



A MANAGED CARE NETWORK for OLDER PEOPLE in LANARKSHIRE

A SCOPING REPORT

Introduction

There are two kinds of paper that could have reasonably been incorporated into this report:

- a paper on *ends*: that is, what sorts of policies on older people do we want and for what purposes?
- a paper on *means*: that is, what sorts of arrangements between the stakeholders would be most likely to achieve the desired ends.

Only the latter of these possibilities is covered in this paper on the ground that the former is the province of local stakeholders, although issues will be raised about the general direction of the former. This review should be understood as a ‘scoping paper’ on means – one that focuses upon the nature of networks, the determinants of network effectiveness and ways in which they might be evaluated. In doing so the report draws upon a wide range of established literature from diverse academic disciplines, but the aim is to use these literatures to inform practical developments.

It is important to emphasise that this paper has been written in the absence of any fieldwork in Lanarkshire and indeed any contact at all with the key participants. Although reference has been made to some existing Lanarkshire documentation, it would be wise to consider any references to the Lanarkshire situation as highly provisional – hence the notion of a ‘scoping paper’.

The broad content of the paper is as follows:

- **Part I** considers some conceptual issues: what are networks and why are they considered to be advantageous?
- **Part II** identifies some key issues in network effectiveness
- **Part III** considers some frameworks for evaluation

PART I

CONCEPTUAL ISSUES in the STUDY of NETWORKS

Defining Terms: The Conceptual Slipperiness of Networks

Despite a strong underpinning rationale, the concept of a 'network' remains slippery.

Ebers (1997, p15) notes that: *'it can be employed to characterise any set of recurring ties among a set of nodes'* - a definition sufficiently wide to encompass relationships between individuals, groups and organisations over a range of ties such as resources, information and friendship. Indeed, he adds that:

'... the notion of network is so general, its application to organisational analysis runs the risk of extending the notion indiscriminately until it ceases to have whatever analytical and theoretical power it might possess for organisational research' (p16).

This is an important criticism, and one that extends to the related concept of a 'managed care network'. The JIT briefing paper on such a network in Lanarkshire (JIT 2006), for example, observes that *'while the term managed care networks is in use there is no agreed definition or inter-agency framework to support development and evaluation'*, whilst the evaluation report on Lanarkshire stroke managed clinical network concedes that *'a review of the available literature on networks suggested that the concept was poorly understood'* (NHS Lanarkshire 2006).

It is accordingly vital that any attempt to develop a network approach is based upon something more substantial than a warm feeling, and part of the purpose of this report is to unpack the concepts of network and managed care network a little more carefully. A commonly used definition is that of the World Health Organisation (1998):

‘a grouping of individuals, organisations and agencies organised on a non-hierarchical basis around common issues or concerns’

Such a definition certainly seems to add grist to Ebers mill and reveals few practical clues for improving service delivery. Much the same could be said of Baker and Lorimer’s frequently adopted definition:

‘linked groups of health professionals and organisations working in a coordinated way that is not constrained by existing organisational or professional boundaries to ensure equitable provision of high quality clinical care’ (Baker and Lorimer, 2000).

These and similar interpretations are no different to any standard definition of ‘partnership’ or ‘collaboration’ and fail to identify any distinctive features of a specifically ‘network’ approach. Within the understanding that networks are fundamentally about enabling services to be linked across organisational and professional boundaries in ways that would otherwise not have happened, an alternative approach is to identify different types of network distinguished by their degree of complexity and the sort of issues they have been established to address.

A Continuum of Network Arrangements

Three types of network are often identified, each tending to be associated with an increasing degree of complexity and ambition.

Integrated Care Pathways

This model, also known as coordinated pathways or care maps, consists of task oriented care plans which detail essential steps in the care of patients with a specific clinical problem, and describe the patient’s expected clinical course. They offer a structured means of developing and implementing local protocols of care based on evidence based clinical guidelines, but the principles could also apply to the process of case or care management that is associated with social work intervention. They also provide a means of identifying the reasons why care may fall short of adopted standards (Campbell et al, 1998). Typically these pathways are clinical in orientation and restricted to a single treatable condition.

Managed Clinical Networks

This model is envisaged as a means of linking health care personnel working across professional and organisational boundaries to deliver care for a specific condition or perhaps for a specific set of services. Such networks have been used to attempt to deliver coordinated care for a wide range of conditions, notably cancer, CHD, stroke and diabetes. In the case of Scotland a Management Executive Letter MEL(1999)10 defined a managed care network as:

‘linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a coordinated manner unconstrained by existing professional and Health Board boundaries to ensure equitable provision of high quality clinically effective services throughout Scotland’.

Compared with integrated care pathways, this model incorporates an appreciation of the need to work across a wider range of boundaries, including non-clinical partners, and may encompass the integration of *services* as well as professionals from one agency.

Managed Care Networks

A managed care network is similar to a managed clinical network but the focal issue is more complex, and the range of partners is much broader. Critically the focus explicitly goes beyond health services and clinical care – a factor acknowledged in Scotland through a later Health Department Letter, [HDL](2002)69 which refers to the inclusion of social care. The evaluation report on the NHS Lanarkshire Stroke Managed Clinical Network (NHS Lanarkshire, 2006) also emphasises the need to evolve from a ‘clinical’ to a ‘care’ network, arguing that such an extension could *‘support a shift in the balance of care by integration of specialist care across acute, community and intermediate care settings’.*

What this escalation builds up to is a concern with not so much a single condition or even the ‘whole patient’ but in fact the *‘whole person’*. This, in turn, requires an understanding of – and ‘networking’ across – the *‘whole system’*. Again the Lanarkshire stroke evaluation makes the point forcibly:

‘Networks of the future will increasingly be multi-agency collaborations to manage the increasing interdependency of partner organisations which aspire to deliver more personalised services to meet increasingly complex needs and rising public expectations’ (p28).

One useful classification for capturing this escalation of complexity (DfES/DoH, 2005) makes a distinction between the following types of networks:

- *Association*: an informal group that corresponds or meets to consider specific topics, best practice and other areas of interest.
- *Forum*: a more formal group that meets regularly, has an agenda and focuses on specific topics; there is an agreement to share audit and formulate jointly agreed protocols.
- *Developmental Network*: a forum that has started to develop a broader focus on other than purely topic-based issues, with an emphasis on service improvement.
- *Managed Network*: this includes the function of a forum, has a formal management structure with defined governance arrangements and specific objectives linked to a published strategy. This gives rise to the following definition of a managed care network:

‘A linked group of professions and organisations from health care, social care and other agencies working together in a coordinated manner with clear governance and accountability arrangements’.

The distinctions and discussion outlined above are diagrammatically shown in **Table 1** below. The story to arise from this matrix is that the trend in Scotland is away from networks of low complexity towards those of high complexity, and that this shift has been reinforced by an increasing degree of mandation upon local partners. The 2002 Letter was followed by publication of the *Coronary Heart Disease and Stroke Strategy for Scotland* (2003) which endorsed the managed clinical network model and required each NHS Board to have detailed plans for establishing such networks in place by December 2003.

At the time of writing a further circular from NHS Scotland is due to be published that reinforces the role of managed clinical networks but goes on to identify the opportunity to develop the concept further *‘to a more multi-agency managed care network on the basis of partnership working with local authorities and other agencies’*. Indeed, the proposal for such a network for older people in Lanarkshire

is identified as ‘an important area for development’. Moreover, as has been pointed out in other reports (JIT 2006a) the core principles of such a wider approach are consistent with the five principles of public service reform that have been identified in Scotland:- personal user focused care; quality and innovation; efficiency and productivity; joined up whole systems; and accountability.

TABLE 1: TAXONOMY of NETWORKS
TYPE of NETWORK

The Collaborative Advantage of Networks

	ASSOCIATION	FORUM	DEVELOPMENTAL	MANAGED
HIGH COMPLEXITY				<ul style="list-style-type: none"> * service focused * cutting across organisational boundaries * geographic focus * whole person focus * whole system focus * mandated relationship
MEDIUM COMPLEXITY		<ul style="list-style-type: none"> * user focused * tracing the journey of care * clinician or practitioner networks * health services focus * integrated care pathways 	<ul style="list-style-type: none"> * commissioning network * health and social care focus * managed clinical network 	
LOW COMPLEXITY	<ul style="list-style-type: none"> * voluntary association * mutual awareness * sharing of basic information * single service focus 			

Having made some attempt to define and classify networks, it remains to be clear about why the network mode of coordination might – in the right circumstances– be more appropriate than the main alternative, that of hierarchy. Oliver (1990) proposes six reasons why inter-organisational partnerships might be established:

- *asymmetry*, that allows one party to exercise power or control over another one;
- *necessity*, when organisations are mandated through law or regulation by higher authorities to establish relationships;
- *reciprocity*, when through co-operation, organisations can pursue common or mutually beneficial goals or interests;
- *efficiency*, when through co-operation, organisations can achieve higher input/output ratios;
- *stability*, when through co-operation organisations can better forestall, forecast or absorb uncertainty affecting their activities;
- *legitimacy*, when through co-operation organisations can establish or enhance their reputation, image, prestige or congruence with prevailing norms

Apart from the first factor, all of the others are appropriate to the situation in Lanarkshire where – in principle – a combination of necessity, reciprocity, efficiency, stability and legitimacy has the potential to deliver substantial change in the way services are delivered. As the new draft Letter on managed clinical networks (NHS Scotland 2006) points out, the role of each network will vary depending on the issues it seeks to address – it may be concerned with audit, about redesigning the journey of care, making the best use of available resources or sustaining local access to services. In practice it will probably be concerned with all of these, and more.

PART II

KEY ISSUES in NETWORK EFFECTIVENESS

Three key issues determine the effectiveness of any network:

- issues of *purpose*
- issues of *management*
- issues of *governance*

ISSUES of PURPOSE

Issues of purpose will be decided at the ‘problem-setting’ stage where potential partners identify one another and mutually scrutinise possible shared interests. The most crucial decisions will arise in defining the population to which the network will relate – an ambition to encompass tertiary, secondary, primary, community and social care, for example, immediately broadens definitions of the population for which care is to be provided. What is clear is that the field of organisations with interests and capacities must match the complexities of the identified problem and the means by which it can be addressed. The more ambitious the network purpose, the wider will be the inter-organisational domain.

The new draft Letter on managed clinical networks from NHS Scotland (2006) is emphatic about the need for a clear purpose:

‘Each network must have a clear statement of the specific clinical and service improvements which service users can expect as a result of the establishment of the network...it is an essential that networks should have a person-centred approach... services should adapt to the needs of the user, not vice versa’.

In the case of Lanarkshire it is not yet clear how far the proposed managed care network for older people has articulated a clear sense of purpose. The Conference Report (Joint Improvement Team, 2006a) identifies a number of short-term issues:

- identify the gaps, challenges and opportunities where the proposed approach would add value
- clarify the scope of the network by describing which “older people”
- define its role as a ‘change agent’ to support existing structures to improve outcomes

- define its relationship to existing operational structures

The ‘change agent’ role in particular appears to have wide support and is explicated in a paper for the Older People’s Partnership Board (Hendry 2006) which refers to a cross system ‘change agent’, proactively supporting partnerships by providing a flexible but sustainable resource for:

- redesign of interagency services
- improving practice and building capability through education and shared learning opportunities
- reducing variation in practice through evaluation and feedback
- supporting engagement in roll out of new initiatives
- embedding quality improvement across partnerships and thus informing multi-agency inspection in due course
- informing developments and practice elsewhere in Scotland

These are significant proposals relating to the *means* for promoting a network approach, but they still leave crucial decisions on *ends* to be resolved. In developed countries the increasing number of older people creates healthcare challenges, the most prominent of which is the volume of demand. It is, however, the nature and origins of that demand that presents the most profound organisational headaches. Healthcare providers are not usually responsible for all the service delivery inputs that constitute a care package, nor do they have any direct control over the lifestyles of individuals or the activities of other organisations that precipitate healthcare demand. Healthcare demand stems to some extent from the wider socio-economic and cultural determinants of health itself and addressing these health determinants necessitates population approaches stemming from a variety of non-healthcare agencies.

Given that a managed care network for Lanarkshire is still in the developmental phase, this is the appropriate time to determine the purpose of the activity. Three possible purposes associated with increasing degrees of ambition can be identified:

- **ad hoc purposes** in which the network evolves slowly and concentrates upon discrete activities that seem to offer the best prospect for an early win, for

example, through developing and coordinating clinical pathways, developing intermediate care models or building workforce capability.

- **system-focused purposes** in which the network identifies a part of the *system* that is problematic and focuses network energies upon finding a solution, for example delayed discharge or rising emergency admissions.
- **outcome-focused purposes** in which the starting point is the identification of the outcomes that will support high levels of health and wellbeing for older people.

It is evident that in Lanarkshire there is interest in moving towards the second and even the third of these options. The evaluation of the stroke managed clinical network (NHS Lanarkshire, 2006), for example, notes that truly holistic care recognises the wider determinants of health and the whole system approach required for improving health and maintaining wellbeing. It is likely that much remains to be determined in respect of a managed care network in Lanarkshire, and this will presumably be the highest priority on the future agenda.

Such determinations will also shape judgements about how long this direction-setting phase will last – the Draft Letter (NHS Scotland, 2006) suggests that a two to three year period should be allowed for the developmental phase, albeit with intermediate targets. It is important here to remember the conclusion to emerge from Ferlie and Pettigrew’s review of network organising – that network building is a long-term, emergent and developmental process which may conflict with a short-term and task-oriented approach to management ((Ferlie and Pettigrew, 1996).

ISSUES of MANAGEMENT

Top-Down and Bottom-Up Dimensions

Although much of the academic literature argues that the distinguishing feature of networks is that they are voluntary and self-organising, the reality is that a managed care network involves both top-down and bottom-up elements. The need for some top-down steering arises from the complexity of the inter-organisational task, and is one of the key messages to arise from reviews of the cancer networks. An early

review by the Commission for Health Improvement (2001), for example, argued that:

“Networks are complicated partnerships of all organisations and professional involved in commissioning, planning and providing cancer services in an area. They tend to cover a large geographic area and many organisations...This makes for very complicated planning arrangements among the very different and traditionally independent organisations. And the difficulties are further increased by the separate financial and management accountability of these NHS organisations”(p63-4 para 5.3)

A subsequent review of cancer networks by the National Audit Office (2005) went on to highlight the problems that can arise where there is no concerted strategy for network support. It notes that:

‘Making the cross-boundary approach work has not been straightforward...some network boards did not have full representation from acute and primary care trusts in their area. Where present, representation was only at the expected Chief Executive level in around half of cases’ (para 15).

In England the NAO identified some additional difficulties arising from the NHS reforms, with both NHS Foundation Trusts and the emergent Independent Treatment Centres insufficiently connected to the cancer networks – Scotland may be at an advantage in this respect.

However, although networks will find it hard to be effective without top-down support and encouragement, neither can they function solely as creatures of hierarchy. In particular, the management of networks needs to be on a much less hierarchical basis, with a form of management that is *facilitative* rather than based upon command and control. Much of the thinking on network management has come from the 'governance club' at Erasmus University associated with Walter Kickert and Jan Kooiman. They compare the management styles required for network organising to those found in the ‘classical management style’ (**Table 2** below). They suggest that the latter relies on a ‘system controller’ who sets goals, leads implementation and monitors progress – with a view to enforcing these goals – and that this ‘top-down’ approach ‘cannot be used in a network situation. Instead, the focus should be on ‘coordinating the strategies of actors with different goals and

preferences with regard to a certain problem or policy measure within an existing network of inter-organisational relations’ (Kickert et al, 1997).

Dimensions	‘Classical’ Perspective	Network Perspective
Organisational setting	Single authority structure	Divided authority structure
Goal structure	Activities are guided by clear goals and well defined problems	Various and changing definitions of problems and goals
Role of manager	System controller	Mediator, process manager, network builder
Management tasks	Planning and guiding organisational processes	Guiding interactions and providing opportunities
Management activities	Planning, designing, leading	Guiding interactions and providing opportunities

Source: Kickert et al (1997: 12)

Creation of a Network Office

The notion of creating a 'network office' is strongly promoted in the new HDL (NHS Scotland, 2006) which states that:

'As the number of Managed Clinical Networks increases, NHS Boards and their planning partners are developing Network Offices or facilities which form a generic resource capable of providing administrative support for all the Networks in the area. This approach has the advantages of promoting a general oversight of all Network developments, and allowing for the systematic support of the range of recognised Networks, whether these are still at the developmental stage or have reached maturity and are functioning in a steady state. The Network Office or facility also allows for connections to be made between Networks, especially where there are Networks for long term conditions which have much in common, such as CHD and diabetes or the neurological conditions. The office can also act as a point of contact with CHPs and local authority services. The Network Office or facility will also be able to identify gaps and promote the case for MCN development where services are sparse or there is no clinical champion'.

Although these observations are made in the light of the creation of managed clinical networks they will be even more apposite in the case of a managed care network, especially one with a 'change agent' role. However, it is not enough to establish such a network nerve centre; it is also necessary to ensure that it is staffed by people with the right sort of skills, knowledge and attributes. Again, the new HDL is important here, with an emphatic endorsement of the need for a '*network champion*':

'Each MCN must have clarity about its management arrangements, including the appointment of a person, usually known as the Lead Clinician or Lead Officer who is recognised as having overall responsibility for the operation of the Network

The Creation of a Cadre of Reticulists

The identification and appointment of a network champion must not create an assumption that the network is being organised and 'run' by the champion.; the reality is that for the network to succeed it must be seen as 'everybody's business'. This involves revisiting the issue of appropriate skills, knowledge and attributes amongst a wider range of people.

The discussion in managerial literature of 'change champions' whose commitment and charisma become crucial to the successful development of collaborative initiatives, bears a strong relationship to the notion of '*reticulists*' in the literature on

policy implementation (Friend et al. 1974). Reticulists are individuals with a strong commitment to change who act as 'entrepreneurs of power', skilled at mapping and developing networks, identifying where linkages and coupling are possible, able to build coalitions and alliances with other committed and powerful individuals in their own and other organisations. They will have rather different tasks from those with conventional line management functions within organisations. For example:

- managing across and upwards, rather than downwards;
- influencing and motivating others over whom they have little control;
- creating and assembling resources owned by others;
- building trust between partners with different interests, perspectives and organisational imperatives;
- achieving tangible outcomes, to keep members committed to the partnership while moving the wider agenda forward;
- maintaining relationships and communication networks across agencies at a variety of levels.

However, reticulists must begin from a sound position of power and legitimacy. McCann and Gray (1986) use the term '*convenor legitimacy*' and identify several aspects of this status:

- a perception by others as having sufficient legitimacy to assume the role;
- being perceived as unbiased and able to manage multiple points of view;
- a vision or sense about the critical issues and first steps which need to be taken;
- previous experience of an inter-agency approach;
- participatory development style;
- political skills which encourage others to take risks.

It is far from evident that these qualities are readily available or equally distributed within and between agencies. It is also evident that where collaborative initiatives do arise from reticulist activity, they need to be protected against the possibility of the departure of the key actors. What this implies is a need to create an environment in which reticulist skills are nurtured and valued, and a starting point is to pin down precisely what skills are needed and to what extent they currently exist.

The Skills for Health Project on competences for network managers is currently consulting on exactly this issue (Skills for Health, 2006) and it would be valuable for the Lanarkshire development to engage with this exercise. The project aims to:

- identify the range of responsibilities in different network manager roles
- assess the extent to which the functions that network managers perform are adequately described by current occupational standards or other statements of competence linked to the NHS Knowledge and Skills Framework (KSF)
- recommend to what extent it would be helpful to develop new competence statements for aspects of the role.

Early investigations have shown that the role of network managers is variable. Some have direct supervisory responsibility for staff and some do not; some have budgetary responsibility, others do not. In smaller networks, the manager may personally carry out tasks that in larger networks would more normally be delegated to other staff. In larger networks the leadership/management/facilitative/administrative functions may be shared out between a number of people, with job titles of network director, network manager, network coordinator, network facilitator and so forth. However, there are also many obvious similarities, chief among which are that:

- all network managers seek the cooperation of a variety of different stakeholders based in different organisations
- all are reliant largely on influence (rather than on authority) to achieve this cooperation, and therefore need to establish and maintain good relationships with individual stakeholders.

In the light of this situation the Skills for Health project concludes that the following common functions can be identified, although not all network managers carry out all these functions:

- winning support for networking
- organising the network
- environment scanning and strategy setting
- managing information and communications across the network

- leading and managing collaborative work
- coordinating activities across network members
- managing the network hub

It is important to emphasise that these skills need to be distributed throughout the network and not be seen as the sole province of the network leader – a network needs lots of champions. It is only in such circumstances that the development of a collective appreciative capacity can thrive, that is, an ability to recognise and articulate how collaborative responses can be helpful (Cropper et al, 2004).

ISSUES of GOVERNANCE

The Governance Dilemma

The sort of network envisaged in Lanarkshire will not be self-organising and will not function without clear and effective governance arrangements, but network governance is not a straightforward issue. The new HDL (NHS Scotland, 2006) states that:

‘MCNs build on the informal networking which takes place across any large organisation. MCNs go beyond that. They are a form of networking which seeks formal recognition in order to shape and influence the delivery of a particular service’ (para 8).

But despite acknowledging the need for some formal recognition, the Letter is adamant that MCNs should *‘remain as virtual organisations so as to avoid turning into another tier of bureaucracy’*. (para 13). Achieving a balance between formal recognition (and by implication a stake in governance arrangements) and remaining inherently *‘virtual’* will be difficult. Certainly this appears to have been an issue in the Lanarkshire Stroke MCN where it is reported:

‘there remains a degree of tension between the function of the MCN to support cross system service improvement and the role of existing operational structures which continue to have accountability for services delivered in either the acute division or in two community health partnerships’ (Para 8.3).

This is an important issue. Networks compete with other calls on resource, time and attention, and will tend to be accompanied by concerns about productivity and organizational over-commitment. The inter-organisational dilemma is that networks will typically comprise well established programmes and organisations that may be resistant to change. For a network to function effectively, the needs and interests of

the people who work for and support these various programmes must be satisfied, whilst simultaneously building a cooperative network of inter-organisational relationships.

Network Governance in Lanarkshire

In Scotland in general, and in Lanarkshire specifically, this dilemma is fully recognised. The 2006 HDL states that *'the key message is the need to ensure that MCNs are fully embedded in NHS Boards' planning arrangements'*. Indeed, paragraph 15 goes on:

'Whatever the drivers, the development of MCNs cannot take place in isolation. The support of the appropriate planning body or bodies must be sought at the earliest possible stage, so that the development of the Network can, from the outset, be integrated fully with the relevant planning arrangements. Without such integration, it will not be possible to prioritise the MCN's needs within overall aims and targets'.

Finding ways of connecting the proposed managed care network to existing joint forums is also recognised as a key governance task in Lanarkshire. A wide range of such forums is identifiable:

- South Lanarkshire Council Joint Future Management group for Older People
- North Lanarkshire Older Peoples' Partnership Board
- NHS Lanarkshire Modernisation Programme Board
- North Lanarkshire Voice of Experience
- Better Government for Older People
- Princes Royal Carer Network
- South Lanarkshire Council Carers Network
- North Lanarkshire Carers Together
- Independent Providers
- Care Commission
- Voluntary Agencies

Lanarkshire can call upon extensive experience of developing and governing a wide range of managed clinical networks which reported to the Modernisation Directorate and met every two months at the Managed Clinical Network Forum. In this early stage of development of the Managed Care Network the proposal seems to be that a

group of lead officers (the Older Peoples Managed Care Network Development Group) will steer development of the programme and will report to the North Lanarkshire and South Lanarkshire Health and Care Partnerships and to the NHS Lanarkshire Modernisation Board. In time, it is proposed that a Modernisation Board be established to oversee the MCN for older people and a number of additional complex change programmes.

The Change Agent Model

As noted earlier in this report, Lanarkshire proposes to address ‘the governance dilemma’ by developing a ‘change agent’ role for the older peoples’ MCN with the aim of supporting the Lanarkshire partnership groups in implementing, rolling out and evaluating initiatives which deliver better outcomes for older people and their carers. In the July 2006 Conference report this is described as ‘*a supporting infrastructure to facilitate collaborations between partners and their existing structures*’. This is all consistent with the essential basis of a network – reliance upon *relationships* rather than *structures*. As the Stroke Evaluation notes (para 8.2):

‘MCNs do not derive authority or influence from having budgetary or operational responsibilities. The degree of authority and influence which a particular MCN has will depend on its stage of development, the impact it has made across the organisation, the level of connectivity between the MCN and board planning and operational structures, as well as the relationship between lead clinician and manager and the local planning and management teams’.

PART III

A FRAMEWORK for the EVALUATION of NETWORKS

In general it is still premature to conclude that networks are effective mechanisms for addressing complex policy problems, and this situation is not helped by lack of agreement about how community based networks such as that envisaged in Lanarkshire should be evaluated. In the case of the Stroke MCN the evaluation was based around the 12 core principles of managed *clinical* networks laid out in HDL 2002(69):

- clarity of management arrangements: manager/lead clinician

- defined MCN structure
- clear statement of expected clinical and service improvements
- use of documented evidence base
- must be truly multi-professional
- network professionals must agree evidence base and network practice
- clear policy on patient information
- QIS approved QA programme
- maximise education and training potential
- all professions must participate in audit and review
- focus on patient access, CPD and patient representative support
- evidence of exploring better value for money

Much of this is very clinical in orientation and it is not evident that such a framework would be appropriate for the evaluation of a managed care network. An alternative framework is that proposed by Keith Provan and H. Brinton Milward – the doyens of American network theory - who identify the three key evaluation domains of the individual/community, the network itself and the network's organisational participants (Provan and Milward, 2001).

The Individual/Community Level

At the broadest level of analysis, community based networks must be judged by the contribution they make to the communities and individuals they are trying to serve. In other words, networks must be evaluated as service delivery vehicles that provide value to individuals and local communities in ways that could not have been achieved through the uncoordinated provision of services by fragmented and autonomous agencies. The main aim of any change to service provision must be assessed by the impact on the users of services, both in terms of service outputs and user outcomes. In the case of the former this will be measured by the extent to which the managed care network allows services to be more closely aligned with the user's journey of care rather than along traditional organisational or professional lines; and in the case of the latter by the extent to which progress has been made towards user-identified quality of life outcomes.

The Network Level

A network must become a viable inter-organisational entity if it is to survive, and to achieve this it must have legitimacy and external support. The effectiveness of a network can be assessed in a number of different ways, many of which depend upon the relative maturity and development of the network. One simple measure is the ebb and flow of agencies entering and leaving the network. There is no minimum number of organisations required to make a network succeed, but networks obviously need to attract and retain members – particularly during early growth – if they are to survive as a viable form of organisation.

A related way of assessing network effectiveness is by the range of actual services provided or covered by the network. In principle one of the advantages of a network is that it allows for the provision of a broad range of services that collectively address the full needs of service users. If network coverage is limited then users will need to go elsewhere to have their needs fully met, but determining what mix of agencies is sufficient to provide a complete ‘service inventory’ is complex. Over time a successful network should be able to broaden the web of ties to allow information, resources and users to flow smoothly across a full complement of network members.

A third way of evaluating network effectiveness is to assess the strength of the relationships between and among network members. Organisations are likely to experience a period of transitional commitment as they move from relatively informal ties towards a higher degree of formality. A relevant concept here is that of ‘*multiplexity*’ which refers to the strength of ties between network agencies. Organisations can be said to have multiplex ties where they are connected in more than one way – say through referral and planning links – and the greater the number of ties the stronger will be the relationship. If a network is working well and is to be sustained over time then the ties among the members could be expected to gradually strengthen.

A final way of assessing network effectiveness is by evaluating its administrative structure – the role of the ‘network office’. The existence of a network office

generally indicates the network is a viable form and that resources have been committed to development. By contrast the absence of such an office means that the network has no designated agent to guide, coordinate and legitimise network activities, or to monitor network outputs. It will be the job of the network office to ensure that resources (in the widest sense rather than simply financial) are distributed in ways that maximise overall network effectiveness for the benefit of the individuals and communities being served.

The Organisation/Participant Level

It is important to remember that individual agencies and their members are still motivated by self-interest: network members will continue to strive to ensure the survival of their own agency. Networks accordingly need to be assessed by the extent to which they serve the needs of the separate participants, and this may be done along several dimensions:

- *legitimacy*: agencies will hope to enhance their legitimacy in the community by becoming part of a broader network that allows them to share information, ideas and clients.
- *resource acquisition*: smaller agencies may hope to have better access to resources through network membership, and larger agencies may be able to use the legitimacy of the network to bid for funding that would have been otherwise unavailable, such as Big Lottery grants.
- *costs*: working in partnership brings costs as well as benefits, and network members will need to be assured that membership brings more benefits than costs.

Towards an Evaluation Framework and Methodology

Network effectiveness will be based on interactions across all three of the levels identified in this section of the report. An initial attempt to summarise a potential evaluation framework is shown in **Table 3** below. The approach here is *not* to offer a list of specific measures and methods – these will need to be developed if and when the evaluation framework is accepted. However, as in the case of the

Lanarkshire Stroke Evaluation it is suggested that an action research approach is most useful for the evaluation of a complex initiative like a Managed Care Network for Older People. The key features of action research are:

- linking of participants’ action to the development of practical knowledge through emergent processes
- engaging in repeated cycles of diagnosing, planning, implementing, collecting and analysing data
- discussing outcomes with system members, reaching conclusions and defining new sets of action steps
- developing a system that is continuously learning from experiences

TABLE 3: SUMMARY of NETWORK EVALUATION RELATIONSHIPS

LEVEL of NETWORK ANALYSIS	EFFECTIVENESS CRTIERIA
Individual/Community	<ul style="list-style-type: none"> ▪ identification of user based outcomes and extent to which they are met ▪ identification of service outputs and extent to which they are met ▪ extent to which service users experience a seamless journey of care ▪ aggregate indicators of wellbeing/changes in incidence of the problem ▪ public perceptions that problems are being addressed
Network	<ul style="list-style-type: none"> ▪ network membership growth ▪ range of services and activities covered ▪ absence of service duplication ▪ relationship strength (multiplexity) ▪ creation of an effective network office ▪ member commitment to network goals

Organisation/Participant	<ul style="list-style-type: none"> ▪ agency survival ▪ enhanced legitimacy ▪ resource acquisition ▪ costs/benefits of network membership
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CONCLUSION and NEXT STEPS

This scoping paper does not seek to set out a blueprint for the way in which a managed care network for older people in Lanarkshire should be developed, and neither does it propose specific tools for measurement and evaluation. It has been written prior to any fieldwork or even informal discussion, and simply seeks to scope the field on the understanding that the Lanarkshire development is still at the problem-setting stage. The intention is that the conceptual discussion and possible evaluation framework will be of use in Lanarkshire and elsewhere in Scotland as the Joint Improvement Team develops networks as a central theme of its activity.

It is suggested that if the discussion and framework outlined here are seen as helpful then a more detailed evaluation programme be drawn up in consultation with the MCN Development Group and the Joint Improvement Team.

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