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Reducing emergency bed-days for older people? Network governance lessons from the 'Improving the Future for Older People' programme

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ABSTRACT

In 2007, the UK government set performance targets and public service agreements to control the escalation of emergency bed-days. Some years earlier, nine English local authorities had each created local networks with their health and third sector partners to tackle this increase. These networks formed the 'Improving the Future for Older People' initiative (IFOP), one strand of the national 'Innovation Forum' programme, set up in 2003. The nine sites set themselves one headline target to be achieved jointly over three years; a 20 per cent reduction in the number of emergency bed-days used by people aged 75 and over. Three ancillary targets were also monitored: emergency admissions, delayed discharges and project sustainability. Collectively the sites exceeded their headline target.

Using a realistic evaluation approach, we explored which aspects of network governance appeared to have contributed to these emergency bed-day reductions. We found no simple link between network governance type and outcomes. The governance features associated with an effective IFOP network appeared to suggest that the selection and implementation of a small number of evidence-based services was central to networks' effectiveness. Each service needed to be coordinated by a network-based strategic group and hierarchically implemented at operational level by the responsible network member. Having a network-based implementation group with a 'joined-at-the-top' governance structure also appeared to promote network effectiveness. External factors, including NHS incentives, health reorganisations and financial targets similarly contributed to differences in performance.

Targets and financial incentives could focus action but undermine horizontal networking. Local networks should specify which interventions network structures are intended to deliver. Effective projects are those likely to be evidence based, unique to the network and difficult to implement through vertical structures alone.

Introduction

Emergency hospital admissions are increasing in many health systems, especially for 'older-elderly' people (OECD, 2011). Such admissions can be less satisfactory to patients than care in or nearer their own homes and are often avoidable (Johri, Beland, & Berman, 2003). Unplanned hospital admissions and long stays may not be the most appropriate care arrangements for older people, causing loss of functional independence (Garåsen, Windspoll, & Johnsen, 2007), risk of hospital-acquired infections (Mahjeed, 2012), additional morbidity and expense (Huws et al., 2008). A number of health systems (e.g., in Germany, the Netherlands and the USA) introduced case management or disease pathways to reduce avoidable emergency admissions and emergency bed-days (EBDs). In England, central and local government have been shifting from directly providing care (through bureaucratic hierarchies) towards quasi-market contracts and/or networks based on cross-sector collaborations (Graddy & Chen, 2006). These inter-organisational

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and inter-professional care networks supply preventive and responsive care through collaborations between primary care, rehabilitation, social care and other providers (Southon, Perkins, & Galler, 2005). Often, they also operate as 'project networks', redesigning care protocols and pathways (Addicott, McGiven, & Ferlie, 2007).

It remains unclear which governance characteristics make such networks effective coordinators of care (Provan & Kenis, 2008). Using data from nine networks in England, we analyse the impact of governance approaches adopted to achieve a target reduction of 20 per cent in EBDs used by people aged 75 and over. Our core question was: 'What activities and conditions appeared to make networks more (or less) effective in reducing emergency bed days?'

We first discuss characteristics associated in the literature with effective network governance. We then describe the 'Improving the Futures for Older People Programme' (IFOP), its policy context and methods used to address our research question. Next, we systematically compare the characteristics of our networks against those previously identified with effective governance. After summarising our results, we consider their implications, concentrating on how horizontal networks accommodated external drivers of EBD use, particularly NHS incentives, health sector reorganisations and financial targets.

Characteristics underpinning effective networks

Successful networks depend on the ability to identify and deploy actions critical to the achievement of network objectives (Kreuter, Lezin, & Young, 2000). Eleven such characteristics were identified from the literature (Fig. 1) and are summarised here. *Network membership itself needs to be sufficient* in number, skills and resource-ownership (de Rijk, van Raak, & van der Made, 2007) to execute these activities or projects (Agranoff & McGuire, 2001; Balkundi & Harrison, 2006). If network projects are to meet users' needs, *patient and public representation structure(s)* must be enabled through practical supports (Alkema, Shannon, & Wilber, 2003).

The operation of networks depends heavily on trust (Provan, Harvey, & de Zapien, 2005). If members have approximately *equal power*, with no one organisation co-opting the network (O'Toole & Meier, 2006), conflict should diminish and trust increase. Similarly, equal status and power among members rather than hierarchy and obedience, promotes joint learning and problem-solving (Ansell & Gash 2008; Brass, Galaskiewicz, Greve, & Tsai, 2004). Network

effectiveness is enhanced by a *steering group* (Provan & Kenis, 2008) acting as 'broker' to facilitate interaction between network members (Pope & Lewis, 2008; Walker et al., 2007). As trust takes time to form (Rodriguez, Langley, Beland, & Denis, 2007) an existing organisation is likely to be more effective than a new one in coordinating other network members (Ansell & Gash, 2008).

Networks essentially work through *'relational' interactions* between members (Shortell & Bazzolli, 2000). The more frequent and multi-dimensional these interactions, the more likely is effective collaboration (Davies, Powell, & Rushmer, 2007). These interactions enable the exchange of resources through which network members collaborate to produce such artefacts as new referral routes, practices or projects (Balkundi & Harrison, 2006).

Network members must commit the resources necessary for network projects, while *delegating decisions and resources* to enable project implementation (Alkema et al., 2003). At the same time, *implementation group(s)* of network members either instigate the network's practical 'joint production' work (Goodwin et al., 2004) or undertake it themselves along with task coordination (Agranoff & McGuire, 2001; Bazzoli et al., 2003). Small initial gains can launch a self-reinforcing virtuous circle (Ansell & Gash, 2008) so long as the network has sufficient authority to implement its decisions (Cunningham, Ranmuthugala, Westbrook, & Braithwaite, 2012).

Strategic planning is weakened when networks are duplicated. A single network with limited overlap of responsibilities with other networks is more likely to attract the resources and participation it needs (Ansell & Gash, 2008) and act as intermediary between other network members and government (Provan, Milward, & Isett, 2002). Competing and single-professional networks may act as rival sources of authority (Ferlie, Fitzgerald, Wood, & Hawkins, 2005). In quasi-markets, managerial governance is exercised over providers through aligning network members' commissioning functions. A network of care providers is less likely to achieve its aims if their commissioners are pursuing incompatible goals. This risk is reduced when network members can make *inputs to align the commissioning plans* for its various service providers (McDonald, Powell Davies, Cumming, & Fort Harris, 2007).

The *adoption and re-badging of existing pre-network* projects is likely to be a more effective way of realising the network's goals than inventing projects from scratch (Provan, Isset, & Milward, 2004). In primary and community care, voluntary networks emerge from common interests and shared practical cooperation (de Rijk et al., 2007) which can provide an experiential basis for a shared practical ('programme') rationale (Agranoff & McGuire, 2001). However, few studies of networks examine the substantive projects by which networks achieve their goals. Empirical studies of the relationship between network structure and effectiveness of delivery are rare, mostly reporting participant rather than network outcomes. The focus is often on the structural characteristics which can be described by social network analysis, management processes or knowledge exchange rather than on the projects by which those outcomes are produced (e.g., Currie, Waring, & Finn, 2008).

The characteristics discussed above were used to construct a 'predictive' framework, to explore the impact each of our networks might have on their headline target of 20 per cent fewer EBDs.

The policy context

While average length of stay for all patients in England decreased by 10 per cent from 2004/5 (Poteliakhoff & Thompson, 2011), emergency bed-days for those aged 75 and over increased by 15 per cent over the last five years (Dr Foster, 2012). Factors associated with this rise include: *'system relationship factors'* — the structures and processes of health and social care organisations; *'hospital factors'* — management of admissions pathway; *community*

1. Network membership is sufficient for programme execution.

2. User representation structure(s) are in place.

3. Approximately equal power between member-organisations.

4. Pre-existing body becomes steering group.

5. Multi-dimensional links exist between (steering group and other) members.

6. Members delegate decisions and resources to network.

7. Members delegate project implementation to network.

8. Network-based implementation group(s).

9. Absence of alternative network with similar remit.

10. Networks are able to input into commissioning.

11. Networks adopt pre-network projects.

Fig. 1. Characteristics expected to promote network effectiveness.