

Report On The Meeting To Initiate A Managed Clinical Network For Paediatric Gastroenterology For The North East Of England held at Hexham General Hospital on 16th March 2005

A. Baker, M. Wright

INTRODUCTION

Following the successful initiation of managed clinical network (MCN) for paediatric hepatology for the UK, with subsequent work on a managed clinical network focusing on the London area reported to the BSPGHAN, Dr. Andrew Mellon, Consultant Paediatric Gastroenterologist, at Sunderland City Hospital, invited Dr. Alastair Baker and Mrs. Margaret Wright, facilitators of the MCN development so far, to hold a 5th meeting in the Newcastle area. The aim was to begin the development of the MCN for Paediatric Gastroenterology for the North East of England.

Parents and local paediatricians are very clear in their preference for services to be provided as close to home as possible where appropriate, and to develop skills and confidence in local facilities. Nevertheless, the focus of the NHS remains institution-centred with developments of specialities such as paediatric gastroenterology planned and led from within major hospitals for the most part. Managed Clinical Networks (MCNs) are 'linked groups of health professionals and organisations from primary, secondary and tertiary care working in a co-ordinated manner, unconstrained by existing professional and existing [organisational] boundaries to ensure equitable provision of high quality, clinically effective services' They are seen as one way of ensuring that organisations can work together to improve access to the service, the quality of the service, and seamless care across the primary, secondary and tertiary interfaces. They also represent the opportunity to achieve this within a multidisciplinary forum despite the need to sustain appropriate levels of clinical skills and expertise particularly with increasing sub-specialisation amongst the medical staff. *"The concept of managed clinical networks hopes to address the dilemma of centralisation of skills but decentralisation of care by concentrating specialist activity while dispersing expertise through the medical community"* – (Boon 2004). In practice, the term is seen as permitting a variety of arrangements, operating at different possible scales: within a primary care trust, across primary, community, and acute care within a health district, across a number of health districts, or larger geographical area. The exact nature of a network depends on its rationale and purpose. (NHS Executive 2000).

MCNs have been initiated successfully many times within the NHS. Mental health, cardiac services, palliative care, diabetes and paediatric oncology are a few of the possible examples. Their long-term effects remain to be evaluated, with apparent lack of productiveness a concern. (Ferlie E, Pettigrew A. 1996). Resource implications are often seen as a major obstacle to initial development or progress towards targets. The needs and existing potential for paediatric gastroenterology services and the apparent motivation

of multidisciplinary and user individuals as stakeholders in the North-East of England seemed to promise an ideal environment for AI methods to flourish. (Magruder-Watkins J & Mohr BJ 2001). Given the complexity of the current situation, potential conflict with other services and absence of new resources, rather than attempting to create a new organisational structure that might conflict with preferences, practices and institutional politics, we wanted to establish a continuous dialogue to create alignment in core values and mission among participants to accommodate changes, ambiguity and imperfection in the organisational structure, while refocusing the current relationships and practice toward better communication and patient-centredness.

METHODS

Using the appreciative inquiry methodology, which has been so successful in the previous work, the facilitators initiated an appreciative enquiry based discussions around the ideals for a GI network based on existing skills and facilities. The process is detailed below. The slides illustrating the AI method are shown in Appendix C and two references to the methodology are provided.

PARTICIPANTS

<u>Name</u>	<u>Position</u>	<u>Workplace/Organisation</u>
Andy Mellon	Consultant Paediatrician	City Hospitals Sunderland
Debbie Osbourne	Paediatric Gastroenterology Nurse	University Hospital of North Tees
Jeanette Unwin	Deputy B.M. Child Health	City Hospitals Sunderland
Nickie Wray	Speech and Language Therapist	University Hospital of North Tees
Sue Fox	Speech and Language Therapist	City Hospitals Sunderland
Heather Smith	Consultant Paediatrician	Bishop Auckland General Hospital
Alistair Baker	Consultant Paediatric Hepatologist	King's College Hospital, London
Shirley Warrington	Consultant Paediatrician,	North Durham
Bruce Jaffrey	Consultant Paediatric Surgeon	Royal Victoria Infirmary, Newcastle
Stephen Hodges	Consultant Paediatric Gastroenterologist / Hepatologist	Royal Victoria Infirmary, Newcastle
Suzanne Davidson	Consultant Paediatric Hepatologist	Paediatric Histologist, St. James' Hospital, Leeds

PARTICIPANTS (Cont'd)

Barbara Gubbings	Chief Executive	Children's Foundation Newcastle
Melanie Toothill	Medical Student	University of Newcastle
James Fisher	Medical Student	University of Newcastle
Anne Dale	Consultant Paediatrician	Queen Elizabeth Hospital, Gateshead
Anna McCorquadale	Medical Student	University of Newcastle
Helen Elwell	Medical Student	University of Newcastle
Sue Bunn	Consultant Paediatric Gastroenterologist	Royal Victoria Infirmary, Newcastle
Heather Gate	Paediatric Dietician	North Tyneside General Hospital
Ajmal Kader SpR	Paediatrics	Queen Elizabeth Hospital. Gateshead

PROCESS

INTRODUCTIONS:

Mrs. Margaret Wright asked the participants seated in a circle to briefly illustrate one of their proudest achievements outside work. All participants contributed in order.

Alastair Baker defined a managed clinical network as link groups of health professionals and stake-holders working together in a co-ordinated manner unconstrained by existing professional boundaries to finish with an equitable provision of high quality care. He continued to explore ideas around 'the concept of managed clinical networks hopes to address the dilemma of centralisation of skills but decentralisation of care by concentrating specialist activity while dispersing expertise through the medical community'. (Boon 2004). The hub and spoke and fractal models for managed clinical networks were also described (Appendix A). Key features from the liver MCN work so far including - privacy and respect: being treated as an individual - customer services: health care as hospitality, first impressions matter - better communication: faster, inclusive, consistent - potential role of information technology - care as close to home as possible – relationships: trust, equality and involvement - anticipation and planning: no surprises - were all offered as ideas to incorporate.

The National Service Framework for Children (NSFC) was also featured as important in shaping future services and practice. Relevant NSFC principles include holistic needs of children less than 19 years of age, the relationship between healthcare and education, social services and the voluntary sector, the duration of the Agenda for Change being 10 years and impacting on Professionals and Managers. (Appendix B). Children need to become priority

service users and out of hospital services need to be strengthened. The focus of care needs to move away from institutions and professionals towards the needs of families and patients. Services must be designed around the child's journey and experiences, following consultation with children and their families. Continuous small incremental changes will be inevitable rather than single major service and system change, but these changes will move towards radical changes in the culture of the NHS and the professionals' views of patients and their own roles. Eleven standards and the development of a tool kit to audit them are promised. There is no specific funding for this ambitious programme.

Alastair Baker and Margaret Wright moved to describe the AI method initially considering the paradigms for organisational change, theoretical benefits for appreciative enquiry and the Gem 4D model of changes in Appreciative Inquiry, (Appendix C).

Exercise 1

An Appreciative Stocktake

Participants chose one of three groups and were asked to choose a scribe for each group. They were asked to choose a partner that they hadn't met before and to tell a story or listen to one another concerning the best experiences or achievements or relationships available for a managed clinical network in the North East. They then swapped roles.

In groups and on a flip chart they listed themes for quotable quotes from their story; impressions or feedback from the groups which they added to the flip chart. They were then asked to list all their strengths and existing resources. Outputs are shown as figure 1. (Figure 1 – outputs of 3 groups)

RESOURCES

Nurses	Good Network Team Network
Good interactions with Adult Services	MDT Approaches (VG)
Know each other	Compact Area Known expertise
Know feeding care	Who to contact Enthusiasm/Energy
Dysphagia Group	Getting known
Peer support GP Centres of Excellence All over the region Only place in Country	Nicer than other services See more holistic approach to service

PROTOCOLS & GUIDELINES

- Nutrition and Feeding
- Patient information sheet
- NEPGANG – N + NE Paediatric Gastroenterology Group
- Equity – A strategy
- Patient & Parent information and Joint Protocols and Guidelines
- Relationships between
Regional and Supra Regional services
- CAMHS – Services available (Dialogue)
- Parents Groups
- MCN Standards

WORKING GROUP

Local Training

Skills – Multidisciplinary

Consultants work with combined Approach

Joint Clinics – Links with local Hospitals

Paediatric Surgical Support – available immediately

Specialist clinics in special schools

More local charities/contacts

Date/Planning – Action

Undergraduate Input – Ethos Re: Now Think About Medical Students

Practical Solutions

Speech & Language input to undergraduate training

Interest & Knowledge

Shared Resources

Roles – Carrying Information
Sharing Information

Know what resources are around

Flexible around boundaries

Learn a lot from each other

Patient Support Group

Local Knowledge

Know the Patch

Funding – Divided out
to periphery

Children's FDTN
(Funding & Resource)

Innovate way to educate
& fund raise.

Good support from other
groups

Synergy – Funders and
this work
Seize the Opportunity

Exercise 2

Making a Mind Map

The participants were asked to think about the best things they have experienced in Paediatric GI Services in the North East, the strengths and potential recognised to be present and with those in mind consider 'What will Paediatric GI Services in the North East be like in the year 2008?'. They were asked to turn to the person next to them and imagine how it could be, to tell a story or listen and then swap over. Their conclusions were arranged on a mind map (figure 2). The participants proceeded to break for lunch an informal sandwich lunch provided by Dr. Mellon.

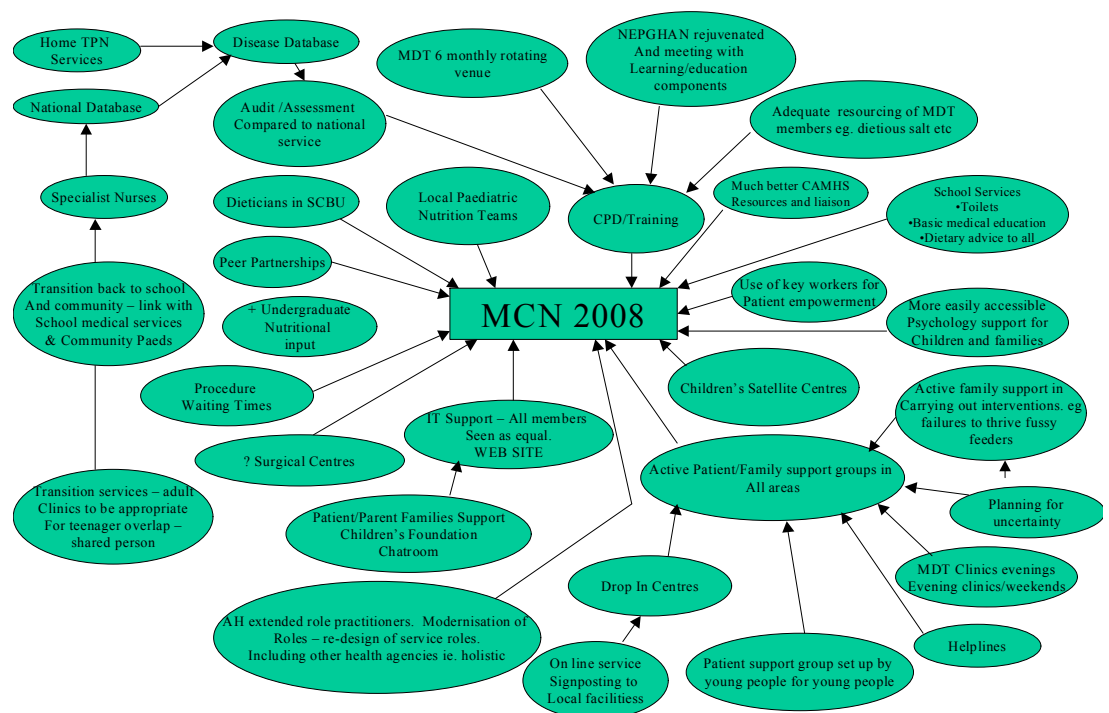


figure 2 – mind map

Exercise 3

Developing the future

After lunch Margaret Wright organised an 'energiser'. Participants were divided into those born in the 1940's, 50's, 60's, 70's and 80's and asked to form groups standing together. They recounted experiences of healthcare or the NHS from their own childhood. They moved on to consider how the North East has changed with respect to health-related behaviours and the use of healthcare. Extremely rich and imaginative stories illustrating what

healthcare meant to all present and its changing role in a changing society became clear in the process of recounting.

Participants were then asked to decide whether they would like to do more work around the development of a MCN or would like to reflect on the work so far. The possibilities for celebrating the work so far included role play, poetry and music. Participants informally and collectively decided further work was appropriate, bearing in mind the current momentum. They began to consider how they could apply their knowledge and experience towards concrete goals, corresponding to the design part of the 4D AI model. Results are shown in Figure 3.

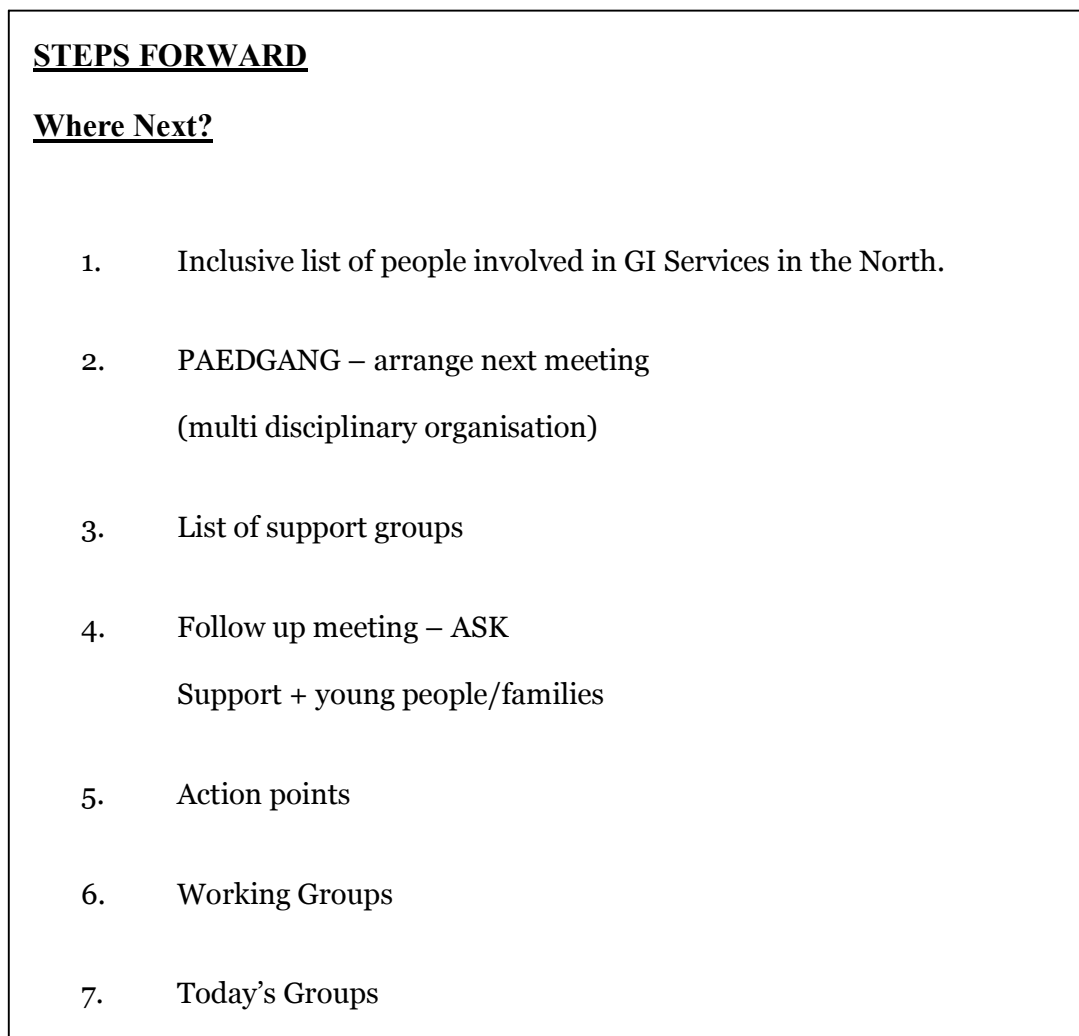


Figure 3.

CONCLUSIONS:

The day made very rapid and energetic progress, and with participants left feeling the need and possibility for further progress. They identified potential for improving services requiring personal and institutional flexibility, sharing

information and teaching between and among units. Skills and resources were identified as available locally including appropriate surgical resources, liver transplantation, dietetic and nutrition related skills, community facilities, NGO input and good links with adult services. A *directory of resources* was proposed. Areas of need were identified including geographical and social. It was recognised that it was necessary to know the area more intimately and recognise where input was required and services should be offered. They also recognised that *standardisation of protocols and common service standards* would be necessary, and work by individuals or groups would be necessary to negotiate, document and disseminate them.

They developed a complex but coherent vision of the future with ideas based on what already exists but also on principles of quality and willingness to provide or contribute to that future. In particular, participants felt very strongly about equity of access as a key feature of quality of healthcare that had potentially been neglected, and began to consider strategies to extend the high quality services that they recognised already exist to areas of deficiency. Participants also recognised the need for the *allocation of tasks* or willingness of individuals to take tasks and responsibilities to create the future that they had planned. Such leadership would be needed, for example, with the *PEDGANG* (North Eastern Paediatric Gastroenterology and Nutrition Group) and also in the development of protocols and contributing to teaching. They also agreed that *a further meeting* was desirable in the near future and that they needed to work towards a time line, setting themselves targets.

Finally the feedback forms were taken showing a very high level of enthusiasm for the process and the outcomes and commitment to develop the service in future. The form and outputs of the feedback appear in Appendix D. References are in Appendix E.

Signed*Alastair Baker*.....
Alastair Baker

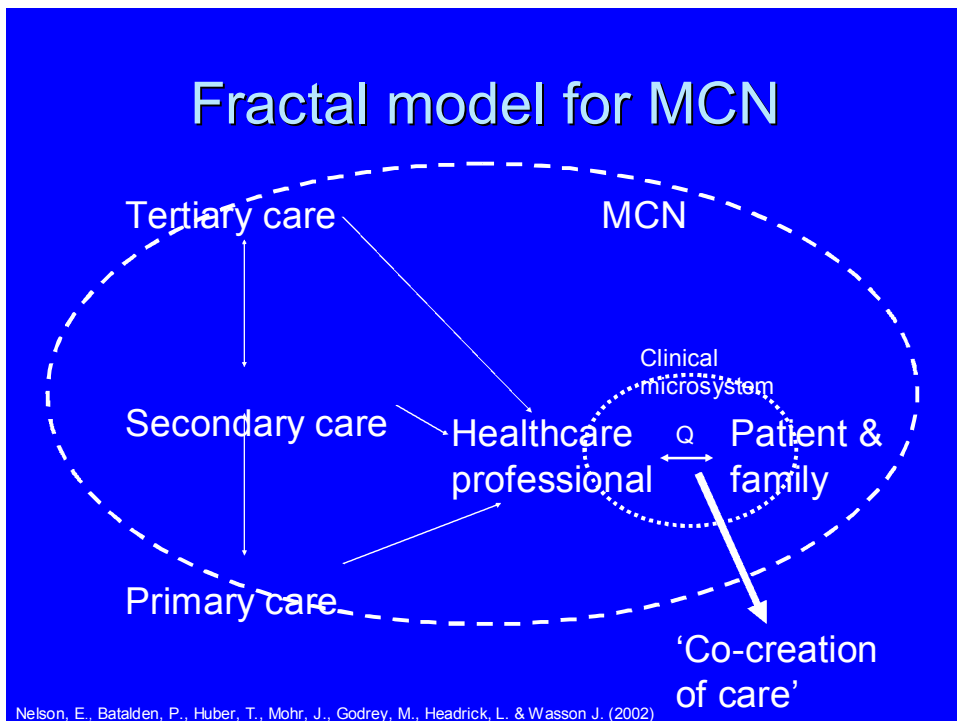
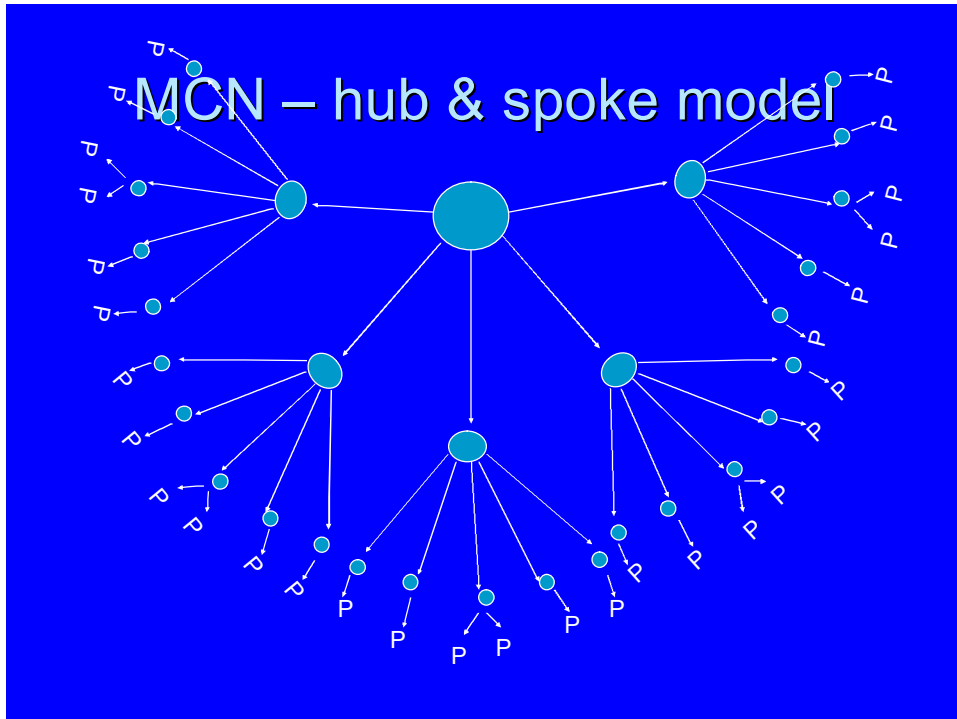
Signed.....*Margaret Wright*.....
Margaret Wright

Appendix A - MCNs

Managed clinical network

Linked groups of health professionals and stakeholders working together in a co-ordinated manner unconstrained by existing professional boundaries to ensure equitable provision of high quality care

“The concept of Managed Clinical Networks hopes to address the dilemma of centralisation of skills but de-centralisation of care by concentrating specialist activity, while dispersing expertise through the medical community” (Boon 2004)



Nelson, E., Batalden, P., Huber, T., Mohr, J., Godfrey, M., Headrick, L. & Wasson J. (2002)

Themes through MCN development

- Privacy and respect - being treated as an individual
- Customer services – healthcare as hospitality – first impressions
- Better communication, faster, inclusive, consistent - Potential role of IT
- Care as close to home as possible
- Relationships – trust, equality, involvement
- Anticipation and planning – no surprises

Appendix B. NSFC

National service framework for children

- Holistic needs of children <19 years old
- In association with education, social services & voluntary sector
- 10 yr agenda for change – in how professionals and managers see services
- Children as priority service users
- Strengthening out-of-hospital services

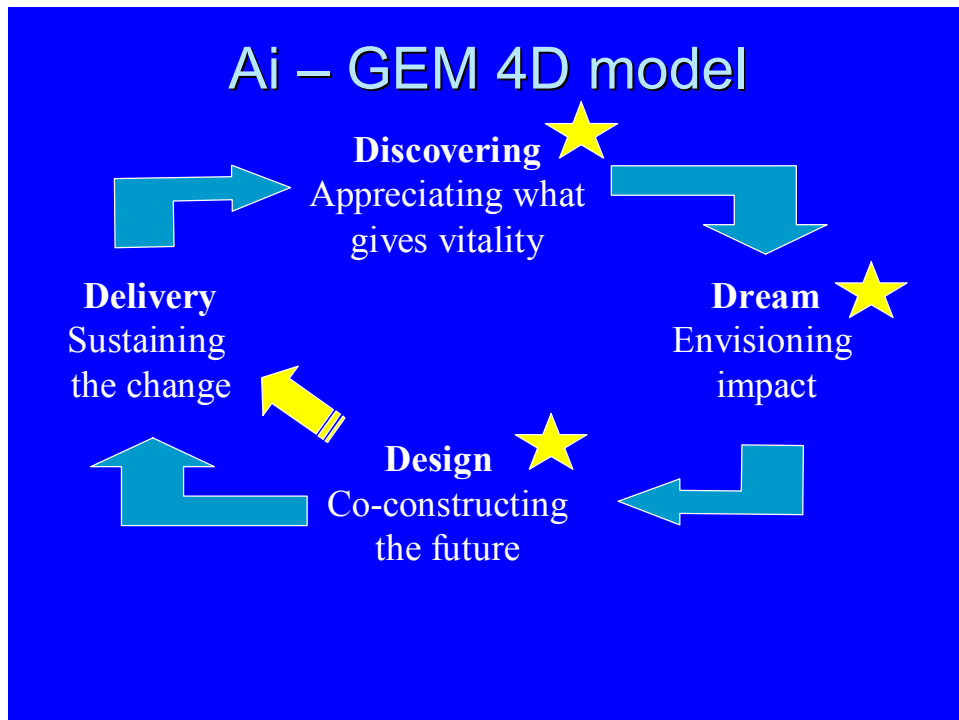
National service framework for children

- Family-centred care based on their needs – as opposed to institution/professional centred
- Consultation with children & families
- Services designed round 'child's journey'
- Continuous small incremental changes
- 11 standards and development of 'tool kit'
- Radical changes in culture of NHS and professionals' views of patients
- No specific funding

Appendix C. Appreciative Inquiry

Benefits of AI

- Maximum stakeholder input - inclusive
- Least chance of conflict
- High chance of creativity and innovation
- Process develops working relationships
- Development simultaneously establishes aims



Appendix D. Feedback

Feedback form

Feedback Worksheet – Managed Clinical Network – Newcastle 16/3/2005.

Name:

Address:

Phone number:

Email address:

What do you feel is exciting and important about the AI method used?

Please share 3 things that would take this work forward

- 1.
- 2.
- 3.

What was the highlight of the session for you?

What have you learned/done that is most useful?

Can you think of an immediate application of what you have learned/done today?

What would you like to see happen as a result of this work?

THANK YOU FOR YOUR CONTRIBUTION AND FEEDBACK!

REPLIES

Exciting and Important.

Free thinking and talking time-but focused with a set of common themes.
Positive feedback on what we are already doing or aiming to achieve, Focus on a future

Missed AM session

It gives you a new perspective

Ensures topics discussed are truly listened to and thought about

Being positive

It didn't seem or feel onerous /boring /work although much was achieved.
Informal atmosphere helped to open up .share ideas, and try to solve problems positively. No barriers discussed.

Focuses best out of people

Positive and affirming

An extremely positive way of looking at service development

Very positive approach, feeling that one can do something

A new way of problem solving

3 things

Further meeting to cement the work and direction

Clear task win working group

Feedback from other groups

Support from management = colleagues

Taking time to focus on what =how I/We can achieve changes

Funding for printing of leaflets etc

Agreed protocols

DB of IBB patients

Be positive, have a vision of where you want to be /want to achieve

Agreed coordinated approach, implement resources ? identified., Regular meetings of group representatives to check changes being made.

Better communication, maintaining enthusiasm

Communication amongst the group, enthusiasm, commitment.

Map of the region and services available regionally, PAEDGHANG, protocols and guidelines

Keep in contact with rest of group , try to make contact with other areas

Networking

Continued enthusiasm, communication, concentration on developing what is current.

Continued communication, sharing this work with others

Highlight

The level of interest = energy from all the different disciplines

Meeting everybody and seeing that all our ideas are similar

The enthusiasm of everyone in the group + communicating with others.

Learning about AI

Meeting new people and reconnecting with those I know

The facilitators insight

I came to know more about the available services , think about the future, plan ahead, involve

Realising there was like minded people locally..

The vision and develop possibilities from the collating of resources

Learning what is going on elsewhere in the region and networking

Seeing how much NE has to offer

Discussions with others, networking

Discussing/meeting with others , putting names to faces

Most useful

The ai method & positive thinking

The mind map

We actually gave good systems /services in place already in the NE but need to build on these.

Positive thoughts lead to positive action

Rekindled enthusiasm(hope it lasts)

Understood more about communication methods , meeting relevant people

Talking to each other helps future correspondence, need for patient support.

Contacts

Made good contacts

Been very positive with my thinking instead of looking backwards.

Talking /? Action points.

More about what is going on around the region

Immediate application

Using the method in general working of positive enquiry

Positive enquiry

No

Improved communication –new contacts need to be kept up

Everday life and achieving goals.

Trying this approach with colleagues

Not yet

Need for PAEDGANG

Working with local teams in shared care

Feeding team work

Will put in place some action points

Discuss with profs in my area who are not present

Involved in

Member of working group and hopefully support some existed work which we have done in the region around creating clinical excellence in services for children with complex feeding difficulties.

Nepgang

Protocols and guildelines + information for patient and parents

Directory of services-i/c support services

Would like to be involved in future meetings

NEPGHAN

Integrating these ideas with training

Reestablishing NEPGANG

CAMHS

PAEDGANG, protocol group

Equitable access to specialist services

NEPGHANG meeting

PAEDGANG

Very interested in being involved in many areas equity, service standard setting protocols.

Other comments

Many thanks a very useful day and great to meet everybody.

Appendix E: References

Boon 2004 in Health Services Management Centre. Birmingham website.

Department of Health (2004) The National Service Framework For Children, Young People and Maternity Services, HMSO

Ferlie, E. & Pettigrew, A. (1996) Managing Through Networks: Some Issues And Implications For The NHS. British Journal of Management; No.7, pp 81–99.

Magruder-Watkins, J. & Mohr, B. (2001) Appreciative Inquiry. San Francisco, Jossey-Bass/Pfeiffer

Wright M & Baker A. The effects of Appreciative Inquiry Interviews on staff in the UK National Health Service. International Journal of Healthcare quality Assurance 18(1); 2005: 41-61.

