



CLINICAL NETWORKS

There has been an explosion of interest in “clinical networks” in health care over recent years. Across the NHS the Department of Health has encouraged and in many cases directed Strategic Health Authorities to oversee the establishment of networks for services from cancer to pathology to public health over the last few years. More recently “Creating a Patient-led NHS - Delivering the NHS Improvement Plan”ⁱⁱ has placed networks as centrestage for the future provision of specialist acute services in the NHS and has given the new NHS National Leadership Network for Health and Social Care a lead role in developing a vision for networks for the future.

However the speed of development of clinical networks seems to have ignored some of the lurking organisational tensions inherent in the concept. Managers in other industries will recognise many of the same organisational issues of horizontal and matrix organisational forms overlaid on more traditional vertically organised structures.

Within the UK, the influential Scottish Acute Services Reviewⁱⁱ in the 1990s, gave an influential push to clinical networks. It defined these as, “linked groups of health professionals and organisations from primary, secondary, and tertiary care working in a co-ordinated manner, unconstrained by existing professional and [organisational] boundaries to ensure equitable provision of high quality effective services.” Their report suggests that the interests of the network would dominate those of individual hospitals compared to other models such as “hub and spoke.” Clinical networks vary in their purpose and form. They may be cover functions (for example public health), clinical support functions (e.g. pathology), client groups (e.g. children), disease (e.g. cancer) or specialty (e.g. vascular surgery).

Nigel Edwards and Sarah Fraserⁱⁱⁱ have pointed out that network organisations have several theoretical advantages. These include their flexibility, robustness, and ability to respond quickly to a rapidly changing environment. Networks have thus been cited as a way of sustaining local services where clinical workforce pressures and sub-specialisation potentially undermine traditionally organised clinical services. Networks also offer a way of making the best use of scarce specialist expertise, improving the consistency and quality of care, and maintaining access. Furthermore they may be able to create sufficient “clinical mass” to exploit any relationships between quality and volume and enable a faster spread of innovation. This together with their clinical focus can make networks attractive to clinical staff.

In reality there is a danger that the term “clinical networks” can mean different things to different people. Increasingly there is something of a reconsideration of their blanket applicability. Under the umbrella of “clinical networks” there is a continuum of network forms described^{iv}. These range from informal “clinical sharing and learning” through “collaborative service delivery” to more formal networks responsible for “supra-organisational strategic planning and decision-making.”

One of the starting points of a socio-technical systems view is the need to understand the boundaries and purpose of a system – and then to reflect this in the organisational design. If a network is required from analysis of the wider system [or national policy diktak] to be a managed clinical network such as the cancer networks established following the Calman–Hine Report, its purpose will include “supra-organisational strategic planning and decision-making.” They are thus horizontal organisational entities seeking real decision-making powers over the allocation of resources, working across a large number [typically over a dozen] of vertically organised NHS bodies. The level of formal structure and resources needs to reflect this. In future with the spread of Foundation trusts and perhaps systems, we might see cancer [and other formal managed networks] being managed on a formal franchised basis by large Trusts.

In considering the design and functioning of clinical networks various underlying organisational tensions need to be considered:

- Mutual network benefit v. individual organisational benefit for example in the allocation of resources. Subordinating the inherent drive of Trusts for the acquisition of resources for institutional survival and growth to the wider benefits of the network population can be difficult - even for the most whole system minded leaders.
- Network targets v. individual organisational targets, with the sanctions stacked up behind the latter!
- Degree of formalisation [and subsequent bureaucracy] v. more informal trust based approach
- Delivery of targets v. space and resources for innovation and improvement
- Network wide quality standards v. individual organisational accountability mechanisms through clinical governance

In practice this debate about whether work should be organised vertically within an area of geography or horizontally across a service or process is one of the perennial debates of organisational design.

Tricordant’s approach to socio-technical systems seeks to enable and empower organisations to be effective, sustainable and healthy. This approach can be applied to clinical networks and systems. The approach seeks to align and integrate:

- Strategic vision and values
- Structure and processes including fit for purpose planning, decision-making and review processes
- Reinforcing appropriate leadership styles, behaviours and culture

The development of clinical networks is a potentially powerful tool for improving the sustainability and quality of health care services. In order to deliver these benefits the organisational design, including roles and responsibilities of network members, needs to reflect with the network’s purpose and values. Paying attention to such issues will enable a design that takes account of the inherent tensions in creating a horizontal organisation across the existing NHS hierarchy. The NHS faces an apparent paradox of responding to the public’s demand for local access versus the drive for improved quality with a constrained workforce. Careful design can ensure that clinical networks can help address this paradox without adding more complexity, confusion and misplaced effort.

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ⁱ Department of Health, *Creating a Patient-led NHS - Delivering the NHS Improvement Plan*, March 2005

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- ⁱⁱ The Scottish Office, Department of Health. *Acute services review report*, 1998.
- ⁱⁱⁱ Edwards N, *Clinical networks*. BMJ 2002; 324:63
- ^{iv} Sarah Barron, *A strategy for networks in North Central London*. Dec 2002.