Delivering health care through managed clinical networks (MCNs): lessons from the North

Executive Summary for the National Institute for Health Research Service Delivery and Organisation programme

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Report prepared by:

Professor Bruce Guthrie
- Centre for Primary Health and Population Care, University of Dundee

Professor Huw Davies

- Social Dimensions of Health Institute, Universities of Dundee and St Andrews

Dr Gail Greig
- Social Dimensions of Health Institute, Universities of Dundee and St Andrews

Dr Rosemary Rushmer
- Centre for Translation Research in Public Health, University of Durham

Dr Isabel Walter

- Social Dimensions of Health Institute, Universities of Dundee and St Andrews

Ms Anne Duguid

- Social Dimensions of Health Institute, Universities of Dundee and St Andrews

Dr Joanne Coyle

- Social Dimensions of Health Institute, Universities of Dundee and St Andrews

Professor Matthew Sutton

- School of Community Based Medicine, University of Manchester

Dr Brian Williams

- Social Dimensions of Health Institute, Universities of Dundee and St Andrews

Mr John Connaghan

- Social Dimensions of Health Institute, Universities of Dundee and St Andrews

Address for correspondence

Professor Bruce Guthrie

Quality, Safety and Informatics Research Group, Centre for Primary Care and Population Research, University of Dundee, Mackenzie Building, Kirsty Semple Way, Dundee DD2 4BF

E-mail: b.guthrie@cpse.dundee.ac.uk

Executive Summary

1.1 Project Aim

The overall aim of this project was to generate deeper understanding about the origins, processes and impacts of network organised care.

1.2 Project structure and methods

Four key components of work provided extensive data:

- *Component 1:* Preparatory scoping work -- used to surface core ideas (theories in use) on 'what makes an effective network' (19 depth interviews).
- *Component 2:* Four comparative intensive case studies -- used to explore the origins, processes, organisational dynamics and impacts of four purposively selected MCNs (total of 109 depth interviews supplemented by survey work and analyses of routine datasets).
- *Component 3:* National surveys of all diabetes and cardiac MCNs in Scotland (n=28) at two time-points -- used to clarify the extent to which local patterns seen in the case studies are replicated more widely.
- *Component 4*: A workshop and consultation with experts on English policy and network implementation, alongside a modified Delphi process (n=49) -- used to help ensure the relevance of emergent findings.

1.3 Addressing the project aims

The work explored – *inter alia* – the following key areas:

- How do 'voluntary' and 'mandated' networks differ in structure, processes and impacts?
- What is the role of local organisational contexts and professional culture(s) in how networks are created, function, deliver benefits or fail?
- How do networks interact with the host organisations and the institutions that they cut across, including commissioning agencies?
- How can managed clinical networks continue to evolve and innovate as the limits of collegiality are reached, and how are succession issues handled?

Additionally, the work sought where possible to examine the impact of MCNs from patient and professional perspectives.

1.3.1 Differentiating ‘voluntary’ and ‘mandated’ networks

The terms “voluntary” and “mandated” were found to be less dichotomous than initial impressions suggested, emerging more as points along a spectrum.

Initially, voluntary origins appeared to confer advantages, however initial advantages and disadvantages became less well defined as MCNs matured.

1.3.2 The mediating role of local context

Local context - geography, culture and existing organisational arrangements - touched on all aspects of MCNs and presented challenges for the provision of, and access to, equitable services.

1.3.3 MCNs’ relations with local Boards

The relations between MCNs and their host Health Boards were influenced by MCN origins and maturity, local contextual issues and changing health policy.

The introduction of the policy mandate enabled Health Boards to develop clearer arrangements for MCN governance. Whilst Boards may have felt more in control of matters, new problems emerged, with tensions within MCNs in terms of their focus (working with clinicians and frontline managers to improve services *vs.* working for and with more senior Board managers). This presented a potential danger of undermining the purpose of MCNs in supporting more integrated healthcare.

1.3.4 Professional and organisational roles

MCNs have influenced professionals and organisations positively, although it is difficult to attribute changes unambiguously to MCN activity. At times, when MCNs have been perceived to become too closely involved in seeking to change professional or organisational roles, this has generated tensions, sometimes leading to professional or organisational participants’ withdrawal.

Participation in MCNs by existing service managers across organisations suggested some measure of enhanced understanding of the roles of other professionals/organisations in service delivery.

1.3.5 Managing across networks

Relationships across MCNs appeared less relevant to study participants than those within MCNs across relevant boundaries. The case studies surfaced resistance amongst those involved in clinical leadership within MCNs to the introduction of generic MCN management, despite policy makers’ enthusiasm to promote such arrangements.

1.3.6 Patient involvement

MCNs involved patients in their activities and this had increased over time, but usually in quite particular and sometimes rather narrow ways. Regardless of their level of involvement, patients' impact is difficult to determine, particularly since the aims of involvement were often unclear.

1.3.7 MCN evolution

Initial MCN activity focused on creating engagement, cohesion, shared goals and collaboration, which was facilitated by demonstrating tangible early wins. In that sense, early work focused on creating a professional enclave.

Despite interviewees' perceptions that MCNs developed and matured, when life-cycle models of network development were tested more systematically, regularity in MCN development was not clear. The data suggest that MCNs do *not* develop in linear or discrete stages. Instead, MCNs may show all the activities associated with setting up, producing and reviewing, not as sequential, progressive stages but as concomitant undertakings.

1.3.8 Handling succession issues

Succession issues relating mainly to lead clinician roles in all the MCNs were problematic. The policy insistence on one identifiable clinical lead, usually a doctor, proved incompatible with MCNs' experiences, and practices changed. Three out of the four MCNs adopted distributed leadership arrangements.

It also became clear that succession crises were one aspect of a more generalised "remaking" of MCNs. This constant reworking of MCN aims, roles, priorities and activities was strongly reflected in the wider data gathering across all CHD and diabetes MCNs in Scotland.

1.3.9 Impact

Potential MCN impact was examined from four distinct perspectives:

Professional perceptions of impact. Professionals described intangible and tangible impacts. Intangible impacts primarily related to better inter-professional and inter-organisational working to create a collaborative professional enclave, and were strongly attributed to the MCN. Tangible impacts related to changing professional practice and service improvements, and were less strongly attributed to the MCN.

Patient perceptions of impact. Patient accounts provided support for professional claims of improved co-ordination, but patients differed from professionals in how they talked about information and in the priority they accorded interpersonal care in clinical consultations. There was therefore a partial mismatch between professional perceptions of MCN impact, focused on a particular disease and standardisation of biomedical care and information, and patient perceptions focusing on the experience of interpersonal care.

Patient experience survey. There was no evidence of differences in patient satisfaction between the four MCNs, nor did perceptions of alignment of care with the Chronic Care Model differ in terms of the PACIC score. Satisfaction was generally high, and PACIC scores in all four MCNs were comparable with US organisations considered as beacons of excellence in chronic disease care. However, interpretation should be cautious given low response rates.

Differences-in-differences analysis of hospital admissions data.

Overall, there was some (weak) support for the professional belief that voluntary MCN implementation had improved the quality of patient care evidenced by differential change in some ambulatory-care sensitive admission rates.

1.4 Integrative theme: governance and boundaries

Governance across a range of boundaries is expected of MCNs in policy documents. In this study, governance *within* MCNs was predominately ‘soft’ in nature, relying on influence, persuasion, facilitation and negotiation, mediated via personal relationships and clinical leadership.

As they matured, MCNs sought to influence and steer Health Boards, but the relationship was problematic. Overall, MCNs found it easier to construct a professional (clinical and managerial) enclave that created a space for effective collaboration than reliably to influence statutory NHS organisations.

The wide range of findings suggests that there are no instrumentalist prescriptions for network success, nor are there specific origins and trajectories that are more or less conducive to sustained MCN engagement and improvements in patient care. Moreover, it is unrealistic to expect MCNs to experience regular stages in an orderly life-cycle. Instead, a succession of tensions and challenges require sustained engagement, revisiting and rethinking, with an emphasis on shared governance alongside influence and persuasion rather than contract and control - all viewed through a detailed understanding of local contextual contingencies.

1.5 Exploring wider relevance

The wider relevance of the findings was explored through national surveys of Scottish diabetes and CHD MCNs, a workshop in Manchester for English clinical network managers and clinicians and a Delphi study of workshop participants. The workshop showed that the findings strongly resonated across Scottish MCNs, and with English clinical network professionals.

1.6 Key messages for policy and practice

Some key messages emerge from this work relating to both the creation and early stages of networks, and the subsequent challenges of managing within networks.

Creating and initiating networks

1. There is no one-size-fits-all model for clinical network creators to follow, because local context, including the nature of the condition on which the network focuses, will influence what is best.
2. The distinction between voluntary and mandated clinical networks is less clear cut than often suggested, and mandating of clinical networks created a space within which new forms of collaboration flourished.
3. Clinical networks need credible and influential leaders, but relying on charismatic individuals created succession problems when they left. More distributed forms of leadership involving several clinicians and managers in a core team was more effective and more stable.
4. Network co-ordination requires adequate, and continued resourcing.

Management within clinical networks

5. Core work for network leaders was the creation of a relatively egalitarian clinical ‘enclave’ through a management style based on negotiation, and the creation of trust and co-operation through facilitation, consultation, communication and the development of personal relationships.
6. Clinical networks have to be inclusive of many different stakeholders. Creating consensus and collaboration needs a clear vision, which was achieved through clinicians and service managers working together on specific projects.
7. While maintaining the clinical enclave, more mature networks increasingly focused on relationships with their host NHS organisations, seeking to engage Health Boards and co-opt Boards’ managerial, commissioning and contractual authority to support network goals. This dual-facing position was a source of significant tension within networks.
8. Clinical networks are always a work in progress, because they are a response to problems of co-ordination across complex organisational and professional boundaries. Such problems cannot be definitively solved, but clinical networks are a means to flexibly address and improve them.