for particular duties, not only so the workers could avoid anxiety about possibly compromising their position with colleagues, but also so the service is measured, timely and seamless for the patient concerned. There was a balance to be maintained between ensuring that services appear responsive and caring, without overwhelming the patient.

Across the study as a whole, we found it difficult to access carers; reasons for this are outlined in Cowley et al (2001). However, one carer reported a service that appeared responsive to her needs as well as the patient's:

> **'I went to the doctor [because] my waterworks had packed up… and she said you know I think you are under quite a strain, let's see if we can find some help. I talked to the district nurse and she said yes, let's see if we can get social services…'**
> (*Carer for social services client 2, Case 1*)

Patient-held, shared records were just beginning to be used in some cases and were seen as helpful, although with some reservation at this early stage. But as a step towards implementing their use, staff from the different services had taken to using the district nursing notes, which were felt to be a useful point of communication and coordination. Other innovative practices were beginning to develop, such as the involvement of patients and carers in review meetings about their care, even discussing potentially difficult funding issues, as one patient explained:

> **'They… come over [to my home] and discuss what is being done and what else can be done to improve it, or what they can't afford to do and what they can afford to do. And the rest of it, it's just a general review, it's like having a board meeting, they just decide what department is doing what, how they can either enlarge it or improve it, or what they have got to cut down on'.**
> (*Social services patient 1, Case 1*)

A service that is supportive of multidisciplinary palliative care and promotes flexible, timely, needs-led and responsive working is likely to be innovative in a number of ways. Patients receiving the service were mainly succinct in expressing their views, but their appreciation was clear:

> **'I think I cope because of all the people that surround me… all give me different kinds of strengths… they are all very positive.'**
> (*Palliative care patient 2, Case 1*)

The key features that made Case 1 a good model of palliative care are summarized in *Box 2*. It seems that palliative care requires not just interdisciplinary collaboration, but effective interagency working at all levels. High quality palliative care stems from the

Box 2. A good model of palliative care

Antecedents	***Geography:*** close enough to encourage easy communication between services ***History:*** evidence of joint problem solving; high expectations; a base of shared values; stable workforce ***Resources:*** sufficient now; historically well resourced so no deficit to recoup ***Skills and attitudes:*** commitment to building a skills base; commitment to palliative care; commitment to interdisciplinary working
Structures	***Facilities:*** large local health centre acts as a base for GPs, other primary care practitioners and district nurses; adjacent pharmacy service ***Good access to services:*** geographical proximity to the local social services area team; specialist palliative care team from voluntary sector housed in nearby trust building; sufficient resources
Processes	***Commissioning level:*** Interest in/commitment to palliative care; joint working practised to develop criteria and procedures; flexible approach to applying eligibility criteria ***Organization of services level:*** Dedicated coordinator post to liaise between specialist palliative care, social services and the community trust as well as acting in an educational role to promote skills; development of district nurse skills in providing generic palliative care across the trust ***Practice level:*** A committed leader to model and promote the philosophy of palliative care, interdisciplinary working and good teamwork Promoting teamwork – regular interdisciplinary meetings; sharing of records/information Promoting communication – individual roles understood; practitioners get to know each other; focused interprofessional planning of care for individuals and families Supporting positive attitudes and commitment – willingness, flexibility; responsiveness; commitment to interprofessional working; needs-led service; palliative care values
Consequences	***Strong links between services:*** Sharing information: district nursing notes are used by all services as a point of communication; out-of-hours support for patients/clients; regular reviews; involvement of patient and carer; timely referrals: early referrals and re-referrals if needed ***Funding issues:*** Eligibility criteria viewed as guidelines, not prescriptive; further promotion of flexibility and interprofessional working; openness about funding; collaboration to identify solutions ***Support for innovative practice:*** Regular joint visits, progressing to some joint assessments between services; patient-held shared records beginning to be used and seen as useful with some reservation ***Impact on patients and carers:*** Supported and enabled to cope; timely access to services; coordinated service provision

ability of all concerned to provide the services when they are needed, so service users experience timely access to services, through which they feel supported and able to cope. Evidence of these key issues was also found in the other case study sites, which all showed some excellent practice.

Organizational interactions

Each of the four case studies had a unique configuration, but there was considerable crossover in the organizations represented. It would be insufficient to suggest that any single sector, organization or level of service planning and delivery cycle could ensure that services all reach the high standards reported in Case 1. Instead, it is suggested that the processes involved in interagency interaction and interdisciplinary working have a significance over and above that involved within each of the constituent parts.

When these processes are disrupted or incomplete, the picture of palliative care that emerges is something of a negative mirror image of the features in a ‘good’ model. From the data as a whole, it was possible to discern and compile a profile of features that would create such difficulties for staff that poor service provision would be almost inevitable. It should be noted that none of the case studies showed all of these features and all included some excellence. *Box 3* summarizes the features that inhibit good palliative care, drawn from a compilation of barriers and problems revealed in our analysis of all the case studies.

Poor palliative care

Antecedents

In all the case studies there was evidence to confirm that geographically dispersed and fragmented services had great difficulty in establishing coordinated services:

> **‘…we work with three boroughs in this area, so it’s difficult to keep a handle on the different systems that work within the boroughs.’**
> (*Health authority commissioner, Case 2*)

Having a history of poor relationships between agencies also meant that tensions were more likely to continue to surface, even about different policies and agendas. The circular relationship between inadequate resources, disputes about who should take responsibility for an aspect of a service, then a breakdown in interpersonal relationships was particularly evident in one case, but permeated many of the answers of senior staff. At the practice level, relationships reflected the dissonance and created a sense of exasperation:

> **'Although [now, extra support in palliative care] is provided by social services, it's paid [for] by [the] health service, this is an arrangement that the local authority has with us. Up until then… you had to predict some ridiculous thing, that if the patient had less than 3 or 6 months to live, then social services wouldn't touch them.'** (*Primary care caseload holder, Case 2*)

Structures

Over-stretched services surfaced repeatedly in conjunction with descriptions of inadequate or inappropriate services. Access to services could be hindered where resources were inadequate or if their location hindered timely referrals. If structural issues, e.g. transport and parking, were a problem, already poor relationships could easily be made worse by a lack of awareness of inconsiderate demands:

> **'… parking is a really big thing, and… parking meters and not coming back on time… are a major cause of stress'** (*Keyworker for specialist palliative care patient 1, Case 3*)

One of the less obvious structures that hampered easy access to palliative care, was specialist palliative care functioning as an outreach service from a large general hospital and cancer centre. Although regarded as an excellent service by those who delivered and received it, it seemed to be available only to former inpatients. Although officially willing to extend their service to patients with non-malignant conditions, the service was largely limited by diagnosis and timing of referral. This applied to some extent to all specialist palliative care services, however, the difficulties were compounded where a large catchment area meant services were not coterminous with local community provision. This led to some liaison difficulties, especially with social services.

Processes

Consistency and commitment are needed to develop the good relationships required

Box 3. Features that contribute to a poor model of palliative care

Antecedents	***Geography:*** multiple service providers spread out over a large area, lack of coterminosity ***History:*** high staff turnover; no clear links or poor communication between services ***Resources:*** services consistently stretched to the limit or beyond ***Skills and attitudes:*** no apparent strategy for professional development, lack of ownership/integration in locality
Structures	***Facilities:*** complex local arrangements; fragmented primary care services such as single-handed GPs (those working as the only principal in a practice) and private GPs; health and social services some distance from one another ***Poor access to services:*** insufficient or over-stretched resources; transport problems due to traffic congestion, distance between services and difficulty parking (staff and users); specialist palliative care with extensive catchment area (for example, an acute-based service) or strict disease focus (for example, a cancer service)
Processes	***Commissioning level:*** Palliative care is a low priority; limited joint planning of services, protocols and policies; strict eligibility criteria for funding ***Organization of services level:*** Services disjointed and fragmented; inflexible approach to applying eligibility criteria; variations/inconsistency in service provision ***Practice level:*** No clear links between services and specific leadership not evident Limited teamwork – few interdisciplinary meetings: only selected staff invited, poor attendance; very little sharing of records/information Limited communication – little face-to-face contact between practitioners; joint working on an ad-hoc basis; much working in isolation; no established system for joint reviews or interprofessional planning of care for individuals and families Low expectations – high turnover and use of temporary/agency staff; unclear professional development; palliative care values and interprofessional working low on agenda
Consequences	***Weak links between services:*** Few opportunities for staff to share information or meet one another; uncoordinated services leave gaps in cover; reviews are unidisciplinary or exceptional; practice is reactive not proactive; poor referral systems: too late, to the wrong service, insufficient information provided ***Funding issues:*** Eligibility criteria viewed as prescriptive; dissent between services, further promoting inflexibility; these lead to personal animosity and disputes ***Inconsistent practice:*** Constant changes in staff; variations in service provision; specialist services used to compensate for resource shortages; junior staff experience high stress levels and lack good role models/supervision; poor understanding of different roles and incorrect expectations of joint working ***Impact on patients and carers:*** Access to services delayed or inappropriate; struggling with a maze of service provision or irrelevant information; not well supported

'Lack of clarity regarding the application of policy was reflected in the organizational philosophies of the cases and impacted on the ability of professionals to provide a quality service.'

for successful palliative care and interprofessional working. Where these were low on the agenda, staff described a continual up-hill struggle to renew and develop relationships and a sense of shared understanding with colleagues. They tried to understand the pressures other teams and staff might be facing to explain perceived deficiencies in the service and conveyed the notion that low expectations and poor standards were associated with staff shortages, and disjointed and over-stretched services:

> **'...working in small teams [with] big case loads... doesn't make a very motivated nurse, it doesn't make them [nurses] want to take on more...'**
> (*Specialist palliative care caseload holder, Case 3*)

Under such circumstances, it would not be long before getting face-to-face meetings or even contact with all the interdisciplinary team became problematic. As always, engaging those who were on the 'outside' of communication networks would be more difficult than acknowledging the need for such contact.

Where meetings were limited, the more junior members of the team found it difficult to get support and there were insufficient opportunities for them to familiarize themselves with individual colleagues or understand the different roles.

Just as a good model of interprofessional working can soon become self-reinforcing, so problems develop more easily where there is a lack of regular reviews and meetings with colleagues. Poor referral systems are associated in our data with situations where individual team members are insufficiently aware of each other's roles, preferred ways of working or skills. Problems are likely to arise when there is a lack of opportunity to share ideas and discuss roles; this can lead to confusion about what is encompassed within palliative care:

> **'I think probably we have got different definitions because we have got different job descriptions.'**
> (*Keyworker to palliative care patient 1*)

In a poor model of palliative care, there is likely to be limited leadership and no discernible philosophy or commitment to developing staff or the service as a whole.

Consequences

In the situation described above, poor palliative care would be almost unavoidable. Junior staff would be likely to feel unsupported and if there were staff shortages and services were over-stretched, professional development would become increasingly difficult. Time, always a precious resource, may be wasted through inappropriate referrals and a lack of coordination, as this social worker indicates:

> **'A lot of time[s] I find that because people don't know each other's roles and boundaries, there are a lot of inappropriate referrals made, for example ... from GPs, sometimes from people from hospital.'**
> (*Primary care caseload holder, Case 4*)

Team building becomes problematic because of wrangling over 'whose job it is' and working together becomes a burden instead of a source of support. Resentment can easily be fuelled by the rigid application of inflexible eligibility criteria, which in turn limits the accessibility of services for patients and carers.

Prescriptive eligibility criteria seem more likely to cause dissent between services than the clear, but flexible, criteria highlighted in the good model. Once a disagreement about one aspect of organizational arrangements begins to permeate the service, associated discontents are likely to follow. If adverse attitudes are accepted as the norm, service users may experience a drop in the quality of the care they receive. Discontent may be voiced about specific issues, like staff turnover, but a general lack of trust in service provision is a likely outcome.

Discussion

The importance of interagency and partnership working is widely recognized within current policy and has been for some years. However, 52 policy documents all showed a surprising lack of consensus in terminology and a paucity of definitions. There was little detail regarding exactly what is meant by interagency or joint working, or about precisely how it is supposed to happen. This lack of clarity regarding the application of policy was reflected in the organizational philosophies of the cases and impacted on the ability of professionals to provide a quality service.

The facilitators and barriers described in the policy documents and summarized in *Box 1* were all readily recognized in the data, but in this study, individual activities, roles and specific service configurations seemed far less important than the overall culture, stability and long-term commitment to the service. Clearly, no area can change their history to become a place that has long enjoyed an adequate resource base or stable workforce, but when developing joint working, the different 'starting points' of various areas need to be taken into account. The testimony of those who had successfully developed a good model of working and of those struggling to achieve one, is that it takes a long time to develop interpersonal trust and successful interagency processes. The multiple changes within care provision over the past 10 years have mitigated against this. Time is required for new service configurations to stabilize and enable staff to develop the necessary facilitators for quality care provision.

Following analysis, it is clear that the service planning and delivery cycle (*Figure 1*), used as a basis for organizing the data collection across four levels of service delivery, is not mirrored in such a simple form in reality; one level of planning and action cannot be expected to always lead directly to the next. The levels themselves are far from clear cut, and there are significant differences both within and between primary care, specialist palliative care and social services. These differences interact through the multiple processes that occur within and between each level, having an influence back and forth within the cycle. Although the structures and plans set up at each level are relevant and important, a consistently good model of palliative care provision can only occur once the processes have successfully bound them all together into a meaningful whole.

The study demonstrates that an effective model of palliative care provision can be found where professional groups and organizations are able to capitalize on the differences in philosophy and culture of different professional groups.

The key aspects identified as features of good or poor interprofessional and interagency working in palliative care may provide a model for use in other care situations where successful service provision requires multiprofessional collaboration. Furthermore, proposed organizational changes to bring primary health care and social services together in a single organization in England (DoH, 2000b) may help. They provide an opportunity to develop the processes through which palliative and continuing care are provided, allowing service provision to cross boundaries in order to focus clearly on the needs of individuals and their families.

KEY WORDS

- Communication
- Interaction
- Location of services
- Organization
- Facilitator
- Barrier

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