

A background network diagram consisting of various sized grey circles (nodes) connected by thin grey lines. Some nodes are larger and have dashed outlines, while others are smaller and solid. The connections form a complex web of relationships.

networks in healthcare

Managing Complex Relationships

Becky Malby Murray Anderson-Wallace



NETWORKS IN HEALTHCARE

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BY

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Foreword

Any developed nation wishing to deliver sustainable health and care services will need to make a significant shift in three directions — harnessing the power of people and communities; focusing on place and its impact on our health; and using information to engage, inform and target interventions. At the heart of this assertion is a view that we need joined up care that includes people and their families as part of the team. This means organising care around them and not our professional egos or organisational boundaries.

This is a challenge to traditional, hierarchical models of health and care. Patients and citizens relentlessly tell stories that show the need to join up care services; in the West our elderly population has increasingly complex needs that require professional disciplines to work together. Alongside this need for more collegiate working, there is the advance of new technology, economic pressures and changing ways that citizens engage with their health. Services are no longer discrete, they are interdependent. Patients are no longer passive, they are informed and active. Any change in one part of the system ‘pops up’ as a consequence in another part and can be driven by patient power as much as active decision-making in the system.

Here in the United Kingdom we have a generation of leaders that have been raised on command and control models of leadership. At the turn of the millennium, significant investment in the National Health Service was conditional on a centrally driven ‘cash for change’ agenda. This was designed in Whitehall and cascaded through a set of direct line arrangements that defined access targets, activity and

financial arrangements in detail. I know because I was programme managing the £5bn transformation fund. It worked for the problem it was designed to overcome and the NHS got a lot better.

A decade later, the Leadership Academy found that the majority of its NHS 'Top Leaders' had one defining style of leadership — a 'Directive' or a 'Pace-setting' style. This is a problem as the defining language of the NHS is now around collaboration and partnership, with citizens, staff and other organisations. Telling people what to do will never work in this context. Luckily, there are a new generation of leaders in the United Kingdom who understand and work with collaborative styles of leadership. They are delivering integrated health and care service, new models of care and innovative prevention schemes.

We increasingly need to understand the differences between leading networks versus leading hierarchies. It's interesting to note that the best predictor of effectiveness in partnerships is having experience in working in partnerships before. Leaders with a history of effective collaboration are required as we embark on large-scale change that requires peer-based networks and forms of organising.

Many leaders can find networks messy places that don't respond predictably. This creates anxiety in a highly-regulated and performance-managed system. Becoming familiar with the power of networks and the skills in leading networks is critical for any leader now, particularly as many of the familiar ways of leading are the very practices which stifle networks.

This book sets out to explain networks, what makes them thrive, how to lead them and how to make the most of this creative and innovative way of working. In our world of ambiguity, complexity and variation, we need networks more than ever. They will help respond to variation with variable skills and experiences. They will bring clarity to complexity. They will bring capacity to deal with uncertainty and help sense making. This book is critical reading in the current context for any leader in health and social care.

Professor Rob Webster
Chief Executive,

South West Yorkshire Partnerships NHS Foundation Trust



The Rise of Networks and Network Working

Networks have become the predominant organizational form of every domain of human activity.

— Castells (2011)

We live in a highly networked world. Social networks are integral to how our children and, increasingly, we ourselves live our lives. We can ask questions of people all round the world and get answers and ideas almost immediately. Whilst hierarchical organisational forms have delivered predictability and order, in our newly connected, highly-dynamic environment where our social networks are part of our identity, and where the solutions of the past don't appear to be delivering for an even more complex future, networks as a way of organising are becoming a natural part of organisational life.

In healthcare it seems to be the coming together of personal preference, people's experience of health services that transcend organisational boundaries, and a mixture of policy intent and mishap, that has shaped the sense that networks are becoming a new, emergent 'norm' for learning and working together.

Networks, however, are unlike the traditional model of command and control that underpins the experience of most people

who work in the National Health Service (NHS). The NHS, whilst varied in how it operates locally in terms of focus, is a very top-down, hierarchical structure, unused to rapid innovation. In fact the distrust of professionals, arising from the Thatcher era, has in effect killed off the natural orientation of professionals towards learning and change through networks. This, combined with the dominance of performance management and regulation as the 'force for change', means that networks (which we argue are an essential mode for adaptation to rapidly-changing environments) are poorly understood and supported.

The NHS in the United Kingdom is itself following global trends in organisation, moving over the last 30 years from bureaucracy to general management (to get a grip on the power of professionals and bring a stronger management discipline and hierarchy to bear); to markets and the purchaser/provider split (on the assumption that competition drives up quality and brings costs down); through a period of modernisation (quasi-markets and collaboration); to the current mixed model of operations that seems to combine some aspects of competition (procurement mainly), with strong regulation (to protect citizens from poor performance), and collaboration (the focus on devolution is a good example, alongside the move to collaboratives and health systems leadership, and the co-dependence on the third sector to deliver services as funding shrinks).

The other key trend (also global) is the bringing together of management and clinicians in leadership, with high-performing health systems taking significant strides in clinical leadership. Some form of 'both and' is emerging, which in itself poses challenges to the dominant ideology of what it is that effects change and innovation. Perhaps the best articulation of this is in the following model of improvement is shown in [Figure 1.1 \(Berwick, James, & Coye, 2003\)](#), which describes two parallel processes for measurement — one for performance and one for innovation.

This begins to show some of the tensions between the hierarchical performance management system, and the professional, peer-based innovation system required in any organisation or wider, interdependent system. It demonstrates how both are needed for

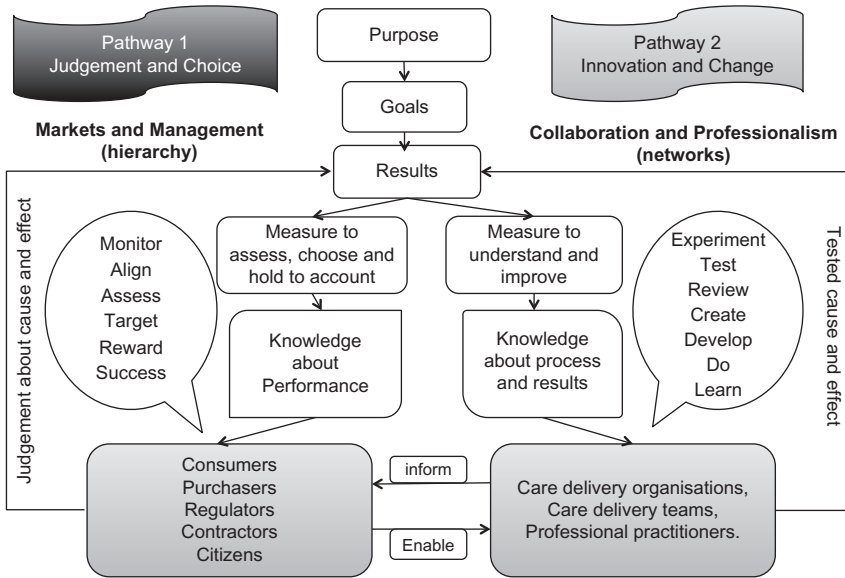


Figure 1.1: The Relationship between Quality and Performance.
 Source: Adapted from Berwick et al. (2003).

different and specific purposes and, we argue, not only are the measurement systems different, but so too are the learning and change systems within each. Interestingly in Intermountain Healthcare, the directorates are now run by a tripartite team of a doctor, nurse and data scientist; the use of data and the discipline of evidence-based decision-making have reduced the need for management as we know it in other health systems.

Alongside these trends there is now a recognition globally that markets do not deliver innovation or efficiencies. This, combined with the emerging citizen voice in the design of health services demanding better experience across their whole journey, and the new realisation that collaboration is vital in a cash-strapped economy, means networks are emerging as a way of innovating and enabling change through combined intelligence, resources and effort.

Put together all these factors from policy, to organising, to theories of change, and you can see that networks are vital for the future of health services.