Networking

Give health networks a real chance!

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Network development in the NHS in the UK has, by and large, not been based on evidence. Now, following perceptions of failure, some are calling for networked approaches to be abandoned. This paper reviews the evidence in two ways: factors which are known to motivate individuals and organizations to join networks; and the essential elements of network design necessary to ensure sustainability.

Key words: network development; network governance; network instigation; virtual organizations

Introduction

To open, an anecdote. During a recent meeting a colleague told of a health funder's review visit to his university to assess the work of his health research group, and in particular to look at their dissemination efforts. He was advised verbally that his progress report should contain no reference to 'networks'. 'Networks are out,' he was told.

At one level this is understandable. No public organization in the UK has a better record than the NHS of finding semantic lifeboats at a time of crisis, only to abandon them when they are seen to spring a leak or, more likely, a galleon full of new glistening treasure appears on the horizon.

But, in the case of 'networks', their potential demise could be hastened because of a failure of the NHS to observe one of its own core tenets – to be, as much as possible, evidence based in all it does. And this could be disastrous, because horizontally organized networked activity is known to be superior in effect to hierarchical activity whenever the problems to be solved are complex and delivery systems fragmented. This describes much of primary care, where integrated action is so important.

Evidenced development

In 1997 one of the authors stated the belief that the future of co-operative working, both within the NHS and in its relationship with social care, lay not in reorganization but in the development of virtual organizations (Warner, 1997). In 1998 we undertook a detailed literature review to see if there was good evidence to answer two vital questions about 'networks', which we saw as the fundamental building blocks of virtual organizations. These were:

 (i) What it is that has to be present if individuals and organizations are to be motivated to form or join a network?
(ii) What are the essential elements of network design that will ensure sustainability?

What conditions are favourable to the formation of inter-organizational networks?
Figure 1, which presents a composite of the primary conditions for network formation, is derived

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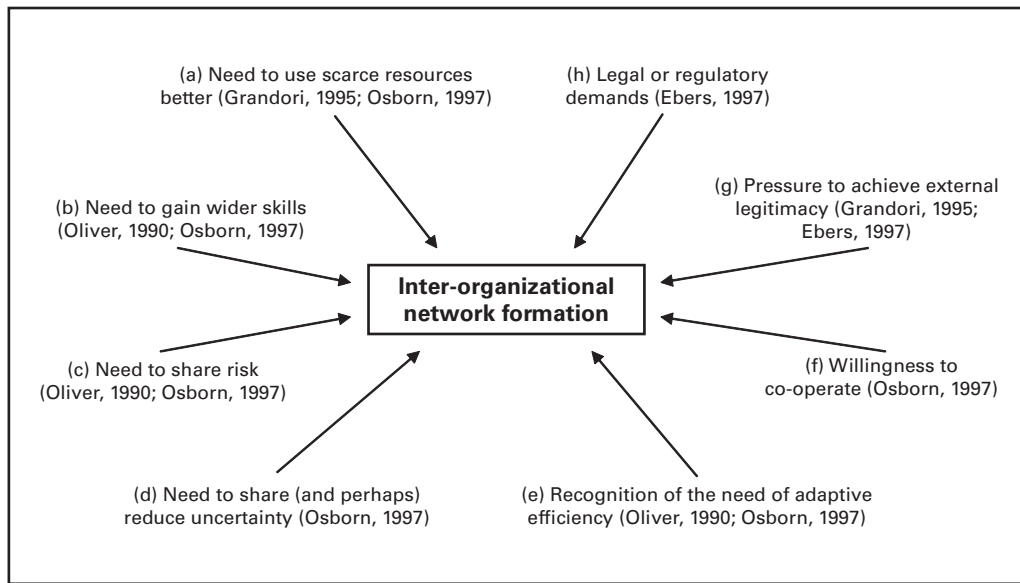
Figure 1   Factors influencing network formation

from a number of reviews identified during the literature search (Oliver, 1990; Grandori and Soda, 1995; Ebers, 1997; Osborn and Hagedoorn, 1997).

Applying the factors to integrated care, they can be grouped under three conventional reference frames:

- *Resources* (a and b): In isolation, health and social care providers often duplicate some services whilst being unable to resource others. Furthermore, formal care providers may lack specific expertise and need to interface with volunteer and informal carers, who in turn often have inadequate financial resources. Networks, then, can be given cause to form when resources are scarce or used inefficiently.
- *Contingencies* (c–f): Care agencies often serve populations where large numbers of clients suffer from multiple pathologies, and requirements continuously change. In this situation, characterized by high risk and uncertainty, and requiring adaptive efficiency, network structures may emerge. These external stimuli may exist alongside an already present willingness for inter-agency co-operation.
- *Institutional* (g and h): Networks in themselves can be perceived as a more democratic and more

legitimate form of organizing than hierarchies. Prospective network members may also feel that they can derive greater legitimacy in the external world by being seen to be part of a larger grouping. It may also be that governments regulate activity in favour of networks by financing not-for-profit organizations to assist in the delivery of integrated care, or by relaxing rules about the pooling of public funds to encourage partnerships.

If 'willingness to co-operate' is lacking, even the presence of seven of the eight factors may not be sufficient to guarantee network formation. Furthermore, when the network form offers organizational advantages, *effort* may still be required to overcome structural inertia or the other reasons for potential network failure (Hannan and Freeman, 1984; Miles and Snow, 1992). Reference to 'effort' serves as a reminder that networks require management (Ibarra, 1992; Gould and Warner, 2004).

What is the minimum set of concepts for useful representation of networks activity?

In this respect, 'Leavitt's Diamond' (Leavitt, 1965) proves useful. It represents organizational
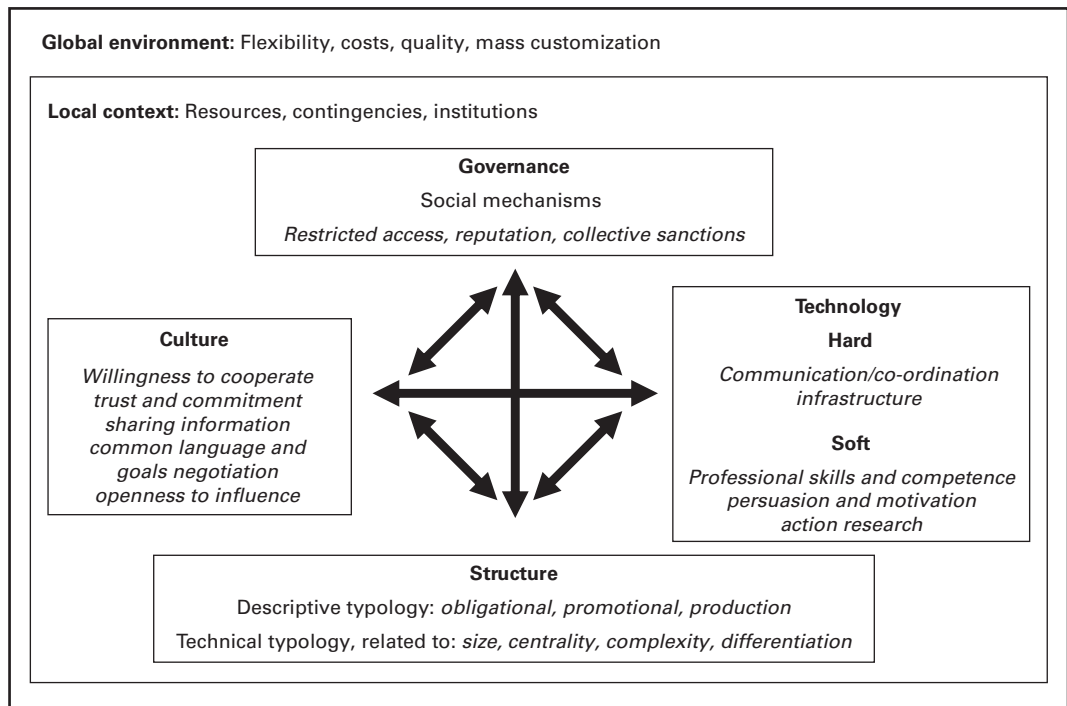
Figure 2 Network design

arrangements using four dimensions: social structure, technology, participants and goals. In Figure 2 we have retained Leavitt's (social) structure and technology but replace 'goals' with 'culture' and 'participants' by 'governance'.

The notion of organizational culture includes goals, and thus a gain in descriptive power. The use of governance is seen as appropriate for network organizations because it is more dynamic, implying not just the involvement of participants but also their social interactions and relationships, including the role of leadership.

To have a more complete understanding of the role of networks in promoting an integrated approach, involves consideration of the technology and culture elements in the figure, and the interactions between them, as well as of structure and governance. Throughout (as indicated by the two-headed arrows) the *interdependence* of dimensions within each given environment is stressed. The evidence suggests that networks which fail to take into account even one of the design headings are very likely to fail.

Conclusion

The challenge lies ahead. Clinical and other 'network' activity is prolific and growing in the NHS (http://www.networks.nhs.uk/networks.php?dir= all); and the duty of partnership between the NHS and Social Services being made more explicit. Many of these networks have, without examining the evidence base, felt their way towards a design which is proving less than wholly satisfactory; and a considerable number might be considered no more than informal groups, meeting few of the criteria for network formation.

One development that might benefit from the considerations set out above is the emerging UK Clinical Research Collaboration networks, which include primary care as well as specific disease areas. To date they are 'networks' in name only and tend to be hierarchical in nature.

Now, then, is not the time to abandon 'networks' but to approach their formation and operation in a more systematic way and give them a real chance to be more effective. A greater level of efficiency will

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be the result; but so, too, will be an increase in the creative thinking that comes about when individuals from different perspectives come together in a non-hierarchical way and work outside the 'psychic prison' of their own organizations (Morgan, 1997).

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