

THE PURSUIT OF PURPOSEFUL PARTNERSHIPS-MAKING A HEALTH MATRIX SUCCESSFUL

Phillip Lewis Way¹, Patricia M Davidson¹, Gail Winkworth², Michael White³

1. Hunter New England Health
2. Australian Catholic University
3. Successful Collaborations

Correspondence: phillip.way@hnehealth.nsw.gov.au

ABSTRACT

OBJECTIVE:

To analyse a matrix model of management to optimize the partnerships, collaboration and interaction between vertical management structures (services and geographical clusters) and horizontal clinical structures (Clinical Networks and Streams) in a large Local Health District [LHD] in New South Wales, Australia.

APPROACH:

An 'Action Research' approach utilising a maturity tool, the Collaboration Rubric®, an evidence-based model for Network analysis. The rubric describes four types of collaboration and defines the three essential drivers that allow successful collaborations.

OUTCOMES:

Benchmarking comparisons indicate that this LHD is operating at a level well above base level for the three drivers that enable collaboration [capacity, authority and shared value]. The professional relationship between Clinical Networks/ Streams and Operational Managers, is the main barrier to improving collaboration. The Operational Managers have clear positional authority related to the organisational structure and are accountable to their Executive for good governance and financial management. Clinical leaders hold substantial influential power derived from their professional authority.

The following actions have been identified to improve collaboration.

- Ensure all leaders actively "manage for collaboration"
- Executive fosters joint innovation projects characterised by collaborative practice between the Clinical Networks/Streams and Operational Managers.

- Ensure leadership accountabilities are held as close as possible to any projects (locally) involving reform or innovation
- Clinical Network/Streams' operational plans are jointly agreed with local management and signed off by Executive
- LHD recruit leadership with skills in managing for collaboration

CONCLUSIONS:

This evaluation supports the use an Action Research approach using the Collaboration Rubric® as a useful tool to define not only the type of collaboration required but the key drivers that must be addressed to facilitate improved [horizontal and vertical] partnerships leading to better outcomes. This local health district will build improved collaboration utilising the insights gained from this analysis.

KEYWORDS

Clinical Networks, Collaboration rubric, Matrix structure, Partnerships

INTRODUCTION

The Local Health District (LHD) developed and implemented the Clinical Networks Program (CNP) in 2007 as a key priority for ensuring clinician engagement in the strategic planning and performance of health care across the region.

Over the past ten years the organisation has conducted several evaluations to guide the development of the CNP. These reviews have focussed on how the Clinical Networks are formed and understanding the factors that make Clinical Networks successful. [1] This knowledge allowed

the development of strong and effective Clinical Networks whose role in the LHD is now unquestioned but leaves open the opportunity to undertake further research to translate the learnings into practice

The development of the Clinical Networks Program has seen the LHD develop a Matrix organisational structure. This paper describes a review of the CNP and how this operates in the matrix model of management, with the goal being to optimise interaction between the vertical management structures (services and geographical clusters) and the horizontal clinical structures (Clinical Networks and Streams).

BACKGROUND

This LHD was formed in 2005 from the merger of three smaller health services. This health service is responsible for services across more than 120 sites, from small rural community health centres to major tertiary referral hospitals. With over 16,000 staff and an expenditure budget of 2 billion AUD per annum, it provides services to a population of more than 900,000 people across an area of 130,000 square kilometres.

Due to the size and range of services within the health service, the Executive, identified the development of Clinical Networks as a key strategy to engage clinicians in decision making and planning for the health service. This is conceptualised as a matrix organisational structure. In this structure, reporting relationships comprise a grid, rather than clustering employees exclusively in terms of function (i.e., by department). The matrix structure allows employees to form additional groups around areas of expertise or goals (Diagram 1). Advantages of this structure include increased information flow across boundaries, deeper development of expertise and knowledge, and greater flexibility and responsiveness. To ensure these benefits are attained challenges must be actively managed. Typical challenges are misaligned goals, conflicting loyalties, confusion about roles and responsibilities, and delayed decisions due to shared decision making with lack of clarity on accountability or delegated authority. If these are successfully addressed the organisation greatly benefits from a richer resource base of expertise and experience. [2]

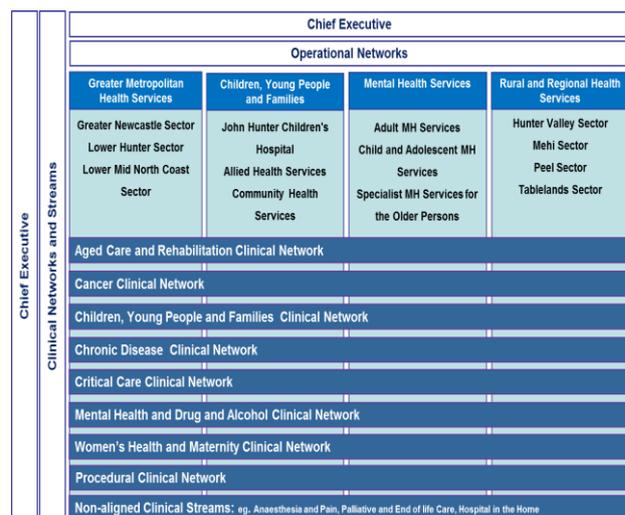
Previous Evaluation of the programs (2009-2010) have articulated nine core success factors required to develop

successful Networks [1], which have been monitored and optimised on a regular basis. While the internal functioning of the networks has been enhanced with alignment to the nine success factors, challenges for effective functioning, within the matrix, are evidenced by ongoing leadership and resourcing tensions, lack of clarity in regard to accountability/delegated authority and communication across the organization. If these factors are not addressed partnerships within the matrix may be driven by the "suppression of mutual loathing in the pursuit of funding". [3]

A review of the literature [3-9] identified that Clinical Networks rely on effective collaboration through partnerships to produce sustainable outcomes. Collaboration should not only be seen as an ideal but as a basic design element to improve public services. [3] Currie et al [10] supported this and highlighted the importance of "Brokering" where interventions that mediate interprofessional and intraprofessional hierarchy and utilise social mechanisms are essential for service improvement.

This analysis aimed to identify ways in which this LHDs matrix model of management might best operate including the interaction between the vertical management structures (services and geographical clusters) and the horizontal clinical structures (Clinical Networks and Streams). A particular focus of the analysis is to improve collaboration through partnerships that improve patient experience and outcomes.

DIAGRAM 1 LHD MATRIX ORGANISATIONAL STRUCTURE



APPROACH

An 'Action Research' approach was chosen for this analysis. 'Action Research' and 'Action Learning' refer to a group of research methodologies which pursue both change (action) and understanding (research), simultaneously. [11] These approaches, which focus on cyclical models of planning, acting, observing, reflecting and planning again, are particularly well suited to health contexts, in which practitioners are typically reflective about their work and keen to improve practice as quickly as possible.

A review of the literature identified the Collaboration Rubric®, as an evidence-based maturity tool, developed over time in Australia to enhance collaboration and partnerships across a range of Human Services Contexts. [12, 13, 14, 15, 16, 17] Through research and working with many organisations and sectors an action learning framework was developed which allows point in time evaluation data while at the same time encourages network leaders to take responsibility for improving the commitment, operational capacity and the public value of their partnerships at both a clinical and management level.

The Rubric® draws on well-established theories of change [18; 19], key concepts in the broad collaboration literature [20, 21, 22] and the extensive practice experience of the developers in human service settings.

The Rubric® is based on two central features: four Collaboration "types" (Diagram 2) which increase in complexity; and three essential drivers for sustaining and building these four types of collaboration (Diagram 3)

The three essential drivers are:

1. Capacity - time, skills and resources - (the Capacity) to work together.
2. Authority - a shared commitment across leaders and key stakeholders (an Authorising Environment) that allows partnerships to develop.
3. Shared value- a shared understanding of what can be achieved together and how this will be measured (the Shared Value of the Partnership)

As the following diagram illustrates, within these 3 drivers are 15 key enablers

DIAGRAM 2 TYPES OF COLLABORATION

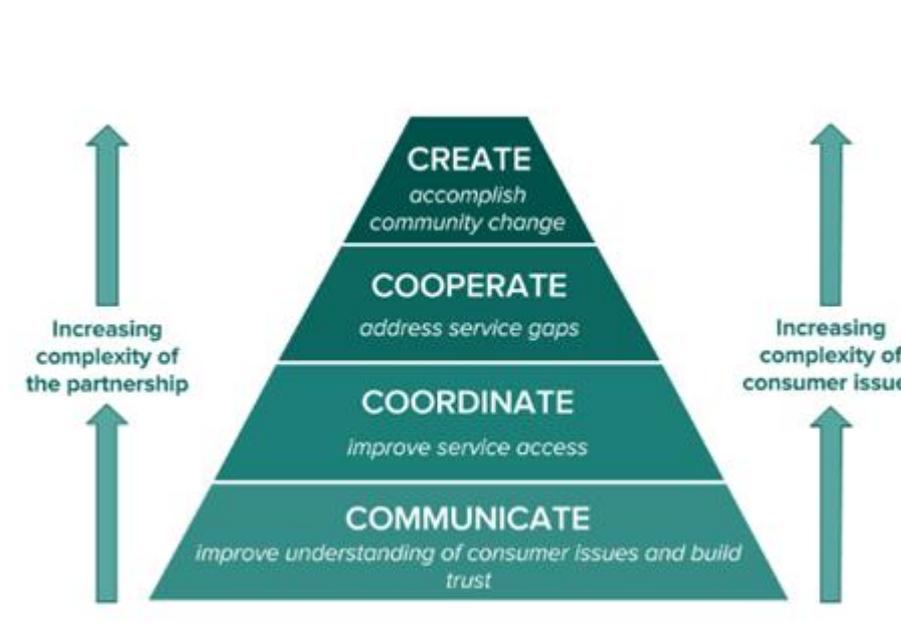
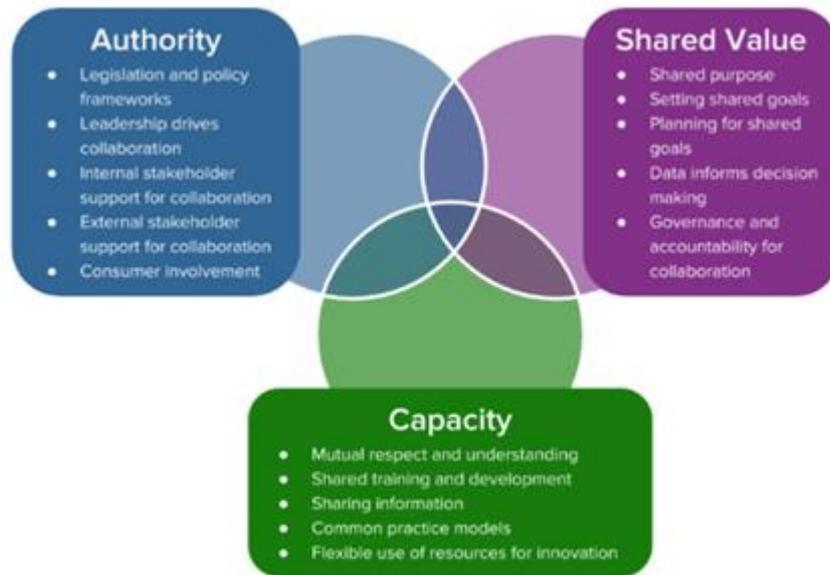


DIAGRAM 3 THREE DRIVERS OF COLLABORATION



METHODOLOGY

An expert reference group was commissioned to oversee the conduct of this analysis consisting of external academics, organisational leaders and researchers. Given the complexity of the project the organisation engaged the developers of the Collaboration Rubric® as consultants to provide additional design experience to ensure a comprehensive approach to the matrix. A mixed method approach using two main sources of data collection was employed:

- A survey containing both closed and open questions
- Two case studies using semi structured interviews

The survey focused on two aspects of collaboration; partnerships within the Clinical Networks and Streams and partnerships between the Networks and Streams and the Operational Managers.

Two case studies were identified as providing the opportunity to add depth to the analysis. Data was collected through 12 one-hour interviews with 16 participants who responded to a lightly structured set of questions about the achievements, enablers, barriers and priorities of the CNP. The interviews were conducted on a face- to- face basis and via videoconference. The case studies were transcribed and coded in the same way as

the open-ended survey questions. Given the substantial scope of the project, and although the case studies contributed to the findings, those results are not discussed in detail in this paper. These will be the subject of a subsequent publication.

FINDINGS AND ANALYSIS

The survey was sent to 955 people of whom 550 responded. Three hundred and twenty comments from the survey were analysed using the Rubric® as a coding framework. Each comment was aligned to one of the drivers of collaboration (Shared Value, Authority, Capacity), then further coded, each into one of the 15 enablers which most closely matched its meaning.

Initial benchmarking was undertaken by the consultants comparing this LHD to another organisation where the “Base” figures are the initial assessments of that organisation and the “Advanced” figures are the results of the survey after intervention to address issues identified by the first survey. The Chart indicates that this LHD is operating at a level well above Base level.

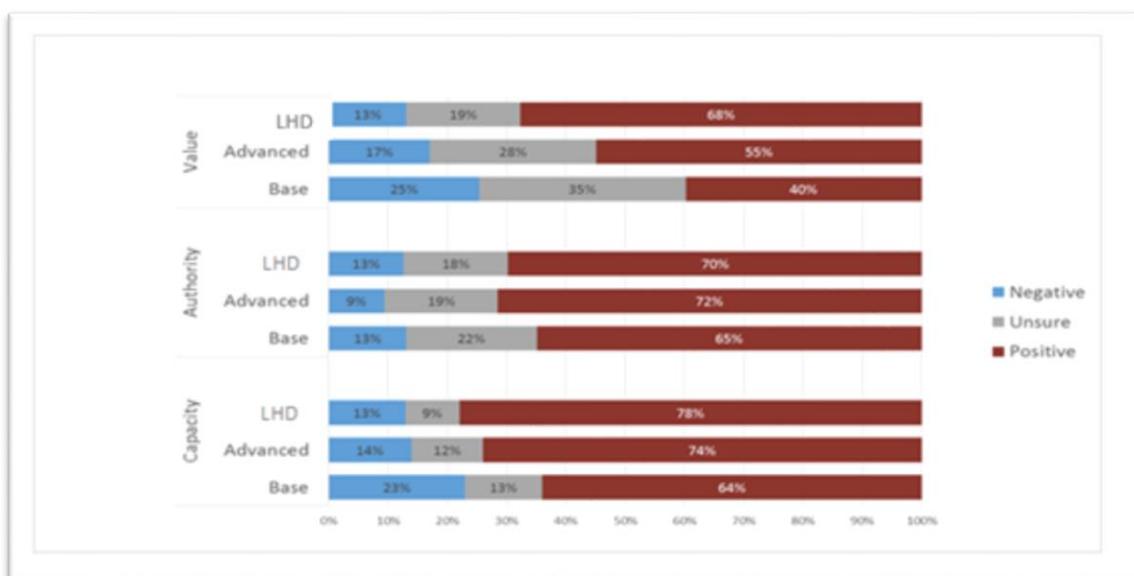
FUNCTIONING OF THE CLINICAL NETWORKS AND STREAMS AS COLLABORATIVE PARTNERSHIPS

The survey responses indicated that the fundamental aspects of the three Collaboration Rubric® drivers were well established. The statements which were most strongly endorsed by all respondents are those related to the Network/Streams' role in improving practice, sharing information and promoting multidisciplinary approaches. Respondents indicate that Network/Stream members believe that it is important to collaborate with staff from other professions to solve problems and that strong informal networks exist between staff across the Clinical Network/Stream. In the driver of Shared Value, statements which received the strongest endorsement were those relating to the Network/Streams' understanding of their role

in delivering high-value healthcare and whether they have a shared operational plan to achieve their agreed purposes.

These statements indicate a strong foundation is in place for the Clinical Networks/Streams and the practices of these Clinical Networks/Streams are consistent. Review of the survey data and case studies identified a number of areas should be developed to improve the functioning of the Clinical Networks/Streams, these included Strategic use of data, ensuring they have the right partners to achieve goals, including consumers as partners and ensuring there are committed resources to specifically support the coordination of the Clinical Networks/Streams

DIAGRAM 4 BENCHMARK COMPARISONS



THE RELATIONSHIPS BETWEEN CLINICAL NETWORKS/STREAMS AND OPERATIONAL MANAGERS

The result of the survey was analysed utilising three groups of staff: those who only had a role in a clinical network, those who only had an operations role and those that had both a clinical and operational role. Survey respondents were asked to rate the overall status of drivers of collaboration; Authority, Capacity and Shared Value as it applied to the relationship between Operational Managers and Clinical Networks/Streams. The overall ratings for the drivers from these three groups is represented in Diagram 5.

Only one of the positive ratings exceeded 50%, which was the assessment by the group of staff with both Operational and Clinical Network/Streams' roles commenting on the capacity to develop effective partnerships. For the other

assessments, positive ratings were approximately 30%-35% for those who worked within a Clinical Network or Stream. The Operational Managers' own rating of the shared sense of value with Clinical Networks/Streams was only 15% positive.

The Operational Managers in particular are less confident that the relationship is well-founded, generally rating the statements less positively than the other 2 groups. The managers with both operational and Clinical Networks/Streams leadership are most positive with regard to this relationship.

Review of the survey data and case studies identified a number of areas for development to improve collaboration

between the Clinical Network/Streams' and Operational managers these include;

Policy Leadership

- The Executive Leadership Team and General Managers need to speak convincingly about the need to work in partnership

Executive Leadership/sponsorship

- General Managers can play a significant role in focusing the work of the Clinical Networks/Streams on operational management issues at the same time as they advocate on behalf of Networks and Streams with other Operational Managers.

Operational managers' authorising environment

- The endorsement and support of Operational Managers for agreed activities undertaken by Clinical Networks/Streams

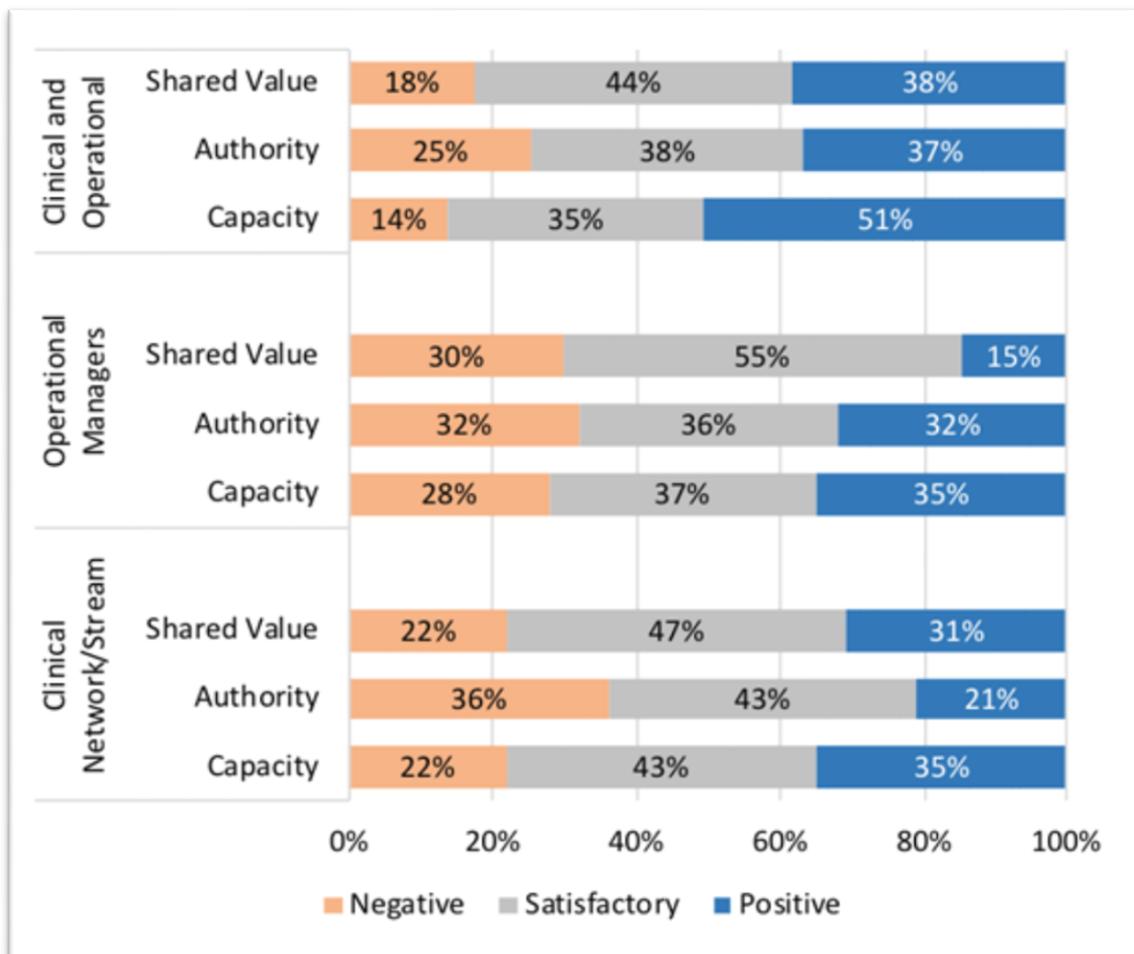
Structured opportunities to meet and plan

- The need for respectful communication, clear purpose and performance measurement against agreed outcomes with defined time frames, to build a shared sense of purpose, joint leadership and success.

The Role of Clinical Network Managers

- These positions are central to the creation of good quality partnerships. The Clinical Network Manager must bring operational and clinical experience to allow them to provide the bridge needed between Clinical Networks/Streams and operational management.

DIAGRAM 5 OVERALL RATINGS OF PARTNERSHIPS BETWEEN OPERATIONAL MANAGERS AND CLINICAL NETWORKS/STREAMS BY 3 GROUPS OF RESPONDENTS IN 3 RUBRIC DRIVERS



DISCUSSION

Overall this LHD has a well-developed and recognised Clinical Networks Programme that bench-marked satisfactorily with other industries. The current matrix does not realise its full potential for collaboration, as evidenced by the lower responses between the Clinical Networks/Streams and Operational Managers, and this structural issue impeded the shift to creative partnerships which are required to solve complex problems (Diagram 2).

The survey has shown how Clinical Networks/Streams can, through creative, collaborative practice, achieve positive outcomes for patients and consumers that could not have been achieved through more siloed approaches. However, there is a risk that the lack of shared purpose between Operational Managers and Clinical Leaders could be counter-productive to the delivery of high quality services. Clinicians express their great frustration that they are either not 'heard' or their issues are being "stage managed" by management, while Operational Managers indicated frustration that they are not told about projects or initiatives being led by Clinical Network/Streams.

The central issue in a matrix model is that Executive and staff alike need to resolve the issue of two forms of power operating in a single domain. The Operational Managers have clear positional authority related to the organisational structure and are accountable to the Executive for good governance and financial management. Clinical leaders hold substantial influential power derived from their professional responsibilities. Without clear intervention and leadership that ensures collaboration it is possible (in fact quite common) that the two will have separate and competing goals. The realisation that network managers & operational managers with clinical experience functioned more effectively and reported higher satisfaction in the matrix model leading to improved collaboration was a new understanding that can lead to strengthening of the model.

Five areas were identified to resolve conflict, build clarity and improve patient experience and outcomes:

- Relationships will be improved by explicitly providing a policy framework for Clinical leaders and Operational Managers to work together for improved patient experience and outcomes.

- Inclusion in leadership positions a key accountability to manage for collaboration to drive recruitment with relevant skills.
- Joint innovation projects characterised and managed for collaborative practice between the Clinical Networks/Streams and Operational Managers.
- Local accountabilities; the accountability framework should be used to ensure accountabilities are placed as close as possible to any projects (locally) involving reform or innovation into particular locations. For example by holding the Operational Managers and the Clinical Leaders responsible and accountable for defined outcome measures in key clinical areas in a given location, managers explicitly required to work together with clinicians, depending on each other, in achieving outcomes.
- Clinical Network/Streams' operational plans, with agreed and defined accountabilities, need to be supported by Operational Managers at the local level and signed off at an Executive level.

CONCLUSIONS;

Clinical Networks and Streams have proven successful in engaging clinicians in providing leadership in strategies to improve patient experience, outcomes and reducing clinical variation. At times these efforts have struggled due to lack of collaboration with the right partners including operational managers. This analysis supports the use of an Action Research Approach utilising maturity tools such as the Collaboration Rubric® to identify the necessary elements of successful collaboration. This approach proved helpful in defining not only the type of collaboration required but the key drivers that must be addressed to facilitate improved [horizontal and vertical] partnerships leading to better outcomes through encouraging reflection about and actions to improve collaboration between clinical networks/streams and operational managers. This LHD will build improved collaborative partnerships utilising the insights gained from the evaluation.

FUTURE PUBLICATIONS:

Information derived from the evaluation allows for further exploration of a number of themes including how the Collaboration Rubric® can be used to:

- describe the “Types of Collaboration” required to meet the desired organisational outcome, so that effort is matched to outcome,
- optimising the role of the Network Manager to “manage for collaboration”

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COMPETING INTERESTS:

Developers of the Collaboration Rubric® M. White and G. Winkworth were employed by HNELHD to assist with this evaluation.

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