



NR89: Management and Effectiveness of Clinical and Professional Networks

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Research aims

- ♦ What organisational structures and processes facilitate, and which ones obstruct, effective functioning of linkage and of care networks?
- ♦ Development of tested methods of network analysis for the health sector. Production of tools for analysis and therefore management of networks.



Research questions

- ♦ How do networks emerge as rational coordination structures?
- ♦ How does re-organising affect network processes?
- ♦ How do the different network layers influence each other?
- ♦ What determines the performance of mandated and non-mandated networks? E.g. incentives?
- ♦ What determines the way in which general practices use relational coordination structures (or fail to)?
- ♦ How are organisations within a PCT-centred network tied to organisations outside it?



Methods

- ◆ Comparative multiple qualitative case studies of:
 - ◆ 3 coronary heart disease networks
 - ◆ 3 networks caring for children with chronic care needs
 - ◆ Option of studying in 'real time' the formation a new network if a suitable opportunity occurs.

- ◆ Data collection:
 - ◆ Longitudinal qualitative narratives
 - ◆ Serial collection of quantitative data of formal network properties
 - ◆ (Re-use of) managerial data

- ◆ Methods piloted in one north-western PCT
- ◆ Advisory panel – experts + stakeholders



Stage reached so far

- ◆ Ethics clearance for pilot & main study, research governance clearance ad hoc.
- ◆ Pilot study, trial and selection of analytic software options
- ◆ Site recruitment – and drop-outs ('re-organisation blight'). Includes network formed 'from below'
- ◆ First round of fieldwork – case studies + network analysis data being collected.
- ◆ Add-on element for one site
- ◆ Initial outputs



Provisional initial findings (1): Methods

- ♦ 'Top down' data collection for quantitative analysis is difficult – main problem is access to general practices. More practicable to collect data 'bottom up'.
- ♦ Two definitional questions:
 - ♦ How to define the boundary of non-mandated networks
 - ♦ How to define the study care group (child health)
- ♦ Data collection trade-offs in large networks e.g. matrices of 25 * 25 organisations vs. matrices or of 130 * 130 persons?
- ♦ Ucinet 6 as preferred analytic software option



Provisional initial findings (2): Mandated vs. voluntary networks

- ♦ 'Mandated' vs. 'voluntary' is a continuum rather than a polarity
- ♦ Voluntary networks get incorporated into the NHS by:
 - ♦ Increasing financial dependence on NHS
 - ♦ NHS network members use network to implement (other) policy priorities
- ♦ Formation of voluntary networks is value-driven (e.g. to help patients, solve coordination problems) or motivated by self-help
- ♦ Voluntary networks deal with conflict by peaceful co-existence rather than voice or exit



Provisional initial findings (3): The life-cycle of a voluntary health network in England

- ♦ Local enthusiasts or volunteers set up network
- ♦ Public sector organisations 'validate' the network ...
- ♦ ... then try to manage the network
- ♦ The network receives resources and legitimacy
- ♦ Other bodies start duplicating the network's functions – competing or substitute bodies appear.
- ♦ Network faces 'merger' or restructuring
- ♦ Two scenarios – bureaucratisation or opposition.



Provisional initial findings (4): The hypotheses – T, F or Q (qualified)?

- ♦ Are structured by a priori policy decisions, not emergent from pre-existing work processes {Q}. Serve 'rational' functions {T}.
- ♦ Have homogeneous internal links, few external links, tend to have a central 'core', little variation between networks, uniformity across networks, closed and stable membership {?}.
- ♦ Use centralised, 'vertical' coordination processes {T}. Formalised, uniform information flows {?}.
- ♦ Experience (internal) opposition as 'voice' or non-compliance, not exit {F}. 'Duplicate' networks co-exist {T}.
- ♦ Implement policy swiftly {Q} but are less open to wider innovation or patient / carer influence {Q}.



Provisional initial findings (5): Other emerging findings

- ♦ NHS re-organisations affect networks much as they do bureaucracies such as PCTs. NHS managers try to manage networks as if bureaucracies (organisations).
- ♦ Networks getting bigger
- ♦ Study networks show little interest in becoming marketised or commercialised
- ♦ Networks can be function stably over long periods even when there are value-differences between and within the different occupational groups
- ♦ What matters to network members is the legitimacy of the source (organisational, professional) of practical contributions to the network's work – not ideological adherence.



Next steps & foreseeable problems

- ◆ Network merger blight / drop-outs
- ◆ Outcome data - paucity of network management information systems
- ◆ Analyse e-mail traffic?
- ◆ Outputs so far
 - ◆ Research report to one PCT / City Council
 - ◆ 3 * conference presentations
 - ◆ Academic papers in production

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