

# **The art of integrated multi-disciplinary partnership working: are there people who just don't want to play?**

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## **Introduction**

The NHS is currently operating policies that encourage joint working (Alexander & Macdonald, 2001), both within its different structures and with various external partner organisations. Part of this context includes a number of directives on the development of Managed Clinical Networks and cancer services (e.g. Scottish Executive, 1999 and 2001). As an idea that was first mooted in the Acute Services Review (Scottish Office, 1998) as offering, 'the best prospect for delivering high quality services which make optimal use of resources and offer more uniform access to patients than is the case at present,' the networks are groups of professionals working together across traditional NHS boundaries. They aim to smooth the patient journey around the system as they transfer between the different NHS organisations, hence the need to cross boundaries.

Managed Clinical Networks have recently been reaffirmed in a new Directive (Scottish Executive, 2002a) that further promotes the development of Managed Clinical Networks, rolling them out beyond the national demonstration MCNs in vascular and stroke services, the cancer services networks, and a pilot Cardiac Services MCN in Dumfries & Galloway (D&G). In terms of MCN evaluation there is not much published evidence available, apart from the D&G MCN interim report (Hamilton et al, 2002). This was based on a review of existing documents and it concluded that this pilot MCN had adhered to most of the core principles (Scottish Executive, 1999), but the authors had found it difficult 'to provide evidence of the widespread involvement and commitment of all the professionals involved in cardiac care in the region.' There are also some valuable lessons to be learned from other developments around Scotland and beyond, but these have not been disseminated in any formal evaluations. The formal evaluations of MCNs that have been commissioned (of the national demonstration MCNs or the commissioned evaluation of the South East Scotland (SCAN) Managed Clinical Network) have not yet been completed, nor have any interim results been reported publicly. Nonetheless, the 15 NHS Boards across Scotland are to have MCNs for Coronary Heart Disease and Stroke in place by April 2004 and their progress towards this is to be reported in the Executive's accountability arrangements (Scottish Executive, 2002b).

It would appear, therefore, that the creation of Managed Clinical Networks seems to be rolling out across Scotland with little information from the formal evaluations of their early development. While it may turn out to be the case that this way of working is inherently beneficial to professionals and patients, at present we have little firm evidence for this view or practical guidance resulting from experience with MCNs thus far. From our previous work evaluating joint working, we have some concerns about the inter-personal relations that can exist between partners ostensibly working towards a common goal (Alexander & Macdonald, 2001), hence the question posed in the title of this paper. We present very preliminary results from a small number of

exploratory interviews with people involved with the West of Scotland Managed Clinical Networks to help us begin to look for an answer.

## **Methods**

Increasingly we are finding with our evaluations of multi-agency partnerships that it is helpful to begin with a series of key informant interviews. These generate themes of relevance to the people involved with the partnership and create a platform from which to design an evaluation that has the potential to help solve some of the difficulties that are likely to be uncovered. Although no series of interviews can hope to uncover all of the issues involved, it seems sensible to try to ground the evaluation in as many of them as possible.

This paper reports preliminary results from the first six of 14 key informant interviews with representatives involved with the West of Scotland Cancer Managed Clinical Networks. The key informants were nominated by two members of the West of Scotland Regional Cancer Advisory Group and included management (network and NHS) and clinical (medical and non-medical) representatives. It had been hoped that all 14 interviews could have been completed for this conference paper, but it has proved difficult to contact some nominees and synchronise diaries with others. None of the 14 have declined to participate.

Interviewees were contacted initially by email with a request for their participation. Attached to this message was a copy of the semi-structured interview schedule, sent to inform the decision about taking part. Those who responded were telephoned to arrange a suitable time for the interview, and those who did not were subsequently sent a reminder by email. The six interviews that have been conducted lasted between 40 minutes and 70 minutes. The questions covered involvement with MCNs, views on their development, strengths and weaknesses, and issues for the future. The interview transcripts were subjected to content analysis in order to extract the main categories and these were then reviewed to generate themes. The analysis of all of the interviews will form the basis of the design of the main evaluation phase, but those results relevant to the hypothesis set above are reported below.

## **Results**

The results are reported using the main themes emerging from the interviews as sub-headings. With a topic like multi-professional working it can be difficult to extract only those themes that relate to inter-personal relations as much of what was said in the interviews could be viewed from this perspective. In this case we have erred on the side of inclusiveness where there was any doubt about relevance.

### ***Behaviours and communication***

One person reflected that 'a lot hangs on how people get on.' While this may appear somewhat trite and even an inevitable fact when relying on people working together, some behaviours had been witnessed that might suggest changing working practices may be perceived as threatening at times. Interviewees had watched 'the egos at work' and noted that there was 'a lot of friction between people' and it was felt that 'a lot is about people being defensive.' One person said that 'we are all human beings and we

need to break through the pain barrier,' a reference to the need for better basic communication between partners.

A number of the responses that related to openness and sharing of data reflected very positive experiences, for example, 'there was no hiding of data and no preciousness about who was responsible or who owned it.' There was also endorsement for people no longer working in isolation and the advantages of peer review and more visible working practices. While it was considered to be 'healthy' that some problems had been brought 'to the surface,' the development of MCNs had 'thrown into sharp relief some uncomfortable issues' that could make working relations more difficult than before 'unless carefully managed.'

There was clear evidence that some people were fully engaging with the development of MCNs while others were less committed. It was pointed out that 'some people feel energised while others feel threatened and want to regain their position of power.' Various possible motivators were suggested, including political imperatives and a 'genuine desire to see things get better.' Disincentives included cynicism, tiredness, and not seeing the value of it. Interestingly, personality was mentioned as both promoting and hindering joint working.

It was overtly stated that 'some people are not playing' and various respondents put forward reasons for this. These included people 'who just seem to want to destroy it,' others who would like to control it, people with their own agendas, and people who 'don't see a wider remit' beyond their own jobs. It was noted that 'people may not want their practice examined or advice from colleagues.' There were also some 'bruised egos' among those who felt they had not been included. While they should theoretically have access to minutes etc., they were unlikely to do so because they were 'not playing.' Some people asked questions about how to overcome this non-participation, but others felt strongly that there should be 'a sanction for positively obstructive people.' One person had noticed that 'people become more communicative when things start to look more successful and they begin to want to participate.'

Communication was specifically mentioned in relation to the many staff dealing with cancer patients who are not part of a Managed Clinical Network. It was suggested they could be reached via 'a better structure for dissemination and communication' to make them feel 'included and valued.' Better communication might also enhance what networks could learn from each other, particularly for those who had been established longer to pass on lessons to the newer networks.

### ***Multi-disciplinary working***

There was a general sense in these interviews that 'getting people round the MCN table [was] a good thing.' While many clinicians had pre-existing informal networks and groups of doctors had come together in multi-disciplinary teams, MCNs included non-medically qualified professionals and allowed 'everyone to get round the table.' It was suggested that the realisation that everyone was in the same boat might help to 'break down tensions.' There were, however, still people 'not committed to the concept' who may need to see more tangible benefits to change their minds. Some of these benefits might include 'personal and professional benchmarking' and getting to

know colleagues at a regional level, making it 'easier to refer to regional specialties' and letting the specialists know that 'the referral is not inappropriate.'

### ***Clinician and Manager perceptions***

Alongside some very positive views on Managed Clinical Networks, these interviews also recorded some negative perceptions. One person described the spectrum as there are those 'committed to making this work, there are those paying lip service to it, and there are those paying lip service to it but at the same time making sure that it does not work.' Part of the tension related to resources, and it was felt that 'Scotland's networks are not supported in a way that suggests to contributors that managers take them seriously' and there were also mixed feelings over who was perceived to have most power and control e.g. 'Glasgow must not be seen as the driver - it has to be shared.' Three of the comments called for closer working between managers and clinicians, both parties being necessary for success. For example, managers have to 'respond to the work going on,' 'clinicians need to be involved with management to feed results into cancer management systems,' and there needs to be a 'coming together of network and management processes to make them efficient.'

### ***Structures and the loyalty dilemma***

A number of the interviewees mentioned the tension between vertical lines of accountability and the horizontal networking that cross-boundary working requires. This was mentioned from a management perspective e.g. 'managers are in a very hierarchical system' and 'Chief Executives are charged with ensuring corporate governance' of their own organisations. MCNs may appear as a threat to this because they 'cut across the system' and the 'current division of money was incompatible' with strategic thinking that reviewed service provision across areas/boundaries. This also created a loyalty dilemma for clinicians working in the networks, as they retained loyalty to their employing organisation, but 'MCNs can make clinicians feel disloyal to their institutions.' One person said their role was to bridge the gap, 'I interface between operational and higher executive level.'

Inter-personal issues were also important in establishing MCN structures, given the perception that 'network managers' creation has been off-beam.' This was a reference to the fact that these people did not fit easily into the health service management hierarchy and that this might make it difficult to recruit good people. Networks would have to integrate with NHS management structures, although it was noted that the network managers would need to be 'supported to do the job.' Some strengthening of the network structures was called for as there was a concern that the structure was not 'robust enough to survive on its own if the personnel change dramatically.'

### ***Contributions and responsibilities***

The current reality was felt to be that 'networks are here to stay' and that 'expectations have been raised and they could be flattened.' They have the potential to be 'very powerful levers for strategic change - the trick is whether we let them work well.' There was also a clear message that people had a responsibility to contribute to the networks and to 'keep colleagues informed of what is going on.' But it was suggested that different levels of involvement could be condoned, as appropriate, e.g. 'the level of contribution is not likely to be the same for everyone' and 'there may be sub-groups or corresponding members to raise issues.'

But there was also a view that this obligation to participate failed to take full account of some of the realities people faced in practice, especially the clinicians. Networks were relying on 'clinicians doing this in their spare time' when 'implementation takes clinical time, but they don't get this back.' Networks had no budgets to resource the contributions of some desirable partners.

One person said that 'everyone is busy, but if there is the will, it will get done.' But 'the people involved should feel it is worthwhile' and need to 'see definite professional and service benefits.' There was currently a 'shared enthusiasm from all clinicians' but this may be time-limited if 'there is not an opportunity to influence strategy or areas to be resourced.' Also progress may be slow and people can 'lose interest.' There was a grave danger that 'if things continue as they are, the cynicism will become destructive in time.'

### **Discussion and implications**

Obviously any conclusions reached in this paper must be viewed tentatively. The results reported are very preliminary and although almost half of the planned interviews have been analysed, the remaining eight may generate completely different themes. However, the six completed thus far have been subjected to qualitative analysis and the themes related to inter-personal relations illuminate some interesting aspects of Managed Clinical Network development.

One person summed up the multi-professional working within MCNs as being heavily dependent on how people get on with each other. Such an obvious statement surely demands further examination? It could easily be dismissed as an integral part of everyone's working lives, except that one of the contrasts described before and after the development of MCNs was that there are now many more groups represented round the MCN multi-disciplinary table than got together previously. In addition, people were no longer expected to work in isolation. There may, therefore, be issues related to how colleagues develop new working relationships and people feel about what may to some be a fairly radical change in working practice.

So, it seems reasonable to ask if the impact of how people get on has this been taken on board seriously, or whether there is any assumption that working practices can be separated out and treated differently i.e. can people be made to work together in networks, or are there at least ways of encouraging them to do so? We should remember that change per se is threatening to certain people, and given that so much of people's identities are wrapped up in the jobs they do, isn't it possible that radical changes to working practices can be doubly threatening?

There was also reference by all six interviewees to tensions that exist between people involved with the MCNs. Mostly this was manager-clinician tension, but there were also issues between some clinical groups. Given that some of these working relationships are relatively new, perhaps we should not be surprised by this finding, but rather we should ask whether most of these negative perceptions can be attributed to a lack of clear channels of communications and mutual respect. And again there is a question over whether these aspects will sort themselves out in time, or whether more active intervention is required. If the latter, what form could this take?

A very common theme in the interviews was lack of clarity surrounding the structure of MCNs and how they are expected to reconcile the cross-boundary working with hierarchical accountability systems. While some people suggested cross-boundary working was incompatible with current NHS resourcing and accountability structures, this is not the view expressed in the latest HDL rolling out MCN development in Coronary Heart Disease and Stroke to all 15 NHS Boards in Scotland (Scottish Executive, 2002b). Rather the MCNs are to link into Board strategy development and progress is to be monitored via the Performance Assessment Framework. Plans for evaluating these developments have not yet been described, so neither the networks nor the Boards have clear guidance on how to proceed, nor is there ready access to examples of good practice for reference.

A number of people referred to the potential for learning that the development of MCNs created. Some suggested that those networks that had been established longer could provide more advice to newer MCNs related to their experience thus far and some of the pitfalls to be aware of. Similarly there were questions over attracting and retaining good people to take on the role of network managers, the level of support provided, and various administration issues. Taken together, these two issues of learning and network operation suggest that it might be timely to review the potential for greater joined up thinking, now that a number of networks have been established and others are at different stages of development.

There was a warning that new developments often only maintain excitement and enthusiasm for a short time. At present there was dedicated funding and the audit procedures had led to some welcomed changes in practice. While some people looked forward to this way of working being rolled out much more widely in the NHS, others questioned whether even the current wave of developments were sustainable. In looking to the future, some interviewees clearly felt that further progress was dependent on some reconciliation of the cross-boundary-vertical accountability issue. Given the difficulties described in relation to finding the time to participate at the current level of involvement, there may need to be discussion around appropriate levels of engagement and mechanisms for MCNs to feed into strategic planning processes. Whether this requires more dedicated support for the networks or not cannot be decided in isolation from the discussion of how to go about it. There remains a question over what the drivers of sustained participation will be.

Finally, there is a need to determine whether the evidence presented from these six interviews supports or refutes the question posed in the title. We conclude that there is clear support for the idea that some people do not want to play, both from people using exactly that terminology and more widely in comments about working in isolation and the tensions that exist between some parties. As yet, however, we can have only tentative suggestions for what can be done about it, and completion of the remaining interviews may alter these preliminary conclusions. Time will almost certainly be required, but whether any active interventions are also needed is not known, especially since there was mention in the results of both the sanctions that might be introduced for obstructive people and the fact that network success had already been seen to turn around previously negative perceptions.

## **Acknowledgements**

The authors are very grateful to the key informants who gave up their time to participate in these interviews and provided such a wealth of data.

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