

Learning report:

Leading networks in healthcare

Learning about what works – the theory and the practice

January 2013



Identify Innovate Demonstrate Encourage

Acknowledgements

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Foreword

In autumn 2011, the Health Foundation launched a programme to support networks in healthcare, and invited applications from leaders of new and established networks focused on improving the quality of healthcare. From these applicants, they selected 30 networks and linked them with a faculty of experts, and with each other, to provide an exchange of ideas, advice, support and training in network leadership and development.

The Health Foundation has been working with, and through, networks for some time as part of its commitment to support the continuous improvement of health services. The aim of this latest initiative was to see what could be achieved by combining the experiences of those who are building and running networks with the theory and knowledge from a range of sectors about what makes a network succeed.

This report describes a work in progress. It captures the experiences of the programme participants as they began working together, highlights key learning and early insights, and examines how all this relates to what the research evidence tells us about running networks.

The report includes the voices of many of the network leaders who took part in this programme. They come from a range of backgrounds, and types of network, but they have certain characteristics in common: they are motivated by a passion to improve the way we provide healthcare, a frustration at the limitations of existing organisational structures, and a curiosity to try different methods to achieve change. They demonstrate huge personal commitment and drive, yet they remain acutely aware of how much their success depends not on their own individual achievements, but on how they work with those around them.

These individuals are leading networks that are in great flux at a time of significant upheaval in our health services. We hope that others with similar goals can learn from their experiences and draw inspiration from their conviction.

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Introduction

In recent years there has been a huge increase in networks – interconnected groups or systems focusing on a shared purpose. In just four years, networks have helped to elect the first black US president, led to regime change in several Middle Eastern countries, created some of the world’s youngest billionaires, and temporarily closed down St Paul’s Cathedral.

So, the huge potential that networks have to address complex challenges is increasingly accepted in political, business and social spheres. But what impact could they have on the way we improve healthcare?

The Health Foundation works with and through networks as part of its commitment to support the continuous improvement of our health services. In response to the apparent increase in the number of networks operating in healthcare in the UK, and having reflected on its own work with networks, the Foundation undertook some scoping work to assess the situation. The aim was to test new techniques for supporting networks that encourage quality improvement.

The scoping work included:

- two brief literature reviews¹ focusing on network effectiveness in healthcare and the impact of social networks
- a programme supporting networks in healthcare

- interviews with people who lead healthcare networks
- an evaluation commissioned by the Health Foundation team working on the networks support programme.²

Exploring the state of healthcare networks

A network can be a powerful way of sharing learning and ideas, building a sense of community and purpose, shaping new solutions to entrenched problems, tapping into hidden talent and knowledge, and providing space to innovate and embed change.

In 2010, Helen Bradburn, the then Director of Communications for the Health Foundation, began to seriously explore the organisation’s potential to extend its work with networks. She says: ‘We are interested in how change happens at scale. We knew from our own experience how networks had been used to sustain collaboration during times of upheaval, or to build support for improvements to quality. We wanted to explore what role we could play in supporting networks to be more successful, make connections and learn from each other, and how we could engage more people in our work in the process.’

The scoping work identified numerous examples of networks, working at all levels of the health system. However, it was not possible to conclude whether networks had become more numerous, or whether they had simply become more visible during a period of change.

¹ Malby B, Mervyn K. *Summary of the literature to inform the Health Foundation questions*. Leeds: Centre for Innovation in Health Management, University of Leeds; 2012. www.cihm.leeds.ac.uk/new/wp-content/uploads/2012/07/Summary-of-literature-May-2012-FIN1.pdf

Malby B, Mervyn K. *Social networks: an additional brief literature review for the Health Foundation*. Leeds: Centre for Innovation in Health Management, University of Leeds; 2012. www.cihm.leeds.ac.uk/new/wp-content/uploads/2012/07/Social-Networks-Review-for-HC-Improvement-FIN.pdf

² Edwards S, Caley L. *Supporting Networks that Improve the Quality of Healthcare; stage one and two evaluation reports*. London: Health Foundation; 2012.



The scoping work identified several factors that may have led to the growth of network activity.³ These factors included:

- redefined organisational boundaries in the health services
- a need for increasing interdependence between healthcare organisations in order to provide services that are more personalised
- networks emerging as a potentially more effective way of working on intractable complex issues that have not been solved through traditional organisational models
- the huge growth in the use of professional and social networking tools, with social networks often providing invaluable support in times of change
- networks being noticed, and therefore becoming more visible.

However, the study also demonstrated how current pressures might also prohibit networks from developing at this time. In the words of one network leader:

I think a lot of hospitals, at a time when finance is tight and what is expected of us is getting greater and greater, are developing a bunker mentality of ‘When the going gets tough, hide in an office and try and think of solutions’, rather than saying ‘This is the time to go out and use networks to understand a problem’.

Interviews with network leaders found that they were often grappling with common issues, such as how best to achieve congruence between their networks’ form and function, how to manage relationships with members, and how to maintain momentum. Many reported feelings of isolation and an absence

of tools or advice to help them in leading a network:

The job of a network director is very lonely because you have colleagues, but they are far flung.

We’re not convinced that we really understand the science that goes behind an effective network and the skill sets we have to display that we’d want to develop in other people.

‘We were seeing what seemed like a growth in network activity in healthcare, and at the same time we were aware of a growing body of knowledge about networks – however, that knowledge seemed remote and inaccessible to a lot of these network leaders,’ says Helen Bradburn. ‘We wanted to help people make connections between the theory and the practice, and, in turn, find ways to ensure our own understanding is improved by the network leaders’ experiences.’

The networks support programme

The Health Foundation launched its programme to support healthcare networks in October 2011. Applicants were asked to outline evidence of their current or potential impact on quality improvement and how their work related to the Health Foundation’s areas of interest. Of the 45 applicants, a deliberately diverse range of 30 networks were selected to participate in the programme.

The participating networks would be supported by the Health Foundation network support faculty. The faculty is a group of independent organisational, leadership development and technical consultants. Faculty members have extensive experience of working with networks in many sectors, both in the UK and internationally

³ Malby B Mervyn K. *Summary of the literature to inform the Health Foundation questions*. Leeds: Centre for Innovation in Health Management, University of Leeds; 2012. p24.



Having been selected, the chosen networks then underwent a diagnostic process. This involved working with the Health Foundation faculty to identify the effectiveness of how their network organises and their development needs. With the faculty, each network co-designed a bespoke support plan, which included a tailored programme of one-to-one support through the faculty and a variety of training and development modules, workshops and Web Exes.

By July 2012, the networks were in the early stages of implementing their support plans.

Three examples of participating networks are described in the box below. See Appendix A for a full list of participating networks and a map showing the areas they cover.

The diversity of network types

Both the scoping study and the applications to the programme demonstrated a wide diversity in the networks operating in healthcare, in terms of provenance, aims, governance, structure, size and maturity.

By their very nature, networks defy neat categorisation, but the scoping study identified the following stages of development for networks.

- **Pre-emergent** a network that is at the planning stage and not yet an independent entity.
- **Emerging** a network that is set up, but is not yet clear about its strategy, form and function.
- **Established** a network that has a clear strategy, form and function.
- **Dormant** a network that has been established at some point in the past, and may still have a remnant infrastructure or membership, but has ceased to fulfil the intended function.

Networks participating in the programme come from across this range, and include those with local, regional and national remits. Some of the networks are highly formal, with a clear management structure and detailed governance arrangements, others have grown organically in response to a specific need. While some have been set up by groups of individuals who run the network in their spare time.

Three participating networks	
NHS Quest	A member-convened network of foundation trusts, NHS Quest aims to improve quality and safety. Members work collectively to innovate and share learning, supporting leaders at all levels in running improvement projects, promoting best practice and measuring their impact.
The Network	Established in 2010 as an online community of medical students, junior doctors and newly qualified GPs and consultants with an interest in clinical leadership and medical management. Since its launch, The Network has attracted more than 2,000 members.
Advancing Quality Alliance (AQuA)	AQuA brings together healthcare organisations in the North West of England to help them provide the best possible healthcare services. It helps to stimulate innovation, spread good practice and support local improvement work.

EXPERIENCE: Widening membership through consensus building

Iain Smith runs the North East Transformation System (NETS) – an improvement collaborative that includes foundation trusts, commissioners and improvement networks. NETS was originally set up by a strategic health authority, but has since shifted to become a regional coalition of interested organisations.

About our network:

We have changed significantly in six years. Our direction is now driven by consensus rather than top-down directives, and success now depends on adding value. Although our original model was appropriate at first, it's also been a barrier to engaging with some organisations – foundation trusts, in particular.

We're now providing training in organisations that wouldn't have been involved with us before. Training small groups of staff to run rapid improvement workshops has a real multiplier effect. Within nine months, we can reach potentially hundreds of people in one organisation.

This much I know about running a network:

You can't take for granted that everyone is going to do what seems obvious to you. Building consensus is time consuming, but it is time well spent.

What I wish I had known when I started:

Probably how to run a network! I am still no expert, but I've learned some techniques along the way. We are running more engagement events that start with our audience, prompting them to help us shape our work as a network. Rather than telling them what we're doing, we're asking them what we should be doing. It does help build ownership.

What I wish I knew now:

The magic ingredient that turns someone into an advocate overnight. If there was one, I'd bottle it.

Our work with the Health Foundation:

It's provided us with the impetus to make things happen. The diagnostic work has helped us to focus on our purpose: what do people want from us, and how do we describe what we're trying to do? The work's also made us more aware of other Health Foundation opportunities, and we've since won funding for another initiative.

Iain's tips for network leaders

- Face-to-face meetings and events are essential, but don't overload people. And keep your meetings fresh and varied so they keep coming back.
- Borrow ideas from others. Another network introduced us to a technique they call 'flipchart road show'. Delegates draw up a flipchart outlining a problem they'd like help with. Then everyone circulates around the room for 45 minutes, discussing them and including their own comments. We found this worked well to get people talking and exchanging contact details. .
- Ask for freebies, share resources and piggyback other events. You'll be surprised at what you can achieve for little outlay, or even for free.
- Don't worry if overall consensus feels unachievable. There's usually some action that everyone agrees on. Simply trying something – however small – can help to move you in a positive direction.
- If you're passionate about your subject, give it a go. There are many different leadership styles for achieving a strong network, but it's the passion that counts most.

www.NElean.nhs.uk

EXPERIENCE: Setting up a community of interest

The North East Shared Decision Making Community of Interest focuses on shared decision making (how patients can be engaged with clinicians in decisions about their treatment and care) and shares knowledge and understanding about how best to do this. In less than a year, the network has grown from an idea conceptualised by two founders to a programme of meetings, events and publications that involves more than 250 people across the North East. Richard Thomson, Professor of Epidemiology and Public Health at Newcastle University, helps oversee the network.

About our network:

Our goal is to embed shared decision making across the North East. We would describe ourselves as a movement. Shared decision making is increasingly prominent in NHS reform. There is strong evidence that involving patients in decisions about their own care is of benefit to patients, to clinicians and to the NHS – yet less than half of patients leaving hospital report that they feel adequately involved in treatment decisions. Awareness of this gap continually drives us forward.

From day one, our approach has been open, responsive and inclusive. We have tried not to manage groups of people interested in this area, but instead to get them talking about these issues, and to create influence through their interactions and discussions.

This much I know about running a network:

It is essential to think about what you're setting out to achieve, to be self-critical and to continually revisit your goals.

What I wish I had known when I started:

Don't underestimate the importance of a central skilled resource to support the network. Early on, we were able to identify funding to appoint a coordinator. It's a critical role: someone dedicated to organising and running our meetings and keeping good records.

Our work with the Health Foundation:

The Health Foundation work has provided us with a sounding board and a source of facilitation and challenge. We are not experts in networks: we had an idea and got on with it. So, it has been helpful to talk through the typology of networks. This helped us articulate what we were.

Richard's tips for network leaders

- Start with the enthusiasts, and work with people who already have strong informal networks that you can plug into. We set up a steering group early on, which ensured representation from a good cross-section of these people.
- Spread your net wide in recruiting members. Diversity in membership can become one of your biggest assets. For example, we have active involvement from patients, carers and a number of patient groups. They bring an important perspective, and we have been able to create a unique space for patients and clinicians to discuss these issues together.
- Use a thematic approach to bring in new members, reflecting the priorities that have emerged from the community. There is a core group of people who come regularly to our meetings, but the use of themes has helped us widen out. For example, we have been able to recruit more pharmacists as a result of a recent focus on medicines management.
- In all your activities, always identify a product or a take-home message or action.

There is a growing body of knowledge about networks, their characteristics and what makes them effective. The Health Foundation's scoping work included two brief literature reviews.⁴ The Health Foundation faculty members have drawn extensively on this review of the evidence base, alongside their own knowledge, in their work with participants in the networks support programme.

This section summarises the major insights from this research into networks.

What are networks?

Networks are defined as cooperative structures where an interconnected group, or system, coalesce around shared purpose, and where members act as peers on the basis of reciprocity and exchange, based on trust, respect and mutuality. Networks can be set up for a variety of purposes: to promote a policy agenda, to support collective learning, to advocate for change or to actually change practice.⁵ The literature on networks spans many disciplines, and draws on multiple theoretical perspectives.

Various studies have identified the characteristics that networks typically share. Networks tend to form and reform continually, in a dynamic way, with leadership commonly emerging from different parts of the network for different types of work.

⁴ Malby B, Mervyn K. *Summary of the literature to inform the Health Foundation questions*. Leeds: Centre for Innovation in Health Management, University of Leeds; 2012.

Malby B, Mervyn K. *Social networks: an additional brief literature review for the Health Foundation*. Leeds: Centre for Innovation in Health Management, University of Leeds; 2012.

⁵ Malby B, Mervyn K. *Networks – a briefing paper for The Health Foundation*. Leeds: Centre for Innovation in Health Management, University of Leeds; 2012.

Leadership of the whole network is usually temporary, and networks vary hugely in their permanence, with some being ad hoc or temporary while others are established and long term.

Becky Malby is Director of the Centre for Innovation in Health Management at Leeds University Business School. She helped to set up and lead the Health Foundation's faculty, undertook the brief literature review, and has extensive experience working with healthcare networks. 'As a means of organisation, networks are relatively poorly understood in the NHS – and yet I'm not surprised that many types seem to be emerging,' she says. 'Networks are often creative, innovative places where resources can be shared for the common good. They are highly relevant at a time when resource is under pressure and when long-established working patterns have to change.'

The research literature shows that the distinctiveness of networks lies in:

- their ability to be innovative and creative, and their reliance on diversity
- the distribution of power and leadership across members
- reciprocity and exchange as the defining relationship between members, based on mutual interest around a common purpose
- fluctuations in member engagement and impact
- their adaptability to survive and thrive
- their focus on generating and sharing knowledge.

Becky emphasises one particular way in which networks are distinctive: they need to be managed, but in collaborative, non-hierarchical ways. Becky believes that the time



it takes to do this is often underestimated. She explains: ‘Those network leaders who are now working with the Health Foundation and our faculty are managing complex relationships with a dynamic and diverse group of people. They are operating outside the more traditional command and control structures that have historically determined change in the NHS.’

She adds: ‘As a group of people, the network leaders have tremendous energy and conviction, but they are all working in a difficult context. Many are managing constant change and need to continually re-visit and clarify purpose.’

What are networks useful for?

As networks are primarily innovative, creative places, they are useful for rapid learning and development, and for amplifying members’ effectiveness. Networks can also be useful for advocacy on behalf of their members, and for delivering services in ways that make the most of network members’ capability and resources.

The box below summarises the key functions for networks identified by Mendizabal and Hearn.⁶

Primary functions for networks

- **Community building** The network functions to promote and sustain the values of the individuals or groups.
- **Filtering** The network functions to organise and manage relevant information for members.
- **Amplifying** The network functions to help take new, little-known, or little-understood ideas and make them public, give them weight, or make them understandable.
- **Facilitating** The network functions to help members carry out their activities more efficiently and effectively.
- **Investing or providing** The network functions to provide members with the resources they need to carry out their main activities.
- **Convening** The network functions to bring together different, distinct people, or groups of people with distinct strategies to support them.

⁶ Mendizabal, E and Hearn, S. 2011. ‘Inter-Agency Network for Education in Emergencies: A community of practice, a catalyst for change.’ In: Anderson, A and Hodgkin, M. (eds.) *IIEP research papers*.



Networks in the UK healthcare system

The scoping study identified huge variation in the scale, type, interests and development needs of the existing networks, and concluded that ‘Networking is perhaps... a field of the health services that is less naturally inclined to classification than others.’

The literature review⁷ categorised the main types of network, and explored how these might translate to networks operating in the UK. It found that networks exist on a continuum from the ad hoc to more established, encompassing coalitions, partnerships, alliances, unions, leagues, associations, federations and confederations. These may be local, regional, national or international. The table below highlights several distinctive types of networks identified by the literature review.

Type of network	Description	Examples
Developmental or learning network	Focuses on specific issues, such as improving access to healthcare or standards of care for specific patient groups, where the members can learn and change	Advancing Quality Alliance (AQuA) Communities of Practice Collaboratives Enclave networks, such as Disrupting Poverty in Leeds
Agency network	Characterised by cooperation and shared services across interdependent members	Shared Lives Plus
Advocacy network	A network that advocates for change and/or a shared cause across its membership (organisations or individuals)	Parkinson’s Action Network
Managed network	Associated with service delivery. Central leadership, hub and spoke governance, with the hub having clear authority. Arguably more closely aligned to a hierarchy than a network. Work is carried out through peer task groups. Governance is a professional model. Successful where authority is balanced with member engagement	Diabetes Research Network Integrated Care Programme National Cancer Action Team North Lanarkshire Partnership
Social network	An individualised network of social relationships, as opposed to formalised or structured relationships. The purpose is individual learning, connections, creating personal visibility and support	Doccom LinkedIn Twitter Informal local social peer networks
Social movement	A network with a common cause that connects individuals prepared to campaign, lobby and share intelligence in service to that cause	The Occupy movement The World Social Forum

⁷ Malby B and Mervyn K (2012) *Summary of the literature to inform the Health Foundation questions*. Centre for Innovation in Health Management, University of Leeds.



Many networks within the NHS are hybrids of these ‘pure’ network types. However, if they are to be genuinely effective, experience suggests that their structures and ways of operating do need to be aligned with the type of network they aspire to be.

Network leadership

Research has highlighted differences between leadership of networks and leadership of hierarchies. This is because networks organise principally through cooperation and peer-based relationships.

Network leadership can be described as ‘facilitative, distributed, democratic and inclusive, and making the most of difference for creative ends’. Becky Malby emphasises that for those whose experience is primarily in leading a hierarchy, this can be a challenging transition to make. She explains: ‘Network leaders need to focus persistently on membership and impact. For example, are their members engaged? Are members’ preferences and needs reflected in the network’s activity? Are the relationships truly reciprocal? How is the collective purpose changing over time? How is the network assessing its impact?’

What makes networks effective?

Researchers have found that attention to membership, leadership and impact are all critical for a network to succeed. The Health Foundation faculty involved in the networks support programme drew on the evidence and their own experience to identify a series of features that are commonly found in effective networks.⁸ These features are summarised below.

Shared purpose and identity

Members of effective networks display strong network awareness. They feel ownership and they know why the network exists. They are clear on shared purpose. Members also share a common language and collective narrative.

Addressing big issues or having a compelling purpose

Effective, self-sustaining work-based networks normally address big or compelling issues that are a high priority for key ‘sponsors’, stakeholders or network members. Because they focus on issues that keep network leaders awake at night, they are likely to receive support in some way or another.

Meets member needs

Although effective networks generally address big issues, they also have to be of day-to-day benefit to members in the network. They ultimately have to link back either to helping members to do their job or to helping them to create a change that they are passionate about.

⁸ Malby B, Anderson-Wallace M, Archibald D, Collison C, Edwards S, Constable A, Dove C. *Supporting networks that improve the quality of healthcare. A developmental diagnostic process to support network development*. London: Health Foundation; 2011.



Adapted leadership

Leadership of networks is different to other forms of leadership. In networks, the power does not come from organisational hierarchy. Effective networks benefit from leaders with well developed skills and aptitudes who have the time to perform their role.

Strong relationships and ties

Effective networks are characterised by strong personal relationships and high levels of trust and awareness between members. Leaders can play a key role in developing trust and a culture of sharing, with face-to-face events playing a key role in maintaining relationships and ties.

Generate helpful outputs

As well as connecting people, effective networks tend to generate outputs that are helpful to other network members. These outputs are often developed or co-created, drawing on experience 'on the ground'.

What makes networks fail?

The body of knowledge on networks is still emerging – particularly in relation to why healthcare networks survive or fail. However, research to date suggests that networks can fail because of one or more of the following factors.

- A failure to reach a sufficiently common understanding across members of purpose and direction.
- Institutionalisation, with a tendency to excessively control and to manage out diversity rather than working with it.

- Over-management, with networks getting bogged down in the governance arrangements and bureaucracy they were originally set up to overcome. This is often caused by cementing relationships and structures that should have remained dynamic and evolving.
- Lack of attention to initial design and/or failure to design for evolution.
- Unrealistically high expectations of network members' willingness or ability to collaborate, which damages creativity, and a failure to regularly discuss, share and test expectations among members.
- The tendency to prioritise some network members' interests over others.
- Actions that constrain network members' independence – especially their need to interpret or express the work of the network differently at a local level.
- A lack of recognition when leadership needs to change or rotate.
- Insufficient impact in terms of fulfilling the purpose of the network members.
- Failure to recognise the breadth and depth of different kinds of knowledge from within the network.

Becky adds: 'Our faculty members have been working with the leaders of some of the newer networks to promote an understanding of the range of network types and of how to design their network structure and architecture to enable successful starting conditions. With the better established networks, we have been working to ensure that leadership is more widely distributed as members become connected and committed to the work of the network.'



The impact of health networks on quality improvement

The interviews conducted to inform the design of this work sampled the views of those who already have a stake in networks. The interviewees represent a group of people who believe that networks can address a gap not currently met by NHS structures. As one says:

I'm a complete fan of networks when it works well and everyone really collaborates. Without the network, we would never have had stroke telemedicine. A year ago, none of our patients who had a stroke out of hours received treatment for it. Now they all do. That would not have happened without the network or organisations and commissioners working together to deliver that.

Through the literature review,⁹ the scoping work identified little evidence on the impact of networks in the health sector, and the overall potential of networks in the NHS landscape is relatively untested in terms of impact on patient care and governance. Nevertheless, there is some evidence of the impact that collective learning can have on improvement work.

The emergence of networks can be seen as the NHS adapting to increasingly complex care issues that transcend organisational boundaries, and there is a growing interest in this area. Research is increasingly focusing on how collaborative work across disciplines and organisations might accelerate best practice and how e-technologies might influence the way knowledge is created, accessed, shared and applied.

Meanwhile, research on employee networks has shown that significantly more information can flow through social and informal networks than through hierarchical structures. There are also documented examples of the way that social media technologies such as blogs and social networks can improve healthcare provision.

Becky Malby explains: 'The evidence that would enable us to measure the potential impact of networks on quality improvement is very limited, with even less evidence on which forms of network best support improvement. However, there is a growing energy and enthusiasm in this field and a sense that more healthcare networks are forming to tackle an unmet need.'

She continues: 'There are also early findings that social networks improve individual, team and organisational performance in healthcare – particularly where they lead to more information sharing, and where they are inclusive of diverse groups of people.'

Networks ebb and flow, and it is in their nature to thrive and then to cease. However, as outlined above, there are key design features that can make them more sustainable and more impactful.

⁹ Malby B, Mervyn K. *Summary of the literature to inform the Health Foundation questions*. Leeds: Centre for Innovation in Health Management, University of Leeds; 2012.



Views and insights from the faculty

The Health Foundation faculty has been supporting the networks to develop through this work. Faculty members have extensive experience of working with networks in many sectors, both in the UK and internationally. In this section, some faculty members provide some personal reflections on the work.

On the nature of networks:

By their nature, networks are messy, uncertain, indistinct, and may appear quite illogical from the outside looking in – and that is why they work. Even a more centrally managed clinical network will need to retain this complexity in order to function at its best. The moment a network issues its organisational chart is the moment when it has, perhaps, crossed the line into becoming a regular hierarchical organisation.

Sarah Fraser

Sarah Fraser is an internationally recognised expert on scaling up and spreading good practice.

Networks have personalities and they work in different ways. The more formal you become, the more you risk losing creativity.

Ginny Edwards

Ginny Edwards is a service improvement and change management specialist and former National Director of the Modernisation Agency's Critical Care Programme.

On measuring impact:

The more organic networks shouldn't fear the instinct to follow their nose and their drive for change. It's the fundamentals that matter: know what you're trying to achieve and how you're going to measure the impact you've had. Without this, how do you know you've done what you set out to do? And how do you convince others of the value that your network brings?

Ginny Edwards

On sustainability:

Everyone is worried about sustainability – and rightly so. There's no 'sweet spot' that you will reach where a network will run itself. You have to continually attract and retain your members – you can't make them fall into line. It's got to mean something to them.

Ben Lee

Ben Lee has specialised in supporting public service reform through communities of practice and networks.

On healthcare networks:

The networks I have been working with are trying to turn around 50 years of practice and attitudes – whether attitudes to quality, shared decision making, or working with young mental health users. They are insurgents with a motive, who want to turn 100 people on a course or an email list into a movement of like-minded people. All want to take stock of purpose, all are struggling with the role that service users should play, and all want to better understand how they should communicate and use social media.

Ben Lee



In healthcare, the managed clinical networks have dominated, and they have had a huge and beneficial impact. But we shouldn't overlook the real value that the more informal networks can bring: the less visible networks that pick something up and run with it; the curious and passionate people who may not know the theory but who spot an opportunity or a need, and go for it.

Douglas Archibald

Douglas Archibald has over 15 years' experience participating in, designing, facilitating and reviewing networks in the private and public sector.

On network leadership:

A network leader often doesn't know that they are the leader. They are the people who use their contacts list, who talk about their topic with passion, who are unafraid of pushing the boundaries – and often who are working against a bureaucratic tide.

Sarah Fraser

Leading a network is fundamentally different to leading in a hierarchical organisation. It requires a willingness to work with complexity, to share decision making with others, and to facilitate effective communication and working between network members.

Andrew Constable

Andrew Constable is a leadership development expert.

On adapting leadership approaches:

Rather than coming up with a comprehensive plan or strategy at the outset, networks tend to thrive on constant, dynamic iterations based on changes in context and new knowledge that develops through action. So, developing mechanisms for regular 'in-course adjustments' to keep action relevant and fresh is a crucial leadership task.

Murray Anderson-Wallace

Murray Anderson-Wallace specialises in strategic communications and collaborative strategies.

A change in leadership style is often required between the early stages of setting up a network and leading a more established or mature network. The former often needs an enthusiastic, energising approach to get things off the ground, and to mobilise others. But the latter is often about facilitating and supporting other network members, and responding or adapting to emerging needs and opportunities.

Andrew Constable

On building consensus:

It's important to recognise that in networks, consensus is not a precondition for action. Of course there has to be a sufficient shared sense of the big issues, but agreement about exactly how this is achieved is more likely to be a local interpretation. Creating real tasks and activities that help to build relationships is much more important than seeking 'soggy consensus' in the abstract.

Murray Anderson-Wallace

EXPERIENCE: Connecting in a globalised network

Dr Peter Lachman is one of the leaders of the QI Alumni – a network that provides mutual support and learning to members who have taken part in the Health Foundation's Quality Improvement Fellowship programme. The programme involves one year of academic study and practical learning at the Institute of Healthcare Improvement (IHI) in Cambridge, Massachusetts. Membership grows annually as more fellows complete the programme. Members are based around the world and are leaders in their respective fields.

About our network:

Since we formed, five years ago, the number of times we meet annually has grown. In this last year, we met for three conferences. Our common link is the Quality Improvement Fellowship programme. It is a life-changing experience. No one stays the same after it.

Between conferences, members have worked on quality improvement projects together. It can work to have a defined time or subject when all fellows can come together. In 2011, the topic was the IHI's Triple Aim, a framework for optimising the performance of healthcare systems. Members researched it, created a set of slides, delivered it via WebEx, and then all participants committed to cascade that lecture within the same week in their various locations. This was accompanied by comment and analysis via LinkedIn and Twitter. For 2012 the topic is 'sustainability in healthcare'.

This much I know about running a network:

Aim to make it as easy as possible for people to join in. These people are highly skilled and motivated, but they don't want to feel an obligation – they want to dip in and out. It's important that it is their choice whether to participate or not. The aim is to develop an organic network that meets the needs of members at different stages of their career.

What I wish I had known when I started:

You need to facilitate members coming to the face-to-face meetings, then make sure that the quality is right when they get there. We have a six-person agenda committee and a conference chair that bring it all together. Making use of email and WebEx technology has worked for us, and we need to expand these links.

How our network is changing:

The network gains about six new members every year from the UK and USA, and as it gets bigger the links change. At the beginning, I knew everyone. Now the dynamic is different, and we have to find different ways of working.

Peter's tips for network leaders:

- If the network is remote, make it easy to communicate electronically.
- Put in place a wide range of tools, such as Facebook or LinkedIn, as not all members will use a specific one.
- Develop a LISTSERV (an electronic mailing list) for all members, with clear rules of engagement.
- Consider use of social media. Twitter can connect many with updates of latest news.
- Encourage face-to-face meetings, as these will improve the virtual contact. Ask constantly why some members do not participate, and reach out to them.

EXPERIENCE: Achieving strong direction and shared ownership

Rev Paul Nash, Senior Chaplain at Birmingham Children's Hospital, runs the Paediatric Chaplaincy Network. This network supports spiritual care staff and volunteers who work in hospitals, hospices and the wider community with very sick or dying children and their families. He co-founded the group with Rev Jim Linthicum, Health Chaplain at Great Ormond Street, so that paediatric chaplains could share ideas and support.

About our network:

Our members face some unique pressures and appreciate the opportunity to discuss shared problems and challenges and work together on new resources where these are not available. We now have 95 members, who get together annually, and who communicate regularly over email. We have set up a website where members can access resources. New members enquire every month.

This much I know about running a network:

We call ourselves convenors, not leaders. This means continually stressing to members that 'we are in this together'. Your approach needs to be sufficiently light touch that people feel they own the network, but still firm enough to move everyone forward.

You have to be focused yet inclusive. You can't wait around for everyone to get started, but you also have to be secure enough to give away ownership from the outset. I've never done any work without asking the opinion of members first. We can agree on child bereavement, but you wouldn't believe the strong opinions a new logo can excite!

What I wish I had known when I started:

At our first meeting, I brought along some draft working guidelines that I had laboured over, and I was nervous – and, frankly, paranoid – about how my peers would respond. But they just wanted to get on with it and start discussing things. I've found that most people are grateful that somebody is doing what is needed.

Our work with the Health Foundation:

The programme gave us an opportunity to focus on the development of the network, rather than simply the outcomes. We have had some really interesting discussions about how we take decisions and how we distribute roles. Since then, one member has offered to oversee the website, and we are exploring whether to establish regional and national representation roles.

Paul's tips for network leaders:

- Find a few peers and check if they can also see a need, then tentatively explore the possibilities together. Don't wait for a groundswell: just gather a few like-minded people and see if momentum builds.
- Give people choices to get involved in the areas they are interested in.
- Initiate new projects that meet a shared need. Doing this has given us a focus, and the resources we produce help newer members see that we're not just a talking shop.
- Be ambitious in the long term but realistic in the short term. Don't wear people out by expecting too much. Always stay mindful that they have a day job to do.

www.paediatric-chaplaincy-network.org

EXPERIENCE: Challenges and opportunities in establishing a new network

Dr Miranda Wolpert is a clinical psychologist by background and worked for many years in the NHS and in school settings before founding the Child and Adolescent Mental Health Services (CAMHS) Evidence Based Practice Unit (EBPU) in 2006. Miranda is in the early stages of setting up a new network and chairs the CAMHS Outcome Research Consortium (CORC) – a collaboration of over half of all child and adolescent mental health services in England committed to using routine outcome evaluation to inform practice and service development.

About our network:

We are looking at how to formalise the collaboration between those involved in child mental health services. Our particular interest is in those who are innovating: frontline practitioners, commissioners, service managers.

Through the training we run at CAMHS EBPU, there is already an informal community in loose contact out there. The question is: how can we get people to see themselves as a collaborative network? What are the shared values or views that could bring them together? This is a group of people that are feeling particularly battered and ground down at the moment. We want to link them up with other like-minded souls.

This much I know about running a successful network:

You need a strong common purpose and a central group or individual committed to running the network. Without that, it just doesn't work. You have to be able to meet face to face at some intervals, and you'll need to demonstrate some evidence of progress, both to the network members and externally.

Finding the balance between top-down and bottom-up is a delicate tightrope to walk. It's no good having one person dictating and others doing the bidding, but neither does it work to have everyone debating by committee and no decisions made. That almost needs negotiating on a daily basis. But when it works, I find it very exciting. If the balance is right, there is a real energy and creative buzz to it. If you allow people the space to come up with the answers to problems, they do.

What I wish I had known when I started:

You have to be rigorous about not allowing people with their own agendas to take over, and there has to be a small team with some resource at the core. This means that you need a champion with validity for your network members. They don't have to be full time, but if, for example, your network is for clinicians, they will want to know that there is someone involved who has 'walked it themselves'.

Forget the need for administrative support at your peril, because if you don't have it, it doesn't happen. There needs to be someone to answer emails, check that the website and database is up to date and facilitate events. Long term, that can't be the champion or they will burn themselves out.

What I wish I knew now:

It doesn't work to try to be all things to all people. That's why we're spending time working out the particular niche and direction for this new network.

Our work with the Health Foundation:

We have found the bespoke support from faculty members very useful in helping to clarify our purpose. We're still debating the most appropriate common focus for this network. Is it shared decision making or collaborative practice? I don't want to reinvent it if someone else is already doing it.

They have encouraged us to have a tight audience focus – so we are looking at those innovators who lie at the far left of the adoption curve. And we're spending time exploring the different platforms available for us to communicate with, such as Facebook and LinkedIn. The tailored help from the faculty works. It is totally relevant for our context.

Miranda's tips for network leaders:

- You'll go down a lot of blind alleys, and that's OK. It's good to model failure and to show that it's not a big deal.
- Resist being over-ambitious. Be very clear about what is needed from your network.
- It's the people that matter – not the perfect website. So don't put too much faith in technology.
- Communicate, communicate, communicate. People will come in and out of the network, their attention will peak and wane, they will forget things. You cannot communicate enough.

www.ucl.ac.uk/clinical-psychology/EBPU

www.corc.uk.net

Debates about the reform of the UK's healthcare services have tended to swing between arguments for centrally driven targets versus those for market-led competition. But a growing body of work is throwing light on a different kind of change, brought about not through markets or institutions but by individuals. These individuals are organising themselves into networks or communities, using approaches that 'connect with and mobilise people's own internal energies and drivers for change, in so doing, creating a bottom-up, locally led, grass roots movement for improvement and change.'¹⁰

The Health Foundation's network support programme reflects the growing appetite among health network leaders for increased support and advice, to help them increase their impact.

David Fillingham is Chief Executive of the Advanced Quality Alliance (AQuA), which is participating in the programme. David comments: 'At AQuA, we are seeing different organising structures for healthcare now emerging that blend together the best elements of hierarchies, markets or networks.'

He adds: 'I have become increasingly interested in what we might be able to learn from network approaches. Future healthcare leaders will need to operate in a networked world, and I saw the value of this at first hand during my time as a hospital chief executive in Bolton. The leaders of all the public-sector organisations in the town took responsibility for different aspects of the community's life and then, as a group, pooled that knowledge to better understand the challenges of the people we served.'

¹⁰ Bate P, Bevan H, Robert G. *Towards a million change agents: a review of the social movements literature – implications for large-scale change in the NHS*. London: NHS Modernisation Agency; 2005.

Emerging insights from the networks support programme

At the time of writing, the networks participating in the networks support programme were still at an early stage of implementing their support plans. However, as part of the evaluation of the programme, the Health Foundation's evaluation of the diagnostic phase¹¹ (which included in-depth interviews with 14 programme participants) found that participants had highly valued the work done so far – especially the diagnostic aspects. In particular, network leaders found it helpful to have a fresh perspective and some independent facilitation, and believed that their networks had benefited from the structured and objective process of developing a support plan.

They also reported that the process had encouraged their networks to invest time in considering the networks' purpose, design, governance and leadership. One interviewee explained: 'It gave us a language and tools to reflect on our nature.' Some reported that it had taught them the importance of pacing their development. In the words of one interviewee: 'It's like building a ladder: you need to put the rungs in the right order.'

It is worth noting that many of the networks involved in the programme have been in a state of constant flux. Some have reconfigured, refocused and changed leadership or direction, even during the short time that the programme has run.

Evaluation co-author Sophie Edwards, who conducted many of the evaluation interviews, says: 'Every network has a different story to tell, but all have faced some universal challenges. Many are keen to learn about

¹¹ Edwards S, Caley L. *Network Support Programme: stage two evaluation report*. London: Health Foundation; 2012.



how other networks had overcome these – for example, how they have balanced strong leadership with a member-driven approach. There is also a prevailing sense that some of the problems they face may feel intractable, but that it's OK and inevitable to have a small core of active members and an often much larger, more passive group. It can be helpful to accept this dynamic and work with it.'

Penny Pereira, the Assistant Director at the Health Foundation who has led the work, says: 'We have found that these networks are fulfilling roles and tasks that are hard to achieve in other ways. Networks usually form when there is a need that cannot be addressed through conventional systems and structures. They appear to offer a critical means of achieving change across boundaries, which is a top priority if we are to deliver the design needed to secure high quality care at a cost that's affordable for the long term.'

Penny adds: 'This work is helping us really understand the challenges networks are facing. We are learning as much from the networks as we know they are learning from their work with our faculty.'

Next steps for the Health Foundation

As this report shows, the Health Foundation's initial literature review has thrown up important questions about the evidence of the impact that networks can have on quality improvement in healthcare. It therefore plans to complete a more in-depth analysis of the significant body of published material on networks. It will also take stock of its experiences during the programme, and review how it might share learning about health networks and the impact they can have on quality improvement in the future.

Additional resources

See Appendices B and C for the following additional resources for networks, produced by the Health Foundation faculty.

- Further reading about networks – a recommended reading list, with brief book reviews by faculty members. Appendix B.
- Glossary of network terms – a glossary of terminology used in relation to networks. Appendix C.

If you would like to stay up to date with our work and activities, please sign up for our email newsletter at:

www.health.org.uk/enewsletter

You can also follow us on Twitter at:

www.twitter.com/HealthFdn

EXPERIENCE: How to sustain an established network

Since 2009, Rebecca Larder has been Network Director of the East Midlands Cardiac and Stroke Network – a managed clinical network that has been particularly successful in engaging clinical leads in its work. Over the last 12 months, she – along with leads from other existing networks and clinical work-programmes in the East Midlands – have established a new umbrella network for cardiovascular disease uniting existing networks in cardiac, stroke, renal, diabetes and vascular disciplines.

About our network:

We think there are synergies around the wider cardiovascular disease agenda. The challenge is to find the right purpose for the new overarching network. Each of the individual networks is successful in its own right, with different clinical leads and quality improvement programmes. We need to add to that and not lose anything of what's already working.

This much I know about networks:

I think that networks are fundamental to the future of the NHS. We need to look at whole systems of care: models that cut across professional and organisational boundaries.

Clinicians seem to love networks – not those that are talking shops, but those that really make a difference to practice. It becomes very exciting when you have clinical involvement and buy in. Networks are particularly strong around that common shared purpose: people want to be there. Organisations tend to push people to achieve, but networks pull them instead. It's a person-centred dynamic.

What I wish I had known when I started:

In my experience, strong and effective clinical leadership is key. We made sure that chief executives are on board with our change programmes, but we have always put the clinical case and pathway first. Clinicians need time, support and freedom to contribute, and we have paid organisations to release the clinical leads to do sessions for us. That was important for initial buy in, and the clinicians have been fantastic: always committed and focused on the greater good of the network.

Having some resource for support, including events, is invaluable. It's also been important to demonstrate better ways of working. We've done successful service reviews, with expert multidisciplinary teams walking the patient pathway and assessing how care meets evidence-based, best-practice standards.

Finally, I think you need to focus your energies and efforts. That focus will change over time, but be clear about the one or two things that you are there to achieve.

Our work with the Health Foundation:

Because the Health Foundation came to us with expertise and an agenda-free approach, that enabled us to explore in a very open way what our shared purpose should be for the new network. We've also had some support from them around implementation science. Often, we know what good practice looks like, and we know what the evidence is – but how do we make sure that is understood and the right changes are made at scale? The clinicians have been really engaged by that.

Rebecca's tips for network leaders:

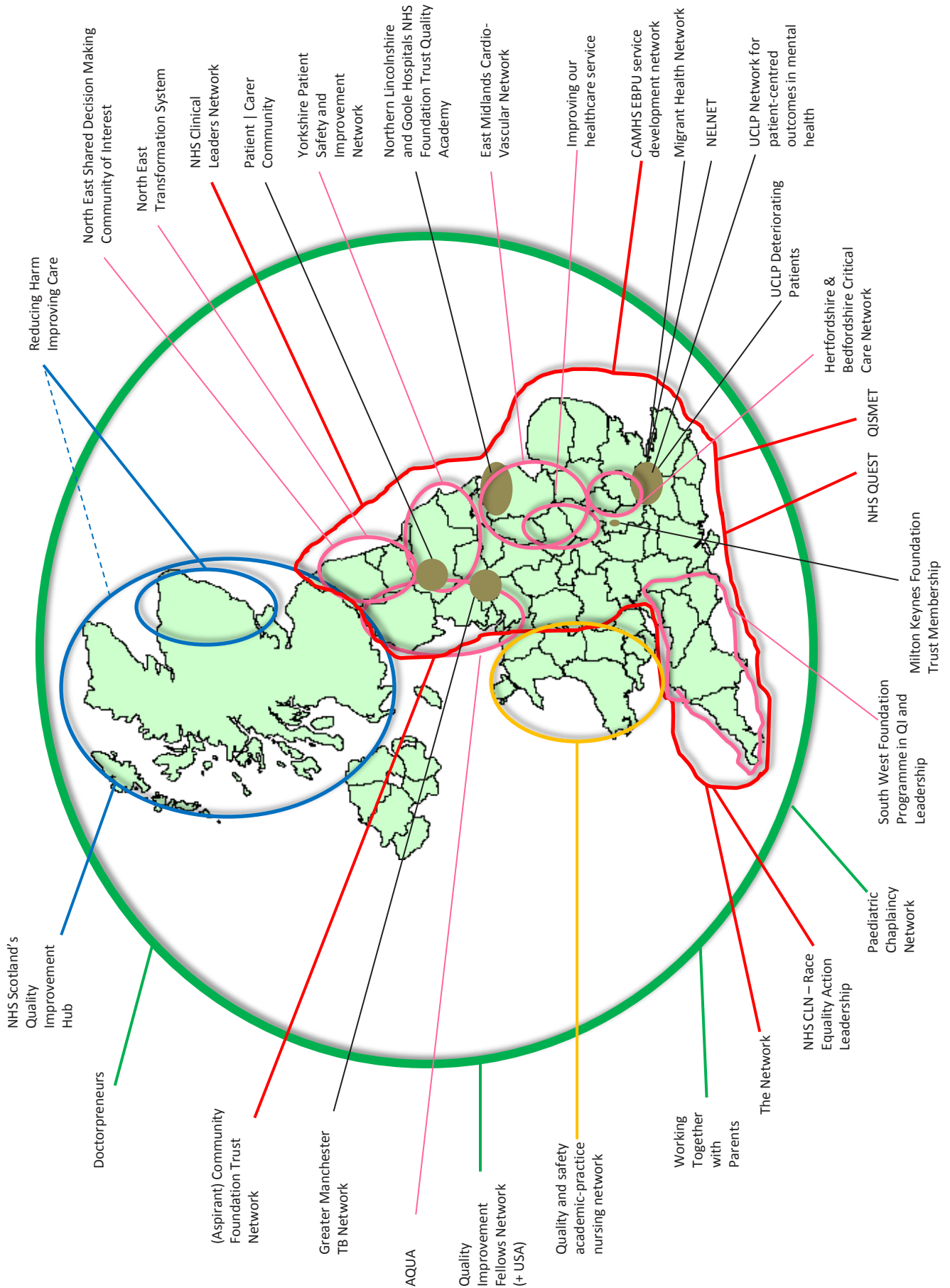
- Make sure your network evolves with the changing agendas and continues to add value. That holds true for members as well as for the external political and economic environment. You need to ask: 'Is this still what members want?'
- Continually think about your purpose and where you add value. You need to know what space you occupy in the NHS, and that will change over time.
- Depending on what projects you've got on, different people will be engaged at different levels at different times, and that's OK. You'll find that people will dip in and out according to their interests and specialism.

Appendix A: Networks participating in the Health Foundation's network support programme

The following networks took part in the Health Foundations network support programme. See overleaf for a map showing the locations of these networks.

Improving our healthcare service	North East Shared Decision Making Community of Interest
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust Quality Academy	Paediatric Chaplaincy Network
Quality and safety academic-practice nursing network	Working Together with Parents Network
North East Transformation System - Transformation and Quality Improvement Network	UCL Partners Network for Patient-centred outcomes in Mental Health
NHS QUEST	NHS Clinical Leaders Network – Race Equality Action Leadership (CLN REAL) Initiative
Patient/Carer Community (University of Leeds)	Migrant Health Network
Reducing Harm Improving Care Network for multidisciplinary undergraduate healthcare workers and University Faculty	East Midlands Cardio-Vascular Network
NHS Scotland's Quality Improvement Hub	Greater Manchester TB Network
South West Foundation Programme in Quality Improvement and Leadership	Hertfordshire and Bedfordshire Critical Care Network
Quality Improvement Fellows network	North East London HIV and Sexual Health Clinical Network (NELNET)
AQuA	Milton Keynes Foundation Trust Membership
QISMET Network	(Aspirant) Community Foundation Trust Network
UCL Partners Deteriorating Patient Improvement Network	Doctorpreneurs
Shared Decision Making in CAMHS virtual network/CAMHS EBPU service development network	The Network
Yorkshire Patient Safety and Improvement Network	NHS Clinical Leaders Network

Map of participating networks



Appendix B: Further reading

Sarah Fraser and Becky Malby, Health Foundation network support faculty

1. Introduction

This reading list has been created by the network support faculty for anyone interested in an informal overview of the literature on networks. It combines suggestions of accessible texts, alongside ideas for more in-depth reading for those who are really interested in the subject.

The list is by no means objective, and we have indicated who has recommended each text and included some commentary from them. We hope the recommendations are useful.

2. Books

Recommended by Sarah Fraser

***Collaborative Advantage* (Dyer, 2000)**

If you're drenched in Lean theory then this is a Japanese take on the benefits of collaboration. Worthwhile thoughts in here if you approach it knowing it is production orientated.

***The Collaboration Challenge* (Austin, 2000)**

The subtitle is 'How non-profits and businesses succeed through strategic alliances'. Enough said.

***The Connect Effect* (Dulworth, 2008)**

More about managing your personal networks, but some interesting insights.

***Connected* (Christakis and Fowler, 2009)**

Ok – Christakis is my hero as he is one of the few to publically take on the dominating Roger's theories of networks and diffusion. This book covers information on the properties of networks, why they form etc. One of my favourites – but I'm biased.

***The Global Brain* (Nambisan and Sawhney, 2007)**

A bit off-beat but full of models and ideas that may be transferrable to health/social/ educational networks.

***The Hidden Power of Social Networks* (Cross and Parker, 2004)**

Thought-provoking content relative to informal and invisible networks. Useful frameworks for thinking what to do to make the best of them.

***The Jazz Process* (Cho, 2010)**

A focus on teams, but the principles can be applied to looser structures like networks.

***Leadershift* (Gobillot, 2009)**

Reinventing leadership for the age of mass collaboration. One of my favourites and all network leads need to figure their role in 'leadershift'.

***Linked* (Barabasi, 2002)**

Covers some useful theory about networks, mathematical models etc. A good introduction if you want to get to grips with what networks are all about – from a more theoretical perspective, without being confabulated by detail.

***The Spider's Strategy* (Mukherje, 2008)**

A bit 'corporate' in view, but sells the importance of networks for business quite well.

***We-think* (Leadbetter, 2008)**

Essential reading if you think your network doesn't need any technology to help it work.



Recommended by Becky Malby

***Markets, hierarchies and networks: the coordination of social life* (Grahame Thompson 2003)**

This book provides a distinctive introduction to the way social, political and economic life is coordinated. It brings together three quite different models of coordination - markets, hierarchies and networks - and places them into a comparative framework.

Recommended by Murray Anderson-Wallace

***Organisational Development in Healthcare. Chapter: Working with Structure* (Anderson-Wallace, M. 2005. Ed: Peck, E. Radcliffe)**

This book introduces the practical ways in which change in health services can be promoted. It includes descriptions of all of the most important approaches to change currently being used in the NHS, discussion of when they work best and details of evidence of their impact.

Recommended by Chris Collison

***Communities of Influence: Improving Healthcare through Conversations and Connections* (Donaldson, Lank and Maher, 2011)**

Newly published work using Macmillan Cancer Support as a case study for bottom-up influence in healthcare.

***Cultivating Communities of Practice* (Wenger, McDermott & Snyder, 2002)**

The seminal work and best-selling book on Communities of Practice, widely read by practitioners and MBA/MSc students alike.

Recommended by Ken Thompson

***Evolution of Cooperation* (Axelrod R, 1990)**

Introduces the concept of ‘Tit for Tat’ as the best long-term cooperation strategy between individuals, shows how it has evolved in nature and how it compares with alternative co-operation models through computer simulation.

***The Wisdom of Crowds* (Surowiecki, J 2005)**

Introduces the ‘wisdom of crowds’ as an important decision-making technique which can be used by networks.

3. Articles

With thanks to: Roger Cowell, Ken Thompson, Chris Collison and Murray Anderson-Wallace.

Leadership: easy reads

Schieffer A. ‘The Essence of Leadership and the Power of Networks: interview with Margaret Wheatley’. *Reflections*, 2003, Vol. 4 No. 4, pp69-71.

Margaret Wheatley is worth reading!
www.c-cell.com/PDF/Schieffer_InterviewWheatley.pdf

Wheatley M. ‘Leadership of self-organized networks: lessons from the war on terror’. *Performance Improvement Quarterly*, 2007, Vol. 20 No. 2, pp.59-66.

Margaret Wheatley has a passion to seek meaning in many situations, and in this article looks at the US Government’s ‘war on terror’ and sets out her explanation for the success of networks such as Al Qaeda: ‘... human networks always organize around shared meaning. Individuals respond to the same issue or cause and join together to advance that cause. For humans, meaning is a “strange attractor” – a cohering force that



holds seemingly random behaviors within a boundary. What emerges are coordinated behaviors without control, leaderless organizations that are far more effective in accomplishing their goals.

<http://margaretwheatley.com/articles/Self-OrganizedNetworks.pdf>

Leadership: more in-depth reads

Miles R and Snow C. ‘The Causes of failure in network organizations.’ *California Management Review*, 1992, 34(4) p 53-72

Network organisations fail due to managerial mistakes in initial design or in ongoing management particularly the impact of over expectation of cooperation (limiting the creativity of the parts of the network); resorting to command mechanisms of management; predicating some network members over others; constraining the operating independence of the network members.

Macnamara D. ‘Leading a Networked World’. Banff: Banff Executive Leadership Inc. 2001. Archived article.

Although this is quite an ‘elderly’ article, it is usefully concise and has some good and still pertinent points to make about network leadership.

www.banffexeclead.com/articles/LeadingNetworked_printout2.pdf

Nature of networks and network design: easy reads

Mendizabal, E and Hearn, S. ‘Not Everything that Connects is a Network.’ Background Note. London: Overseas Development Institute. 2011.

Brief overview of the role and function of networks

www.odi.org.uk/resources/docs/6313.pdf

Plamping D, Pratt J and Gordon P. ‘Networks and nets that work: a framework for thinking about how to organize.’ Paper presented at European Group for Public Administration (EGPA) conference 2001 ‘Governing Networks’ Vaasa, Finland

This easy to read paper described the difference between what hierarchies and networks are useful for, and what you need for networks to be effective, with an example from Cancer networks.

www.cihm.leeds.ac.uk/new/wp-content/uploads/2011/07/Networks-Nets-that-work.pdf

Nature of networks and network design: more in-depth about functions

Australian Institute for Commercialisation *Innovation Toolbox: Networking*, Brisbane: Australian Institute for Commercialisation, Queensland, Australia, 2010.

Produced by the Australian Institute for Commercialisation, a state government entity, this is a tidy little summary of networks and their applications, evaluation etc.

www.innovationtoolbox.com.au/networking

Mendizabal, E. ‘Understanding Networks: The functions of research policy networks.’ Working Paper no. 271. London: Overseas Development Institute. 2006.

Describes the functions of networks and the difference between agency and support roles.

www.odi.org.uk/resources/docs/150.pdf



GrantMakers for Effective Organizations. *How Do Networks Support Scale?* Briefing Paper 2, Washington DC: GrantMakers for Effective Organizations. 2011.

One of a freely available series, it is a clear and useful publication.

www.scalingwhatworks.org/resources/scaling-what-works-publications/briefing-papers-series#Topic_2_How_Do_Networks_Support_Scale

Nature of networks and network design: for the really keen

Stephenson K. 'What Knowledge Tears Apart, Networks Make Whole'. 1998. Reprinted from *Internal Communication Focus*, no. 36, PDF downloaded 7 January 2012 from: www.drkaren.us/pdfs/icf.pdf

An elegantly written, wide-ranging article on the nature of networks, in which Karen Stephenson writes of a network as a seamless and invisible web of entrusted connections. The author, on her website, describes herself as: '...a corporate anthropologist and lauded as a pioneer and "leader in the growing field of social-network business consultants."' Karen Stephenson has an interesting graphic on the extent of her networks:

www.drkaren.us/KS_network01.htm

Provan K, Fish A and Sydow J. 'Interorganizational Networks at the Network Level: A Review of the Empirical Literature on Whole Networks'. *Journal of Management*, 2007, Vol. 33 No. 3: pp 479-516.

The key emphases in this article are on 'interorganisational' and 'whole networks', and these are good reasons to look at it.

www.technion.ac.il/~wyair/479.pdf

Shuman J and Twombly J. 'Collaborative Networks Are The Organization: an Innovation in Organization Design and Management'. *Boston: The Rhythm of Business Whitepaper* [dedicated to Peter Drucker on his 100th birthday]. 2009.

The authors present a distinctive and clear set of propositions on principles of network design, centring on the idea that networks should be designed collaboratively to meet specific needs, and that organizations may comprise and be part of multiple networks.

www.rhythmofbusiness.com/articles.php?id=4&keyword=collaborative%20network%20design

Organisational networks: more in-depth reading

Wei-Skillern J and Marciano S. 'The Networked Nonprofit'. *Stanford Social Innovation Review*, 2008, Vol. 6 No. 2 (Spring): pp 38-43.

How I love SSI Review's articles – always so clear and useful. This is no exception – a gem.

www.ssireview.org/images/articles/2008SP_feature_wei-skillern_marciano.pdf

Appendix C: Glossary of commonly used network terms

Roger Cowell, Centre for Innovation in Health Management

Much of this glossary derives from Appendix B of Robeson, 2009, which is an excellent resource in addition to other resources referenced below.

Actor (node)

Network member that is a distinct individual, group or organisation. (Hawe et al, 2004; Robeson, 2009)

Centrality

The importance or prominence of an actor in a network. (Hawe et al, 2004)

Clique

Subgroup of a network in which actors are all directly connected to one another and no additional actor exists who is also connected to all members of the subgroup. (Hawe et al, 2004)

Closeness

The degree an individual is near all other individuals in a network (directly or indirectly). (Robeson, 2009)

Clustering coefficient

A measure of the likelihood that two associates of a node are associates themselves. A higher clustering coefficient indicates greater 'cliquishness'. (Robeson, 2009)

Cohesion

The degree to which actors are connected directly to each other by cohesive bonds. (Hawe et al, 2004; Robeson, 2009)

Collaboration

A process of interaction through which people, groups and/or organisations work together to achieve desired outcomes; a generic term that simply means teamwork or a group effort. It also has a more specific meaning in knowledge management, where it is often used to describe close working relationships involving the sharing of knowledge. (NHS Glossary; Robeson, 2009)

The collaborative network

A dynamic structure that has the agility to reshape its components and how they relate to one another legally and operationally as the purpose and context of the network evolves. It is a way of organising that is well placed to leverage existing resources and create new value. (Shuman and Twombly, 2009)

Community of practice

Voluntary, flexible networks of people with a common interest or passion in a specific area, who come together on a regular or ad hoc basis to develop, share, and build their knowledge and learn about a practice-related issue. (Lave and Wenger, 1991; Wenger 1998)

Connectivism

'Connectivism is the integration of principles explored by chaos, network, and complexity and self-organisation theories. ... Connectivism is driven by the understanding that decisions are based on rapidly altering foundations. New information is continually being acquired.' (Siemens, 2005)

Core group

A small, socially connected and committed group of network members who value the vision for the network and assume responsibility for the majority of network activity, providing guidance and leadership.

Density

The total number of relational ties in a network divided by the total possible number of relational ties.

Individual-level density – the degree a respondent's ties know one another.

Network or global-level density – the proportion of ties in a network relative to the total number possible.



Domain

Shared interest that provides the incentive and passion for the community to come together. (Lave and Wenger, 1991; Wenger, 1998)

‘Free riding’

Enjoying a benefit accruing from a collective effort, but contributes little or nothing to the effort – also known as ‘social loafing’. One way to reduce free riding is to increase individual accountability. (Lazer and Katz, 2003)

Gatekeepers

‘...invent, communicate, and exploit their boundary spanning positions to keep abreast of current developments, problems, and breakthroughs. They both consume and contribute to the scientific literature; they translate important external results for their colleagues; and they identify trends, threats, and opportunities for their firms. Managers should remain wary of gatekeepers who actively control information. Instead, gatekeepers should use their awareness and brokerage of different clusters to join disconnected individuals who have the potential for fruitful collaboration. Forming simple connections between isolated clusters is relatively straightforward, but the key is to encourage fruitful collaborations. In this respect, the best gatekeeper is one who continuously makes new connections and solidifies the most promising introductions, leaving cohesive clusters in his or her wake.’ (Fleming and Marx, 2006)

Also known as boundary-spanner, knowledge broker, intermediary.

Heterogeneity

Diversity: the extent to which actors and/or their relationships with other actors are different.

Homogeneity

The extent to which actors and/or their relationships with other actors are the same. (Fredericks and Durland, 2005).

Hub

A network actor or node with a large number of direct connections; a connector within the network.

Knowledge broker

A person or organisation that synthesises research findings, clarifies policy resources and fosters collaboration (Roger Cowell, 2009); ‘...a person or organisation that facilitates the creation, sharing and use of knowledge in an organisation by linking people, groups and or organisations with each other or with knowledge and knowledge resources.’

Also known as boundary-spanner, intermediary. (Robeson, 2009).

Network

A system of interconnected actors or nodes and the ties or links between them. (Hawe et al, 2004)

Emergent networks

Informal naturally occurring system of social relationships that aim to enhance the capacity of individuals and/or organisations to manage knowledge, perform their work, and achieve organisational goals.

Mandated network

Organisational form that has been imposed upon, mandated by, or purposely created by an organisation.

Socio-centric (complete or whole) network

A collection of interconnected actors and the relational ties among them in a single, bounded group.

‘... a whole network is viewed here as a group of three or more organisations connected in ways that facilitate achievement of a common goal.’ (Provan, 2007)



Networking

A common activity involving actors working together around a common issue; building relationships with other actors to share knowledge, resources, experiences and expertise (or 'know how'); learning from each other through interaction, dialogue and storytelling.

Network of practice

A set of individuals connected together through social relationships that emerge through the interaction of these individuals on task-related matters when conducting their work; communities of practice are a subset of networks of practice. (Robeson, 2009)

Path length

The distance between pairs of actors in a network.

Small world theory

The theory that most actors in a social network are connected by short path lengths and therefore can readily be connected to other actors. (Milgram, 1967)

Social network analysis

Both a theoretical perspective and a quantitative approach (or set of methods) to mapping and measuring the patterns of interactions among actors in, or in the structure of social networks. Organisational network analysis refers to social network analysis when the actors are organizations. (Hawe et al, 2004)

Stability

A measure of the changes within a network in terms of actors, the relationships between them, and the resources available to support the network.

Structural cohesion

The minimum number of members who, if removed from a group, would disconnect the group.

Structural equivalence

The extent to which actors have a common set of linkages to other actors in the system and thus play similar roles in the network. Actors do not need to have any ties to each other to be structurally equivalent. Actors that are structurally equivalent are in identical positions in the structure of the visual representation of the network.

Structural hole

The gap between actors that share no relationship in a network. (Durland and Fredericks, 2005)

Ties

Connections or relationships between actors in a network.

Ties are also sometimes referred to as connections, relational ties, relationships, or linkages. (MassConect, 2009)

Virtual networks

Dynamic, computer-mediated, transient, organisational structures that are not bounded by geography. These structures are often weak in terms of their ability to develop and maintain the social relationships and exchanges necessary for effective knowledge transfer and diffusion of innovations. As well, the element of trust, often cited as a critical success factor in networks, can be difficult to develop and maintain when opportunities for face-to-face interaction are not available.

Wiki

A website that is developed collaboratively by users and that can easily be revised by anyone. The word 'wiki' derives from a Hawaiian word meaning 'quickly'.



References

- Fleming L and Marx M, 2006, 'Managing Creativity in Small Worlds', *California Management Review* Vol. 48, No. 4 (Summer): pp 6-27.
- Fredericks M and Durland K, 2005, 'Social network analysis in program evaluation', Vol. 75, Single Issue (Program Evaluation) Series, San Francisco: Jossey-Bass.
- Lave J and Wenger E, 1998, 'Communities of Practice: Learning, Meaning, and Identity', Cambridge: Cambridge University Press.
- Lazer D and Katz N, 2003, 'Building Effective Intra-Organisational Networks: The Role of Teams', Working Paper 3, Cambridge Mass: Center for Public Leadership.
- MassConect, 2009, 'SNA Glossary', Cambridge, Massachusetts: Harvard School of Public Health + community partners.
- Milgram S, 1967, 'The Small World Problem', *Psychology Today*, Vol. 1 No 1 (May): pp 61-67. PDF downloaded 9th January 2012 from: http://measure.igpp.ucla.edu/GK12-SEE-LA/Lesson_Files_09/Tina_Wey/TW_social_networks_Milgram_1967_small_world_problem.pdf
- Provan K, Fish A and Sydow J, 2007, 'Interorganisational Networks at the Network Level: A Review of the Empirical Literature on Whole Networks', *Journal of Management*, Vol. 33 No. 3: pp 479-516.
- Robeson P, 2009, 'Networking in public health: exploring the value of networks to the national collaborating centres for public health', Hamilton, Ontario, CANADA: National Collaborating Centre for Methods and Tools, School of Nursing, McMaster University.
- Shuman J and Twombly J, 2009, 'Collaborative Networks Are The Organisation: an Innovation in Organisation Design and Management', Boston: The Rhythm of Business Whitepaper.
- Siemens G, 2005, 'Connectivism: A learning theory for the digital age', *International Journal of Instructional Technology and Distance Learning*, Vol. 2 No. 1.
- Wenger E, 1998, 'Learning as a social system', *The Systems Thinker*, Vol. 9, No. 5.

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