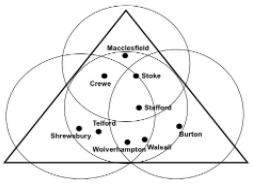
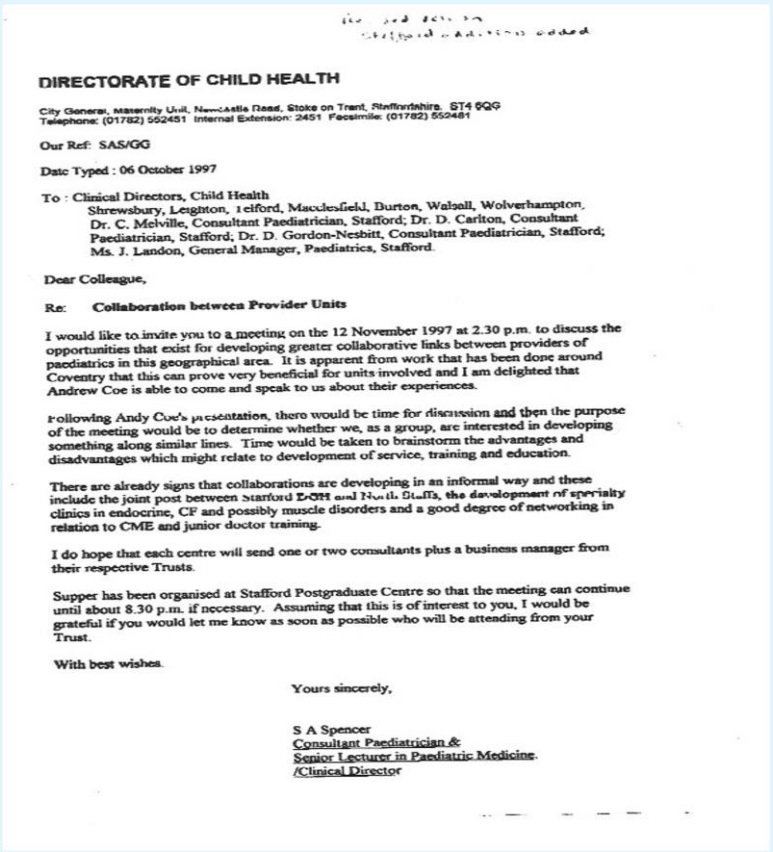


pip partnersinpaediatrics

PiP: Secrets of Survival.

How and why is PiP still here?

Steve Cropper, PiP Academic Adviser
October 2023



DIRECTORATE OF CHILD HEALTH

City General, Maternity Unit, Newcastle Road, Stoke on Trent, Staffordshire. ST4 6QG
Telephone: (01782) 552451 Internal Extension: 2451 Facsimile: (01782) 552461

Our Ref: SAS/GG

Date Typed : 06 October 1997

To : Clinical Directors, Child Health
Shrewsbury, Leighton, Telford, Macclesfield, Burton, Walsall, Wolverhampton,
Dr. C. Melville, Consultant Paediatrician, Stafford; Dr. D. Carlton, Consultant Paediatrician, Stafford; Dr. D. Gordon-Nesbitt, Consultant Paediatrician, Stafford;
Ms. J. Landon, General Manager, Paediatrics, Stafford.

Dear Colleague,

Re: **Collaboration between Provider Units**

I would like to invite you to a meeting on the 12 November 1997 at 2.30 p.m. to discuss the opportunities that exist for developing greater collaborative links between providers of paediatrics in this geographical area. It is apparent from work that has been done around Coventry that this can prove very beneficial for units involved and I am delighted that Andrew Coe is able to come and speak to us about their experiences.

Following Andy Coe's presentation, there would be time for discussion and then the purpose of the meeting would be to determine whether we, as a group, are interested in developing something along similar lines. Time would be taken to brainstorm the advantages and disadvantages which might relate to development of service, training and education.

There are already signs that collaborations are developing in an informal way and these include the joint post between Stafford DGH and North Staffs, the development of specialty clinics in endocrine, CF and possibly muscle disorders and a good degree of networking in relation to CME and junior doctor training.

I do hope that each centre will send one or two consultants plus a business manager from their respective Trusts.

Supper has been organised at Stafford Postgraduate Centre so that the meeting can continue until about 8.30 p.m. if necessary. Assuming that this is of interest to you, I would be grateful if you would let me know as soon as possible who will be attending from your Trust.

With best wishes.

Yours sincerely,

S A Spencer
Consultant Paediatrician &
Senior Lecturer in Paediatric Medicine.
/Clinical Director

PiP Annual Conference & AGM – 25 Years a Celebration!

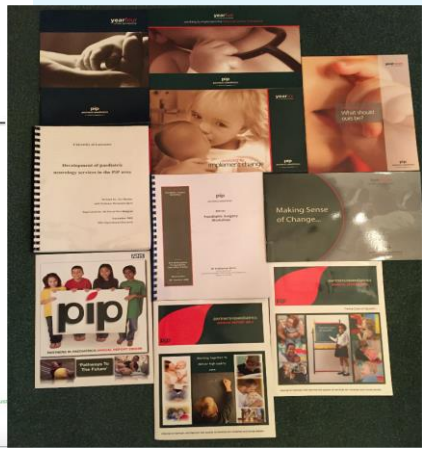
- **1999-2000** 11 members 9DGH 2 Community
- 2002-2003 19 members 10DGH 2 CttyMH 3 ChHos 4PCT
- 2022-2023 23 members (2 assoc) 12DGH 2 Orthop 1 ChHos 1 Amb. 6 CttyMH 1 ICB

PARTNERS IN 1999 – 2000

Burton Hospitals NHS Trust
Combined Health Care NHS Trust, North Staffordshire
East Cheshire NHS Trust
Mid Cheshire Hospital NHS Trust, Leighton
Mid Staffordshire Hospitals NHS Trust
North Staffordshire Hospital NHS Trust
Princess Royal Hospital NHS Trust, Telford
Royal Shrewsbury Hospital NHS Trust
Royal Wolverhampton Hospitals NHS Trust
Shropshire Community and Mental Health NHS Trust
Walsall Hospitals NHS Trust

The current Member organisations are:

NHS Birmingham & Solihull Integrated Care Board (ICB)
Birmingham Community Healthcare NHS Foundation Trust
Birmingham Women's & Children's NHS Foundation Trust
Dudley Intergrated Health & Care NHS Trust
Dudley Group NHS Foundation Trust
East Cheshire NHS Trust
George Eliot Hospital NHS Trust
Midlands Partnership NHS Foundation Trust
Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Trust
Sandwell and West Birmingham Hospitals NHS Trust
Shropshire Community Health NHS Trust
South Warwickshire NHS Foundation Trust
The Royal Orthopaedic Hospital NHS Foundation Trust
The Royal Wolverhampton NHS Trust
The Shrewsbury & Telford Hospital NHS Trust
University Hospitals Birmingham NHS Foundation Trust
University Hospitals Coventry & Warwickshire NHS Trust
University Hospitals of North Midlands NHS Trust
Walsall Healthcare NHS Trust
West Midlands Ambulance Service NHS Foundation Trust (Associate members – August
Worcestershire Acute Hospitals NHS Trust
Hereford & Worcestershire Health and Care NHS Trust (Associate members)
Wye Valley NHS Trust



PiP: Secrets of Survival

How and why is PiP still here?

INTRODUCTION.

The news coverage of the NHS, as it marked its 75th anniversary in July 2023, made sobering reading: Doctors, nurses and other professional groups taking strike action. Even with pay offers declared by the government to be reasonable and final, some groups, including the consultants and junior doctors, have ramped up their campaign. It is about pay, but it is also about 'conditions' – what the Chairman of the BMA has called 'the managed decline of the NHS'. "*Prof Philip Banfield also warned that the health service, which on Wednesday will mark the 75th anniversary of its creation, is so fragile that it may not survive until its 80th*."[1] Little in the news about the NHS serves to calm such anxiety.[2] My colleague, Calum Paton, concludes that the obsession with reform is misguided: far more important are policies to *improve services*[3]. Yet, we now have news of renewed financial straits that will inevitably require cuts to service: already children and young people are experiencing a worsening of their health as they wait for access to the care they need .[4]

Against this backcloth, Partners in Paediatrics is reaching a milestone of its own: mooted at the tail-end of 1997, the Partnership was formally constituted in February 1999 with exactly the purpose of improving services. Now in its 25th year, PiP will hit the official quarter-century in February 2024. PiP has existed for a third of the life of the NHS itself. Its seeds were sewn only one year after the British Paediatric Association received its Charter and was designated a Royal College. PiP has over twice the number of members it had when it formed and more than at any point in its history. The clinical groups and networks that form the heart of PiP are active, many buzzing and 'teeming' with life. Several new groups have been introduced this year. Heading to its silver anniversary, PiP seems to be in good health.

There is certainly reason to celebrate this achievement, but this is also a moment for reflection. That PiP is still around is perhaps against the odds, given the turbulent history of the NHS structure and the swings of attention to children's policy over the past 25 years. Debates about what PiP should be, and what it should do, have been a key part of PiP's story. There have a few moments when doubts may, reasonably, have crept in. Other similar efforts have come and gone. But PiP *has* continued. How and why? Put simply, by luck or by design, it has a) avoided ruinous hazards, and b) commanded sufficient support from its members and acceptance by others to maintain viability. But, of course, that needs some further explanation.

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[1] (https://www.theguardian.com/society/2023/jul/04/most-doctors-think-ministers-want-to-destroy-nhs-bma-boss-says?CMP=Share_iOSApp_Other).

[2] e.g. https://www.theguardian.com/society/2023/aug/04/private-third-sector-nhs-waiting-lists-steve-barclay.

[3] Paton (2023) concludes: "The NHS needs improvement, and in some cases radically improved ways of working within and between clinical departments. But this is not 'reform' in the sense politicians mean: politicians like panaceas. But panaceas cannot be a substitute for resources and the unglamorous work of improvement below the waterline of 'high politics'."

[4] https://www.theguardian.com/society/2023/sep/17/nhs-sinks-into-7bn-cash-crisis-as-inflation-and-strikes-bite?CMP=Share_iOSApp_Other
https://www.theguardian.com/society/2023/sep/17/sick-children-health-worsening-record-numbers-wait-for-nhs-care-in-england
https://www.rcpch.ac.uk/news-events/news/paediatricians-call-government-take-action-childrens-waiting-lists-soar-350000#:~:text=The%20number%20of%20children%20waiting%20to%20start%20treatment,a%20rise%20of%2050%2C000%20between%20November%20and%20April .

A Note on this Note.

This note comes from a particular place. I facilitated a meeting in 1997 to which Andy Spencer invited colleagues from paediatric services in the area around the North Staffs Hospitals NHS Trust: as Clinical Director for Children's Services, he had been struggling to provide or to access more specialist services for local children and young people and he wanted to gauge whether others were experiencing a similar problem. That meeting concluded with an agreement to talk further about what could be done by working together. I have been a member of PiP's core group and Board since then. Involvement has been important to me as an academic with a research specialisation in inter-organizational relations, especially collaboration, and with a bent towards the practical validity and use of knowledge. I'm invested. I can recall certain events, even from 25 years ago, as if they were yesterday. But that doesn't mean that I remember or have experienced PiP in ways that would be recognisable or important to members now. It's through the clinical groups and networks and the support 'PiP Central' provides that most members will know PiP. Whilst I helped a lot with several of these groups until about 2012, I have been less directly involved since then. This assessment of PiP's survival inevitably reflects my eyes and blinkers.

What is clear, and likely a point of agreement, is that the vitality of PiP's clinical groups and networks is the most important reason for PiP's continued existence. It is how PiP brings value to what is already a busy multi-professional world. The chance to interact, swap notes, check practices, and build common ground around achievable standards is an essential part of service oversight and improvement. I refer to Sir Ian Kennedy's remarkable report following the Bristol Inquiry. This opening up of local practice to consideration by others is one of the essential insights that applies across the NHS and children's services. Many other tragic events reinforce the importance of visibility, a vigilant eye, and a willing - even eager - accountability for local practice.

The academic in me was unable to resist some reference to, and use of theory. I hope it adds insight and rigour to the argument, if not elegance or brevity! I have taken 25 pages, in total, to match PiP's quarter-century. There's a substantial evidence base – from PiP's Annual Reports, the minutes of Core Group and Board meetings, Project, Network and Working Group reports and papers, national policy documents, photos, interviews and the wealth of observation and discussions over the years. Some detail has been included in footnotes. But I have tried to retain enough richness in the main text that the basis for my arguments is at least illustrated and the three cautionary tales might serve their purpose - not only to evoke PiP's journey and how it has survived, but also to provide 'caution for the future'. If the full note is too weighty or doesn't appeal, then the following 1-page summary will hopefully give a sense of the argument and build an appetite for more detail.

Finally, if I haven't given sufficient credit to the passion, diligence and abilities of the individuals who have been most centrally involved in PiP's history, then I would like simply to say just how much I respect their vision, efforts and achievements. PiP has survived because those individuals understood what such a framework of cooperation and interchange opens up for the community of children's health professionals, the services they deliver and the children and young people that experience those services.

SEVEN[5] REASONS FOR SURVIVAL: SUMMARY

1. PiP's constitutional form provides a buffer against unthinking /collateral effects of policy. It is 'of' but not 'in' the NHS. Its independence and self-governing status has been maintained and this has meant that PiP's members, alone, could decide whether (or not) *their association* should continue.

2. PiP's membership composition has been fortuitous. Provider Trusts have been less the target of reforms and restructures than have the commissioning arm and the intermediate tier of the NHS. PiP has always been an association of providers rather than commissioners (unlike its West Yorkshire sister, SOAPS, RIP!).

3. PiP avoided liabilities of newness: a certain moral charge and careful development brought energy and a regular flow of resources – financial, human, and a range of other forms of support and exchange - that continued and diversified beyond the initial 'endowment'.

4. PiP found an (initially) uncontested niche. Its most uncomfortable moments (actually, prolonged episodes) have come when the NHS specified or created a part of its organization to be responsible for functions that PiP had taken on. In navigating its way through these episodes, PiP has managed to adapt to retain a distinctive niche, so that it has somewhat changed character and position, inasmuch as these are expressed in its composition and programme of work.

5. PiP has always kept eggs in more than one basket and has been flexible, even agile, finding ways of juggling its work activities and programme to meet the interests of all members, to align with others' schedules where this would be advantageous, and to balance its capacity with the workload. PiP's activities, both individually, and across the programme as a whole, have been sufficiently productive, inclusive and responsive to member interests to maintain member support.

6. PiP has maintained an effective relationship between Core Group and Board. The Core Group has had substantial freedom to undertake PiP's work from day to day and it has respected its mandate through scrupulous attention to formal procedures, transparency and accountability to members. Members have been involved in governance when they needed to be, and they have not been unwilling to hold PiP to account.

7. Importunity! PiP reserved the right to persist 'unreasonably' (well, tenaciously!) in its efforts to improve children's services, but learned a) something of 'how' to persist reasonably and b) different versions of 'the long game'.

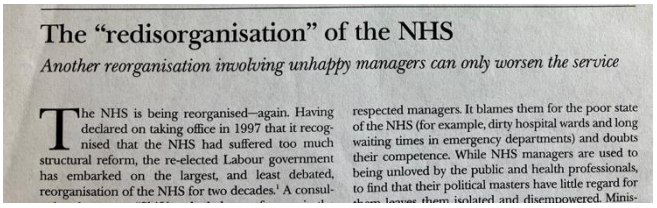
[5] George Miller's (1956) classic text points to the inevitability of a list of seven (+/-2).

SEVEN[6] REASONS FOR SURVIVAL.

The basic argument, summarised above, is elaborated in two ways. We explain how PiP avoided potentially ruinous hazards but note three episodes of 'peril' - when PiP's continuation may have seemed most in doubt. These cautionary tales appear in the discussions of the niche PiP has occupied (point 4) and PiP's dogged persistence (Point 7). We also argue there are (positive) reasons for keeping PiP afloat – its pursuit of good, well.

<u>The Avoidance of Ruinous Hazards</u>

1. ***PiP's constitutional form provides a buffer against unthinking /collateral effects of policy.***



The "redisorganisation" of the NHS

Another reorganisation involving unhappy managers can only worsen the service

The NHS is being reorganised—again. Having declared on taking office in 1997 that it recognised that the NHS had suffered too much structural reform, the re-elected Labour government has embarked on the largest, and least debated, reorganisation of the NHS for two decades.[1] A consul-

respected managers. It blames them for the poor state of the NHS (for example, dirty hospital wards and long waiting times in emergency departments) and doubts their competence. While NHS managers are used to being unloved by the public and health professionals, to find that their political masters have little regard for

PiP sits at the point where health policy and children's policy join. The politics around both, but especially the former, has been febrile throughout the 25 years since PiP formed. But PiP is at one remove from the politics and change brought by policy dictat. PiP is *of* but not *in* the NHS. Its core funding comes from membership subscriptions rather than a grant from an NHS agency. Although nerves can be frayed, PiP is, constitutionally, buffered from the policy and management decisions that directly affect its members and other organisations within the NHS line. As Martin Rees, then Clinical Director of Paediatrics at the Royal Shrewsbury Hospital, noted – being both inside and outside was a good position to be in. Although the effects of NHS reforms *have* been felt indirectly with shifts in the ground, and impacts on the membership, neither health nor childrens' policy, in themselves, has disassembled PiP.

The Partnership has served as a linking pin, identifying and then turning attention towards both emerging and longstanding shared issues and providing 'spaces of engagement' (Cox, 1998). In developing and pursuing its agenda, PiP has not been restricted to any single issue or priority in the way that NHS and other organisations are constrained to defined, usually burning, issues.[7] PiP *has* defined its own priorities for the year ahead. It has had to, since it has always had a set of activities that exceeded its capacity. But it has a broad statement of purpose as a mandate, and it also had the flexibility to respond to other issues emerging or raised: to gather intelligence, deliberate and come to a view about the nature of the problem and ways of addressing it, together. There has been a culture of responsiveness in PiP and often the question is more to do with how to structure work on an issue rather than whether or not to recognise it.

[6] George Miller's (1956) classic text points to the inevitability of a list of seven (+/-2).

[7] In the 2023/24 priorities and operational planning guidance, for example, the broad direction is to re-establish core service capacity and flow, following COVID disruption, and to address inequalities in health across access, experience and outcomes. Whereas in 2022/3, there were a number of more particular areas of service development specified, in 2023/4 it boils down to improving access to mental health support for CYP by a measurable amount against the pre-Covid baseline of 2019 levels of support.

2. *PiP's membership composition has been fortuitous.*

Although PiP has always followed an inclusive policy on membership, PiP's members have been, predominantly, NHS Trusts providing paediatric services. With each wave of reform, it has been the commissioner side of the NHS that has been most immediately affected, with wholesale reorganisation removing and replacing whole populations of organization – health authorities, primary care trusts, and so on. Changes to commissioning organizations brought uncertainty, disruption and 'blight' as jobs changed, people moved, and whole offices were removed[8], but those changes were not terminal for PiP. Had PiP been established as a commissioner-led partnership, as was its 'sister', SOAPS, in West Yorkshire, it would have been hard to survive the upheavals.

3. *PiP avoided liabilities of newness: a certain moral force brought energy and a regular flow of resources that continued and developed beyond the initial 'endowment'.*

New ventures face liabilities of newness and of adolescence that stem from difficulties in moving from an initial idea to an entity with the ability to sustain itself beyond its initial endowment. During PiP's early years, there was both a common cause and a strong degree of cohesion among the members that was energising. The Partnership started with an extraordinary rush of activity, as founder members committed resources to assessing whether collaborative action could help address problems they agreed were significant and shared.

Children were (and indeed remain) a Cinderella service within the NHS. Broadly, children, at 20+% of the population do not receive anything like that share of the NHS budget for dedicated services. As Al Aynsley-Green wrote about his visits to localities as the first National Clinical Director: "*A key message emerged from so many localities that the health needs of children simply were not on the plot for local priorities*." (2019: 173). Furthermore, *within* the child population and children's services, there are postcode differences of great significance. These were evident in 1999 and they remain today, reflected in budgets and service allocations, including within the PiP area.[9]

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[8] In drawing lessons from the history of Strategic Health Authorities and Regions, Edwards and Buckingham (2020) note "an almost two-year period of uncertainty after the government announced its intention to abolish SHAs in May 2010. This led to SHAs being 'clustered' from 10 to four in October 2011. They were finally abolished on 31 March 2013." https://www.nuffieldtrust.org.uk/sites/default/files/2020-07/1593704531_strategic-health-authorities-and-regions-final.pdf

[9] CAMHS was one of PiP's 'Top 6' service priorities identified for attention in 1998 as part of its programme of activity and it, in particular, has remained a service under pressure, not only but not least since Covid.
https://www.politicshome.com/thehouse/article/child-adolescent-mental-health-care-crisis
https://www.theguardian.com/society/2023/jun/09/ministers-accused-neglecting-tidal-wave-child-mental-ill-health-england?CMP=Share_iOSApp_Other
https://www.health.org.uk/publications/journal-articles/inequalities-in-childrens-mental-health-care-analysis-of-routinely-collected-data-on-prescribing-and-referrals-to-secondary-care. https://childrenscommissioner.github.io/mhbriefing2021/spend/pages/spend.html
Of course, the problems are not restricted to mental health services, or to the whole range of health services for children but to all those facilities and services that make for or detract from the health and wellbeing of children in the UK, eg Al

The initiating and founding members of PiP could see, and went on to show, that children in their areas were poorly served[10]. They could also see ways of improving the accessibility and quality of care for those children – through collaborative action. PiP was conceived as a means of gathering and providing a voice for a significant body of clinicians, and children that were being systematically disadvantaged. If 'outrage' would perhaps overstate the force behind PiP's formation, then, there was nevertheless a powerful moral charge. To borrow an idea from thinking about social movements, in which values are also a crucial explanation of participation (Yo, 1992: 224), PiP was **a challenger**, seeking to question a system that was neither working fairly, nor responsive to calls for change.

Part of PiP's work was to press for acceptance of that role. In the 2000s, as childrens' policy developed, there was a stronger articulation of the 'loose network' batting for children that Kennedy had spotted and that Al Aynsley-Green and colleagues (2000) had posed as a question[11]. PiP found its work was of interest nationally, indeed internationally[12].

13. ANY OTHER BUSINESS - Dr Spencer received a telephone conversation from Bernard Crump (Chief Executive from the Strategic HA), Al Aynsley-Green had asked Mr Crump to give a presentation on PiP at the regular meeting of NHS senior executives – the topic in November was children's services. The presentation was duly given and copies of PiP's annual report were distributed to the delegates. They are very interested in the work PiP is doing. Need to invite Bernard to come along to a meeting of PiP's Steering Group.	DON

Minutes of Core Group 28th November 2002

Aynsley-Green (2019); and Polly Toynbee's excoriating note on how (Tory) Government cuts have inevitably targeted children https://www.theguardian.com/commentisfree/2021/sep/24/children-britain-tory-cuts-birthrate
Only schools education has secured recent budget increases that mitigate decline on spend/pupil from 2010-2020. But schools' health provision remains limited, with access to both generalist (school nursing) and specialist services (speech and language therapy, CAMHS, etc) severely restricted. The consequences of school closures during Covid lockdowns are also emerging, not least in child death prosecutions, but also in indicators including school attendance rates. https://www.theguardian.com/society/2023/aug/04/covid-lockdown-england-child-abuse-jacob-crouch?CMP=Share_iOSApp_Other

[10] It is worth just setting PiP's emergence into context. The internal market had largely passed paediatric services by – block contracts were still largely the means by which purchasers, the Health Authorities – secured provision in the District General Hospitals (DGHs). But paediatrics was changing, with sub-specialisation entering. This trend was problematic for DGHs, where paediatrics was often shored up by small establishments of consultant paediatricians – necessarily generalists - for whom referral to a (regional) children's hospital was the means to access specialised services. PiP's origins were in the frustrations experienced in the 'further reaches' of the region – to the north of Birmingham and the south of both Alder Hey and the Children's Hospital in Manchester. The referral systems worked better for children in the cities, or close-by, than they did for children seeking referral from further afield – a well-known distance decay function in health care. The investment decisions of both commissioners and the children's hospitals had not evidently factored in the need to redress this situation. From the North Staffs hospitals, this was despite repeated attempts to negotiate fairer access and so, with a larger than average consultant group, first steps to appoint to specialists to provide local service access had been taken, including diabetes and endocrine, and gastroenterology. But attempts to get recognition of the additional costs of establishing and receiving referrals to these services had fallen on deaf ears at the Health Authority. And so….

[11] Kennedy (2000) BRI Final Report Section Two Chapter 29: para 34 on the 'Leadership of Children's Health Services'. Aynsley-Green et al (2000) Who is speaking for children and adolesecents' health at the policy level?'

[12] PiP was cited in the proposal for a national system of paediatric clinical networks, which formed the basis of a contract between New Zealand' Ministry of Health and the Paediatric Society of New Zealand to establish such a system. PiP and PSNZ swapped notes, with Mollie Wilson, Chief Executive attending PiP's annual conference on numerous occasions.

I observe certain parallels between PiP's work to gather the community of paediatric practitioners together, for the betterment of local services, and accounts of community development activity to address deep inequalities. John Bennington (1997) notes that such a change effort: *"… has to be propositional as well as oppositional. It has to help local groups to decide what they are for, not just what they are against. It has to try to identify and develop the common interests within diverse and sometimes divided communities [and] how to link … government .. to these complex grassroots communities."* (Benington 1997: 239-40)

The values and assumptions underpinning the mechanisms for improvement that PiP proposed were expressed with a good degree of coherence (or plausibility) (eg in PiP's Annual Reports, its 'legacy' document', and Cropper, Hopper and Spencer, 2002). The Partnership was conceived as a collective pooling of populations and of more specialist clinical resources – actual … and justifiable. Andy Spencer, as the individual most frequently invited to rise to the challenge, was able to reframe problems reported by paediatricians as shared concerns that were amenable to collective and collaborative action. He did so with sufficient clarity and confidence to engage members and to encourage authorisation of the next steps of exploration[13]. The briefing note for David Fillingham, then Chief Executive of the North Staffs Hospitals, who chaired PiP's first Conference in October 1998, spelt it out[14].

Notes for DF Briefing on Chief Executives Meeting

Overall Script.

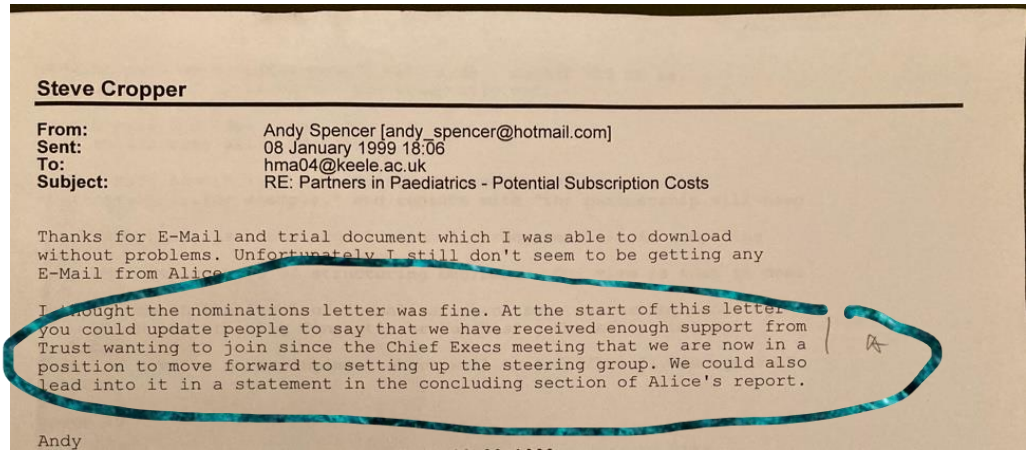
There is a basic premise on which the partnership is founded: this is that children in the area between Manchester and Birmingham could get a better deal if the resources both vested and invested in childrens' services providers were used with a different frame of reference in mind. Currently, that frame of reference is the District population and the District General Hospital: the consequence is a pattern of service provision which minimises the provision and development of specialist services available locally. It is also based on the provision of regional specialty services within the main regional centre - Birmingham or Manchester/Liverpool respectively. If the frame of reference became the population served by partners - 2.5 million - then a case for development of specialist services can be made. The purpose of the partnership is to make that case and to find appropriate ways of making it happen. The vision: to do more through an improved organisation of existing resources and to command development resources as appropriate to meet the health care needs of children in the area.

At this meeting, PiP sought a mandate to continue to explore the potential of collaborative working to improve services. And so, in early 1999, a less-than-excited e-mail message recorded PiP's viability as a subscription association: a critical mass of the initiating organisations had confirmed their willingness to contribute the first year's subscription, which had been essentially justified by the proposal to establish a small, core team – a dedicated presence, representative and administrative and coordination capacity for the Partnership.

[13] The discussion between Mark Prebble and other scholars of public value raises this point exactly – the propositions do not have to be both true and feasible, but plausible and carrying sufficient persuasive force to allow the 'imposition of public authority' (Prebble, 2021), ie to foster collaborative action through PiP.

[14] Paediatric Clinical Leads who had contributed to the work-up of the case for the Partnership brought colleagues from their Trust's senior management– the CEOs or Deputies of a dozen NHS Trusts attended.

The fees were then, and remain today, quite modest. They were originally set at three levels, related (if rather crudely) to the size of the organization and, by extension, to its likely budget, childrens' service interests, etc.). The subs have increased only once in PiP's 25 years (from April, 2020) and PiP's finances, as a consequence have, at times, been a point of pressure.



Steve Cropper

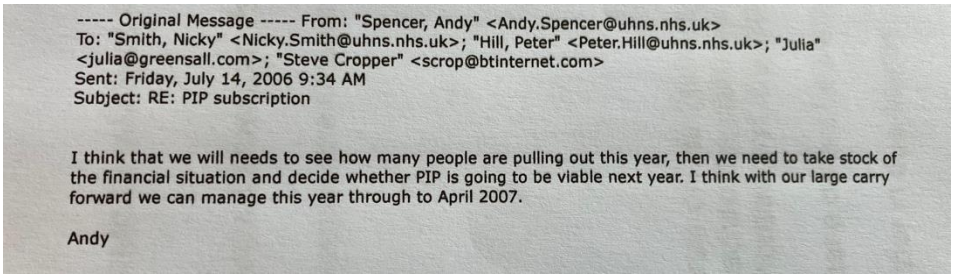
From: Andy Spencer [andy_spencer@hotmail.com]
Sent: 08 January 1999 18:06
To: hma04@keele.ac.uk
Subject: RE: Partners in Paediatrics - Potential Subscription Costs

Thanks for E-Mail and trial document which I was able to download without problems. Unfortunately I still don't seem to be getting any E-Mail from Alice.

I thought the nominations letter was fine. At the start of this letter you could update people to say that we have received enough support from Trust wanting to join since the Chief Execs meeting that we are now in a position to move forward to setting up the steering group. We could also lead into it in a statement in the concluding section of Alice's report.

Andy

The early 2000s, under the Blair-Brown government, were a financial boom period for the NHS, relatively speaking. Paediatrics were a part of a sustained policy focus on children's services, following the inquiries into two scandals, in particular: Sir Ian Kennedy's (1990) powerful analysis of the failings of cardiac surgery at Bristol Royal Infirmary and of its implications for the governance of clinical practice across the NHS; the National Service Frameworks followed up; and Lord Laming's inquiry into the death of Victoria Climbié (1994) which, of all the child deaths from abuse and all of the inquiries, brought safeguarding to the top of the policy agenda along with Every Child Matters. During this period, PiP was able to top up its subscriptions with external monies, where NHS planning agencies saw benefit in supporting PiP's work. Occasionally, a substantial new project emerged – the work PiP facilitated on managing the impact of the European Working Time Directive (for which PiP received £60,000) was the most substantial. Other work on particular services also brought external monies – paediatric surgery, child sexual abuse training, what was known as GP upskilling, and so forth.



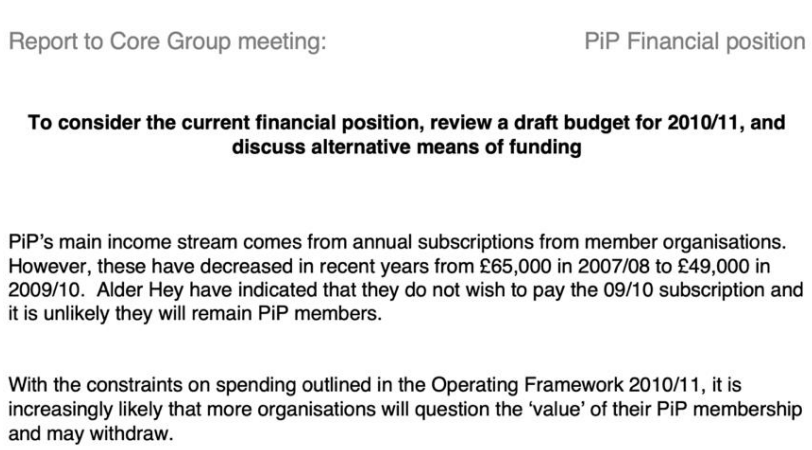
----- Original Message ----- From: "Spencer, Andy" <Andy.Spencer@uhns.nhs.uk>
To: "Smith, Nicky" <Nicky.Smith@uhns.nhs.uk>; "Hill, Peter" <Peter.Hill@uhns.nhs.uk>; "Julia" <julia@greensall.com>; "Steve Cropper" <scrop@btinternet.com>
Sent: Friday, July 14, 2006 9:34 AM
Subject: RE: PIP subscription

I think that we will needs to see how many people are pulling out this year, then we need to take stock of the financial situation and decide whether PIP is going to be viable next year. I think with our large carry forward we can manage this year through to April 2007.

Andy

But such external income could not necessarily be relied on. The minutes of PiP's core group and Steering Group/Board, record frequent discussions of income and expenditure. As a general policy, PiP sought to increase its income through growth in membership rather than by raising fees. There were several recruitment campaigns – in 2002 as PiP sought to develop beyond the founding group, between 2010 and 2012 as PiP and Birmingham Childrens Hospital worked on a framework for managed clinical networks across the West Midlands, and then in 2013 when PiP's Chair, Stuart Poyner, a PCT Chief Executive, sought to attract sister PCTs to the fold. For the latter two, in particular, it proved difficult to make the case for direct benefit though for NHS Trusts in the south of the West Midlands, geography may also have been a key factor.

Retention of members was a strong focus too. Early on, PiP added a line to the terms and conditions of membership to say that members would have to give one year's notice of withdrawal. This gave PiP a chance to 'salvage' withdrawals. Especially where money was the reason for giving notice of withdrawal[15], members mostly remained as members. The period of greatest threat to PiP's financial viability was in the years following the 2008 global banking crisis ('quantitative easing' became a household topic of conversation!!). George Osborne instituted a period of austerity that severely affected public services. NHS organisations, including PiP's members, looked budget line by budget line at their expenditure. Several members indicated that they would be withdrawing from PiP and there was a risk that member withdrawal would become a run.



Report to Core Group meeting: PiP Financial position

To consider the current financial position, review a draft budget for 2010/11, and discuss alternative means of funding

PiP's main income stream comes from annual subscriptions from member organisations. However, these have decreased in recent years from £65,000 in 2007/08 to £49,000 in 2009/10. Alder Hey have indicated that they do not wish to pay the 09/10 subscription and it is unlikely they will remain PiP members.

With the constraints on spending outlined in the Operating Framework 2010/11, it is increasingly likely that more organisations will question the 'value' of their PiP membership and may withdraw.

A series of Position Papers set out options for PiP's future direction – including an option to wind up the Partnership!! PiP tightened its belt, learned to promote the full extent of its activity (eg through an 'achievements' document' in 2012 and a 'legacy' document considered by the Board of July, 2014) and to reinforce the benefits of membership to members (a 'benefits' document, a marketing brochure, the 'service level agreement' - 2013).

Finally, and not because of a financial crisis, PiP decided from 1st April 2020 (no fooling!), to increase its fees and to 'standardise' the subscription, dispensing with the original differentiated rate. It *has* now grown the membership to one measure of 'saturation' – recruiting all those NHS provider organisations in the West Midlands region that hold recognisable interests in paediatric services.

In sum, PiP has avoided financial crisis by: maintaining a stable, core, subscription-paying membership; remaining in dialogue with, and directly accountable to members; pointing to the range of benefits membership brings for what are modest fees; latterly growing the membership; and topping up with external monies whenever circumstances and members' interests allow[16].

[15] Members have also resigned because they were or became affiliated to other regions (eg Burton merged with Derby and then faced eastwards). If PiP's activity was marginal to their interests, and there was no clear prospect of change, PiP would hold up its hands. If the member may have taken the decision without knowing the full extent of its engagement with PiP's activities, then conversations would ensue, to ensure the decision maker had a full appreciation of the benefits..

[16] Ahrne and Brunsson's (2008) argument is that resources largely are not an issue for associations, since members will generally provide what is necessary. PiP's experience essentially supports their hypothesis, though it has also benefited from external buy-in has also support which has enhanced the breadth and intensity of activity PiP could sustain.

Goran Ahrne and Nils Brunsson argue that associations like PiP *will* generally persist.[17] Members tend not to leave but rather manage the commitments they make to the association. There have been suggestions that senior managers in member organizations have seen sufficient benefit simply in being a member of a convenient, regional association that contributes to clinical governance and education.[18] But such a minimalist stance on the reasons for membership does not square with the sustained level of clinical engagement with PiP's workgroups and networks. That release of resources to collective activity has been the mechanism by which PiP has fuelled its activities and produced what Sheaff et al (2012) call 'network artefacts' – resources for the benefit of members. Participation in the making has been as important a means of drawing benefit from membership of PiP as 'consumption' of the resources, once they are ready to circulate. The activities that have required or achieved sustained, intense attention – surgery, anaesthetics, gastroenterology, rheumatology, the guidelines, to name just a few - brought together whole communities of health professionals, the most senior to the most junior, in purposeful discussion of services and clinical practice. But the only points at which the full complexity of PiP's work came together outside the core group and Board was at the Annual Conference. That is clear from the extract below, and it is echoed in Annual Reports, in 'participation stats' gathered for PiP's educational meetings, and so forth.

programme. Martyn stated that we need to be clear as to what PiP is about as well as emphasising the partnership with PCTs - the annual conference needs to attract the clinical staff that have been (and will be) the main contributors to PiP so that PiP maintains its real strength - clinical engagement. We need to ensure people are exposed to what PiP is doing and what the work has achieved rather than making the programme too focused on generic change skills. Rosemary Jones suggested inviting a headline speaker – Prof. Tina Lyon from Liverpool. (A revised programme attached).	Comments welcomed by all on the proposed programme

From Steering Group meeting, 25/3/04 discussing the programme for the July Annual Conference.

4. *PiP found a (mostly) uncontested niche.*

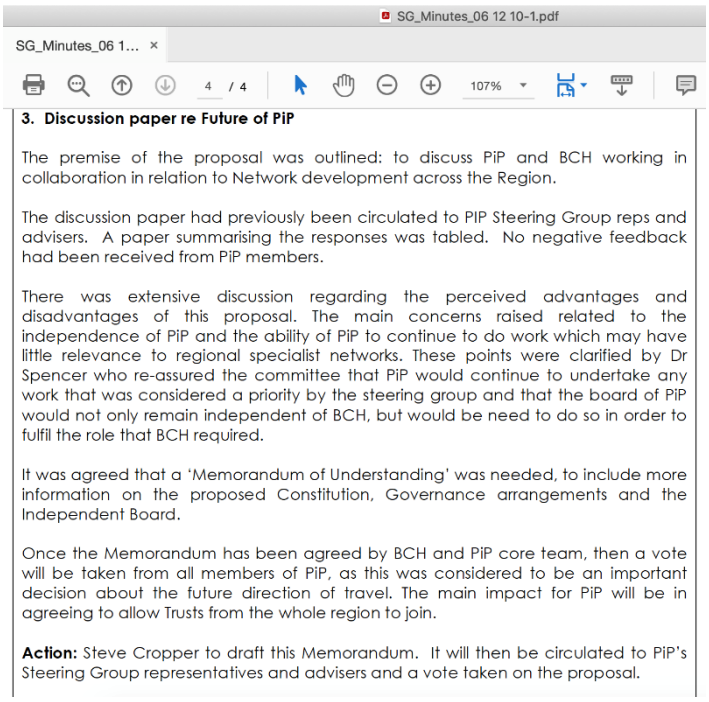
For much of its 25 years, PiP operated without direct competition for its work activities. It created a work-space, filled it with activity, and members and other interests built on it. This was what might be called a 'governance gap', not matched geographically or functionally to the territories of other agencies, which PiP occupied. There have been moments when one or other of PiP's activities seemed, potentially, to be in competition with another (more established) organisation: e.g., the launch by the RCPCH of an authoritative set of clinical guidelines caused some concern over PiP's guidelines. There were many organisations – NHS and other - with shared interests and responsibilities, but none that covered PiP's combination of geography, membership, and activities within, and across, children's health

[17] PiP had worked on a bit of wisdom that said 'Once a budget line has been created, it tends to stick'. Not now. A core group report dated 5th, Feb, 2010 summarised cost reductions already undertaken and listed possible sources of income. The option of increasing subscriptions was dismissed. Other options focused on attracting new members and on raising fees for services to external interests based on PiP's reputation, flexible hiring of consultants to undertake work, and exploiting its knowledge products, eg its child sexual abuse care pathway and associated standards of service could potentially be packaged for sale and the education programme could be promoted to increase income generation.

[18] For example, members' adverts for paediatric specialist trainees have included mention of 'good networking through partners in paediatrics' Eg https://www.westmidlandsdeanery.nhs.uk/Portals/0/Anthony%20Ward/Walsall%20-%20General%20Paediatrics%202017.pdf?ver=2017-07-31-152844-027

services. With Rob Willoughby's Children's Team at Shropshire and Staffordshire SHA, for example, close cooperative relations were there for the making. PiP, alone, served members' *collective* interests in *children's health services in the area*. In due course, fuller 'existential threats' to PiP did emerge, in two lengthy 'episodes of peril', from 2009-2014.

Episode 1: A strategic decision by Birmingham Children's Hospital's Board, in 2009, to focus some of its resources on the development of regional managed clinical networks led to discussions with PiP about whether, and how, to work together.[19] There were potential benefits in an alliance with Birmingham Childrens' Hospital for PiP – extension of its membership to NHS Trusts across the West Midlands, including to the south of Birmingham, greater financial security, and the chance to realise managed clinical network developments that had, so far, been difficult to make happen. One option, discussed, was that BCH would host PiP[20], but this was considered risky by the 'body of the kirk'. There were also risks in formalised cooperation – that specialised service networks would so dominate PiP's work to exclude other matters, a lock-in to NHS priorities, and the loss of PiP's flexibility and responsive approach to members' interests and concerns. PiP might have fallen to internal differences – between members interested in the specialist networks and those more interested in PiP's other work[21]. And, if that had transpired, PiP might simply have gone down a path to irrelevance, redundancy, or servitude as policy on managed clinical networks (later known as Operational Delivery Networks) firmed up, and the lead on this network or that network was given to the Children's Hospital. As Goran Ahrne and Nils Brunsson (2008) argued: "*dissolutions are more likely to occur the greater the similarity between the meta-organization [in this case PiP] and its members. The more alike they become, the greater the chance that they are able to perform the same tasks; thus the greater the level of competition between them….if the members can adopt the core activities of their meta-organization, the level of competition between the two may, in extreme cases, cause the meta-organization to lose its members….*" (p135) Either way, there would have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3. Discussion paper re Future of PiP

The premise of the proposal was outlined: to discuss PiP and BCH working in collaboration in relation to Network development across the Region.

The discussion paper had previously been circulated to PIP Steering Group reps and advisers. A paper summarising the responses was tabled. No negative feedback had been received from PiP members.

There was extensive discussion regarding the perceived advantages and disadvantages of this proposal. The main concerns raised related to the independence of PiP and the ability of PiP to continue to do work which may have little relevance to regional specialist networks. These points were clarified by Dr Spencer who re-assured the committee that PiP would continue to undertake any work that was considered a priority by the steering group and that the board of PiP would not only remain independent of BCH, but would be need to do so in order to fulfil the role that BCH required.

It was agreed that a 'Memorandum of Understanding' was needed, to include more information on the proposed Constitution, Governance arrangements and the Independent Board.

Once the Memorandum has been agreed by BCH and PiP core team, then a vote will be taken from all members of PiP, as this was considered to be an important decision about the future direction of travel. The main impact for PiP will be in agreeing to allow Trusts from the whole region to join.

Action: Steve Cropper to draft this Memorandum. It will then be circulated to PiP's Steering Group representatives and advisers and a vote taken on the proposal.

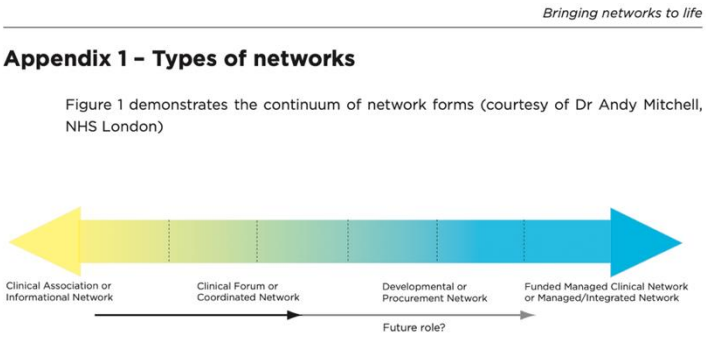
[19] English health policy, in the end, followed that established in Scotland in 1998 by Sir David Carter's acute services review, which recommended the systematic development and support of service networks. There was a late flurry of activity in England. PiP had been working on development of networks for almost a decade.

[20] There are types of inter-organisational 'network' that are organised by a lead member, essentially in its interests and those of the whole service system (Provan and Kenis, 2007). 'Hub and spoke' networks, which are one example, are commonplace in the NHS and the constitution of Operational Delivery Networks has been defined in these terms..

[21] Minutes of several of PiP's Steering Group meetings record questions from member representatives about whether PiP would still be able to pursue other forms of activity should the deal with BCH be sealed. Designs for governance included creating two 'sub-boards' of PiP, one chaired by BCH and focused on managed networks for specialist services, the other on other aspects of PiP's work.

been some tricky terrain to navigate. Discussions about a formal 'alliance' continued for over two years, assessing proposals to accommodate both PiP's and BCH's interests. But no formal agreement about joint working and its governance was sealed. PiP and BCH have simply continued to work together, through PiP and bi-laterally, as appropriate.

Ten years on, the division of labour between BCH and PiP reflects the underlying principles of those earlier negotiations: much as Kennedy had urged and policy had insisted, the specialist service centre, BCH takes the lead on regional specialist service networks (to the right of the spectrum used in the RCPCH's (2012) guidance document; and PiP now supports informal professional networks, education meetings and development of guidelines (to the left of the spectrum).



Episode 2: The second cautionary tale, from the period 2012 to 2014, concerns an external challenge to PiP's position and role. It came as a result of the creation of Strategic Clinical Networks (SCN), announced in July and detailed in November 2012. These formed a part of the NHS's regional apparatus, linked to the formation of Clinical Senates, the combination of advisory and improvement drive being accountable upwards through the Local Area Team's Medical Director[22]. One of the SCNs put into place covered 'Maternity **and Children**', and PiP's world was again threatened. The SCN was charged with running paediatric service improvements. Commissioners and providers were expected, though not required, to engage with, and in the SCN – as members. Though this development clearly offered some considerable hope value for childrens' services[23], it potentially pulled the rug from under PiP's feet. The appointment of Andy Spencer, PiP's Lead Clinician, to the SCN softened the blow and there was even talk of using PiP 'as' the paediatric side of the SCN – to Andy, it made sense to capitalise on the 15 years experience of collaborative work and PiP's infrastructure to make rapid progress on already-established priorities.[24]

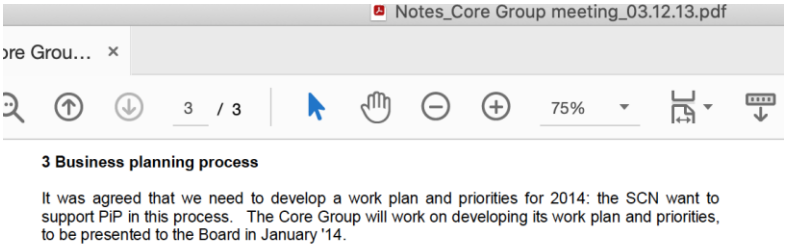
[22] https://www.england.nhs.uk/wp-content/uploads/2012/11/scn-sof.pdf

[23] Spencer, Ewing and Cropper (2013) Making sense of Strategic Clinical Networks. Archives of Disease in Childhood: 98,:843-5, doi: 10.1136/archdischild-2013-303976

[24] There had been various (more casual) suggestions before, noted in PiP's records, that would have brought PiP closer to the NHS itself – by Professor Bernard Crump, Chief Executive of Shropshire and Staffordshire SHA and by Jon Cook, regional planner with responsibility for childrens' services. PiP was seen as potentially part of the planning and consultative capacity needed to oversee development of childrens' services and the configuration of services at the SHA or regional level.

The SCN was launched on 1st May, 2013 with a well-attended consultation conference. Andy's successor as Lead Clinician of PiP, Kathy Bailey, was one of the speakers explaining PiP's range of activities and making a pitch for a regional future. But, almost as soon as the SCNs had launched, the NHS changed its mind: maternity remained, but the mandate to work on children's services was withdrawn – at least after a further unsettling period[25]. PiP was afloat, but very much adrift.

The two cautionary tales reveal that PiP could be lost to substitution – in part or in toto. By luck, and by holding a steady, collective nerve, PiP survived, but these events did lead, in due course, to something of a change in PiP's character and position. Before explaining that, we should note that the subsequent, huge jolt of Covid-19, from Spring 2020, also brought change – in many ways, positive and purposeful for PiP. Rapid adoption of online technology allowed PiPs' core team, working with the clinical networks and groups to maintain its meetings and educational programme, with additional events that specifically allowed members to exchange experiences of the pandemic, coping strategies and processes of recovery. The situation, the ready accessibility of the events, and the low costs to individuals and their organizations resulted in burgeoning participation.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3 Business planning process

It was agreed that we need to develop a work plan and priorities for 2014: the SCN want to support PiP in this process. The Core Group will work on developing its work plan and priorities, to be presented to the Board in January '14.

<u>A transition in character.</u>

PiP's starting values and assumptions can still be seen in its constitution ('PiP is a partnership of equals') and in the technologies it promotes (a system of managed clinical networks, with resources and responsibilities distributed amongst the membership rather than concentrated in one 'hub'; jointly produced clinical guidelines; and an accessible educational programme that provides extraordinary quality and value for money. The totality of these 'Do It Ourselves' activities has added up to a substantial programme of clinical and service development. It is also a contribution to the checks and balances on clinician and provider that Sir Ian Kennedy had demanded in his report on the Bristol Inquiry[26]. While Kennedy argued that assuring quality of services should trump access to services, PiP tried to move both together, but it became clear that the sorts of change PiP envisaged required continuing, and long-term effort.

When, from 2010, the Children's Hospital took on the formal Managed Clinical Networks, PiP started to focus on informal networking among clinicians. And so, when the Strategic Clinical Network (Paediatrics) formed, then was folded, PiP was already moving to a new set of emphases in its work – support to members' interaction, focused on best practice rather than on concerted service redesign and development.

Neither suggestion went far, though PiP carried out work on the impact of the European Working Time Directive and worked closely with Prof. Ed Peile in a fundamental review of childrens' services across the West Midlands.

[25] Greater Manchester SCN for Children and Young People found local money to continue as an advisory and improvement resource, but the majority of children's arms of the SCNs were simply deleted.

[26] http://www.bristol-inquiry.org.uk.

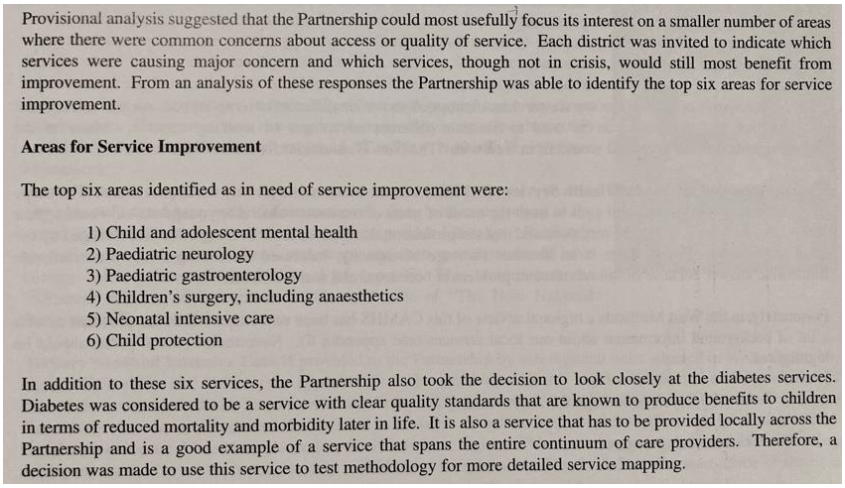
The groups and networks that PiP lists today look rather different to those on the original list. A good number provide a focus for service quality development and control; others start from promote professional networking and mutual support. Projects seeking to redesign service delivery systems are now effectively the preserve of the NHS line, notably through the Integrated Care Boards and lead Trusts in operational delivery networks.

Not all the current groups and networks have been initiated by PiP. Some, existing networks and new initiatives alike, have approached PiP for the quality of support that the core team can provide. Some are charged a fee. The organising teams are not necessarily from organisations subscribing to PiP, nor is membership of those networks/groups restricted to professionals working for those organisations. PiP's members will benefit from these national networks, but not exclusively. PiP supports rather than drives the groups and their activities: the concern is more that the groups maintain an active status and the support system helps ensure that objectives are set, are achievable, and are pursued.

Where the core team and Board lead, for example on the Annual Conference, issues of service configuration, wider health and children's policy and inequalities do still take centre-stage (PiP's 2022 Conference took 'Inequalities in Health' as its main theme). If the more 'radical' campaigning and service planning have become less prominent over the 25 years, nevertheless PiP still maintains vibrant professional interchange across its member organisations about children's service, and about quality and safety in the heartland of clinical practice.

THE PURSUIT OF GOOD, WELL.

5. PiP has kept eggs in more than one basket, and its work activity programme flexible.



Provisional analysis suggested that the Partnership could most usefully focus its interest on a smaller number of areas where there were common concerns about access or quality of service. Each district was invited to indicate which services were causing major concern and which services, though not in crisis, would still most benefit from improvement. From an analysis of these responses the Partnership was able to identify the top six areas for service improvement.

Areas for Service Improvement

The top six areas identified as in need of service improvement were:

1) Child and adolescent mental health
2) Paediatric neurology
3) Paediatric gastroenterology
4) Children's surgery, including anaesthetics
5) Neonatal intensive care
6) Child protection

In addition to these six services, the Partnership also took the decision to look closely at the diabetes services. Diabetes was considered to be a service with clear quality standards that are known to produce benefits to children in terms of reduced mortality and morbidity later in life. It is also a service that has to be provided locally across the Partnership and is a good example of a service that spans the entire continuum of care providers. Therefore, a decision was made to use this service to test methodology for more detailed service mapping.

When PiP comprised essentially acute health care providers in the northern West Midlands, the programme of activities was not difficult to agree. The year of work-up (1998) had identified what became known as the 'Top 6 sub-specialist clinical services', these being 'of shared concern' and potentially amenable to improvement through collaborative action. The list reflected members' shared interests in the acute sub-specialities of paeds, in particular, and those services have been and enduring imprint from the start.[27] As PiP's membership broadened to include community paediatrics, mental health services, and commissioners, and as other (non-member) interests, including the

[27] The identification of CAMHS as a priority was largely because of the increasing numbers of young people with mental health problems on children's wards, and lack of referral option available to the paediatricians.

regional and Strategic Health Authority children's teams, became more closely entangled, the link between PiP's range of work and any member's particular interests became less evidently focused. In particular, there were numerous representations to the PiP Board and core team on behalf of community paediatrics, which PiP recognised and sought to respond.

From Minutes of 25th March 2004 Steering Group: item on Partnership Evaluation and Development.

> The discussion turned to ways of addressing issues raised so far. One key issue concerns the balance of interest in, and work undertaken by, PiP. In particular, relatively little work is being done for community children's services even though

The gastro project did include work on paediatric constipation, for example, spanning acute, community and primary care. The long-running work on child sexual abuse services similarly bridged acute and community paediatrics. PiP's Paediatric Guidelines book now has a section labelled 'Community' and a page with 15 Top Tips for Working with Children and Young People, developed by the Shropshire Young Health Champions.

And there was also a breadth to the programme of activities, with education and training, standards development, care quality measurement, population needs assessment and workforce planning, evaluation, research and publications, and the engagement of commissioners and children and young people, for example, cross-cutting these and other paediatric sub-specialties. We might conclude that **PiP's activities, both individually and across the programme as a whole, have been sufficiently diverse, inclusive and responsive to member interests to maintain member support.**

Secondly, PiP evolved a method or process which helped to stage and pace projects. This gave a discipline to each project, indicating stable points and outputs in a process that could easily become ragged or unproductive. But it also allowed the Partnership to manage workload, including demands on member representatives, by pausing projects and potentially finishing them, to switch core resources from one project to another, and to synchronise PiP's effort with the planning cycles of members or external organizations that PiP was looking to influence.

Successive changes to NHS structure brought different mixes of organization, mostly aimed, in the words of one of the policies involved, at 'shifting the balance of power' (StBoP)[28]. That mostly involved moving health care commissioning closer to primary care, which represented the closest proxy to the consumer/patient. But managerial and economic forces seldom took long to return to some form of agglomeration, e.g. collaborative commissioning by Primary Care Trusts, or recalibration of the intermediate tier - Strategic Health Authorities - SHAs; Integrated Care Boards, and indeed the Regional Offices. Or

[28] Department of Health. *Shifting the balance of power within the NHS.* HMSO, 2001. For a short and useful summary, see https://navigator.health.org.uk/theme/shifting-balance-power-within-nhs-white-paper.

both. There have generally been points in the system/hierarchy to which PiP could relate - where its issues and projects would 'fit'. Some projects were for the regional specialist services planners. The SHAs provided a focus for sub-regional networks, and for collaborative work across the region, from 2002 when they were established until they were disbanded in 2013. Other projects were localised as 'local' demonstration projects. For example, PiP worked with the health economy and the education authority in Walsall and with community and primary care in Wolverhampton to assess the scale of the problem represented by paediatric constipation. PiP's GP and primary care nurse's upskilling project was based in Stoke. **That ability to work at a variety of scales[29], PiP's freedom from lock-in to national priorities, its ability to 'flex' work to keep momentum on its various projects as best possible, and its capacity to respond quickly with attention to problems of significance to members have all been important markers of PiP's resilience.**

6. ***PiP has maintained an effective relationship between Core Group and Board.***

PiP's survival has been dependent on the members retaining confidence in its governance system. One of PiP's core principles is that it is a partnership of equals. The constitution specified a Steering Group with one member one vote, and it, or re-named variants[30], has been the basis of PiP's self-governance. The natural tendency of associations, once established, is to let the enthusiastic few run things (Blau and Scott, 1966) and this can lead to a state of oligopoly in which member interests are addressed unevenly. The minutes of the core group and Board frequently raise the extent of member participation in PiP's governance. But this is countered by a) the extent and quality of engagement of clinicians in PiP's working groups and clinical networks[31] and b) the fact that PiP's members *do* engage in formal govenance when they feel they need to. So, the core team has substantially operated with great freedom, subject to consultation with members and formal ratification of decisions at Board meetings. Informal consultation is continuous and, at times, dense. But PiP's core group has been keenly aware of its formal accountability to members; and members have been willing – as much individually as collectively – to hold the core group to account. They do so individually and collectively, at times of opportunity or pressure or constitutional crisis, and to consider questions about PiP's activity and, in short, whether the benefits flow, in the round, to all members. There is a fascinating note of a meeting – quite early in PiP's life - between the consultant body of founder members in one of PiP's areas, with the lead clinician of PiP. The questions posed were tough and direct, concerning PiP's aims and the distribution of benefits from its activities. The final question was acknowledged as being for the group, itself, to address. "What measures of benefit would

[29] There is a growing interest in how governance gaps can be filled by what is termed scalecraft (McKinnon and Shaw, 2010; Pemberton, 2015; Papanastasiou, 2017).

[30] The last meeting of PiP's Steering Committee was held on 25th February, 2013. Members agreed that, with changes to strengthen the governance of the Partnership, it would be re-constituted as a Board, and the minutes of 16th July are 'headed' as such. The Board became the Board of Members following a root and branch review of PiP and its governance in 2018.

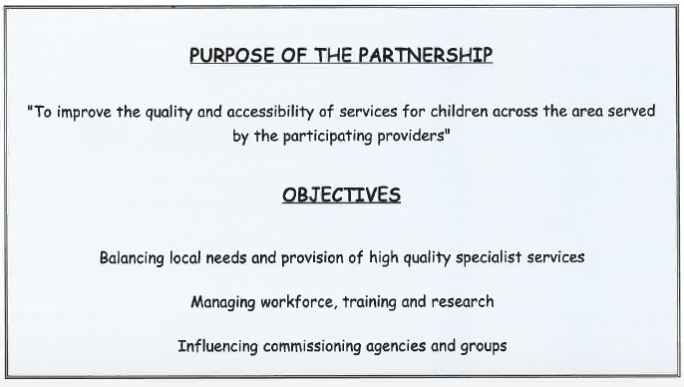
[31] PiP has managed to sustain the involvement of clinicians through its energetic programme of activity – there has been information pooling and exchange, educational activity, analytical work, standards and guidelines preparation, testing and compilation, and service development thinking to suit all types of clinical expert and enthusiast. PiP broadened the scope of clinician's interests to the population level; and it posed the question – how should it be; how could it be improved? The activities of each improvement project made visible the service arrangements and clinical practices of members for comparison one against the other (benchmarking) and against established standards (audit/review).

they use to decide on PiP's value to their member organisations?" Their organisations are still members!

Procedurally, PiP has held faithfully to the specified annual review of its constitution, with external evaluations and internal reviews for the board to consider and discuss. The reviews have brought much tinkering [32] and occasionally more significant constitutional change, but fundamentally they have served to demonstrate the Partnership's robust attention to decision making and governance and to signal the boundaries of the Partnership and the exclusive privileges of membership. A balance between core group focus and drive and participatory governance in PiP has, broadly we can say, been maintained.

Perhaps more important have been the review of the Partnership's system of objectives. As Peter Marris and Martin Rein (1967: 33) observed: *"Any practical organisation will naturally develop by … a pragmatic fusion of means and ends. An initial purpose leads to a preliminary framework of action, that framework suggests other purposes which it might fulfil, the further organisation of action takes these new purposes into account – and so on, until a working structure is evolved which has its own momentum. Once the organisation begins to function, it tends to be as preoccupied with finding a use for its resources as with adapting resources to a predetermined purpose. 'What are you really trying to achieve?' asks the naïve critic, and finds he has thrown down a provocative challenge.* " (p33)

PiP's statement of purpose has remained intact as a powerful covering mandate from the first drafting in December 1997[33]. Its objectives have been subject to occasional revision to ensure coherence with its on-the-ground activities with one major reframing. Objectives originally focused on service and workforce reviews (below, left). Reframed for discussion at the Steering Group of 5th Nov. 2008 (a bonfire of objectives!), version 2 has proved to be a pretty durable summary of PiP's lines of work. It is substantially still there in the current formulation (right). It reflects the focus on more informal clinical networking, the guidelines and the programme of educational events.


PURPOSE OF THE PARTNERSHIP

"To improve the quality and accessibility of services for children across the area served by the participating providers"

OBJECTIVES

Balancing local needs and provision of high quality specialist services

Managing workforce, training and research

Influencing commissioning agencies and groups

PiP's objectives are to:

- Develop high quality clinical guidelines and pathways of care
- Facilitate the development of clinical and non clinical paediatric networks and support associated work streams, where appropriate
- Work with and inform commissioners on the improvement of services – with the overall aim of improving outcomes of care
- Provide educational fora, training events and professional development
- Promote and share good practice at regional and national levels
- Work with organisations to ensure the voices of children and young people are heard

[32] Changing the frequency of Board meetings, issuing requests to members to nominate their representative *and* a deputy, specifying and respecifying the purpose of the Board, inclusion of an educational component to meetings, inclusion of reports from the Working Groups and Networks, or from members on the agenda of each meeting, rotation of location, and changes in nomenclature. PiP moved from a Steering Group to a Board (Feb, 2013) to a Board of Members (Oct, 2018).

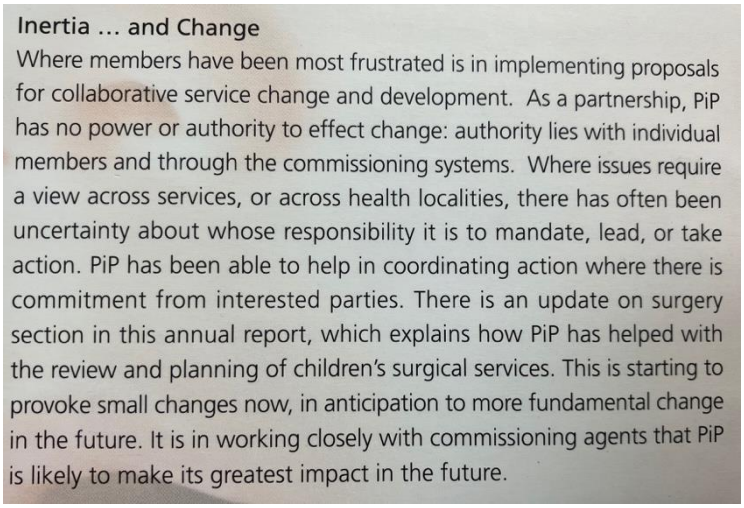
[33] One word has been lost. The statement originally read "The *driving* purpose of the Partnership is to…."

One addition requires mention: a period of activity, championed by PiP's then Chair (2011-16), Liz Nicholson, was aimed at developing the involvement of children and young people in service planning. PiP, itself, had engaged with children and their families as part of its service activities (for the neurology project in 2004, and an award-winning initiative by the paediatric rheumatology network in 2009). But the more extensive activity to inform, encourage and develop members' work to engage with children and young people in service review and planning came in that later period. And the objective was incorporated into PiP's mandate.

7. Importunity and Risks of overreach – PiP reserved the right to persist in its efforts to improve children's services, but learned something of 'how' from tough experiences.

There are broadly two methods by which NHS Trusts (provider organizations) can generate major service improvement in the NHS, by which I mean a change in the disposition of clinical resources to improve access and quality of services. The first is by acquiring resources and mandates, notably from commissioners, locally, and/or through NHS central policy; the second is by a concerted re-direction of existing resources to an agreed plan. PiP tried both.

From: PiP Annual Report 'Year Six, Creating Change' 2005: p6



Inertia ... and Change

Where members have been most frustrated is in implementing proposals for collaborative service change and development. As a partnership, PiP has no power or authority to effect change: authority lies with individual members and through the commissioning systems. Where issues require a view across services, or across health localities, there has often been uncertainty about whose responsibility it is to mandate, lead, or take action. PiP has been able to help in coordinating action where there is commitment from interested parties. There is an update on surgery section in this annual report, which explains how PiP has helped with the review and planning of children's surgical services. This is starting to provoke small changes now, in anticipation to more fundamental change in the future. It is in working closely with commissioning agents that PiP is likely to make its greatest impact in the future.

PiP sought to engage with commissioners several times in different ways over its 25 years. But the deadening effects of the hybrid NHS (part-hierarchy, part-market), the cultural and constitutional distance between providers and commissioners, the repeated disruption to structures, and the difficulties in securing support for wide-area change from increasingly small-area commissioners made the processes of engagement and influence tricky. One effort, the Paediatric Specialised Services Steering Group, set up *jointly* by PiP and the commissioning consortium for Staffordshire and Shropshire in 2004, seemed to hold great promise. Several of PiP's projects were recognised as service priorities by the Group, but ultimately little came of it. In another reorganisation of commissioning, the advisory structure simply disappeared.

In 2005, PiP's Annual Conference focused on 'Implementing Change'. The Annual Report summarised a certain frustration in the discussions: "*What PiP's members would most like to see is greater progress in bringing about tangible service change*." (Annual Report Year 6: p6). By the close of 2007, the Annual Conference and Annual Report were 'Making Sense of Change' – at least, trying to. Looking back, Andy Spencer wrote: "*In reflecting on this year's annual conference… it occurred to me that PiP is continually trying to influence the development of services in an ever changing environment...With change all around us, does PiP have a distinctive role to play?*" (Annual Report Year Eight 2007/08: p9).

Episode 3: Pushing member responsibilities too far. The Paediatric Gastroenterology service project had soaked up significant Partnership resource. With initial attempts to influence commissioning hitting dead-ends, and in an effort to bring decisive progress, two members of PiP took an opportunity to redirect existing resources, making gastro services the priority. The planned sub-specialist centre was set in motion in 2001 with two coordinated consultant appointments, each with a gastro specialisation. An endoscopy suite and other necessary facilities and services were also established. The service started taking referrals, and quickly showed benefits. But by 2003, it was swamped. It took PiP knee-deep into what is termed 'the big muddy'. The network plan required investments from other members in their services to balance the network (dedicated dietetic and nursing support, in particular, to allow the return of children to close to home care). The network also needed dedicated hands-on management. Without the return flow to the other hospitals, the specialist centre was overrun. Referrals were stopped. Although PiP did receive external support from the NHS strategic agencies to continue exploring the potential of a network, with grants to help with clinical development through specification of shared standards and guidelines and workforce planning across gastro pathways, it didn't prove possible to stabilise the network as an operational entity.

The first lesson for PiP was that, without authority over NHS organisations, including its members, and with very limited coordination capacity, PiP could find itself 'over-committed' (Staw, 1976) with potential for 'decision overreach' (Wilson et al, 1999). Whilst this collapse was distressing, members' concern did not develop into a loss of confidence in the Partnership. Other work continued – on paediatric surgery, on anaesthetics, on paediatric rheumatology, in upskilling primary care practitioners, and so on. But PiP has not encroached into members' own decision spaces in that way again.

A second lesson is that of importunity. And patience… And opportunism….

<u>Importunity.</u>
But especially persistence against the goal. Complex, 'big bang' plans seldom bring results in the manner proposed. With paediatric general surgery, although PiP has been a substantial participant in a project that has, off and on, run effectively for the whole of PiP's life, it has been possible to hand off responsibility for the project, having made inroads into change, notably through its two rounds of Trust's self-audit against a battery of agreed service standards: when the NHS structures took responsibility for planning and coordinating region-wide reviews and change, PiP moved to an active, supporting role, with recognition in resource terms for a package of work in the north of the region.

<u>Patience</u>. For gastro, there *was* improvement to local services, but more through the quiet, gradual adjustment of existing resources by members to more general arguments PiP had already established through its workforce strategy: that a) consultant posts could and should attach to a special interest, and b) gastro should be one of these as a priority for members. Although PiP's gastro network has not had a continuous active presence, unlike, say, the Paediatric Anaesthetics Network, it was, nevertheless, still one of PiP's clinical groups and deemed a priority ten years on from the initial attempt to secure change[34]. PiP is

[34] See eg Core Group notes 29/5/2012 for inclusion of a gastro workshop in PiP's forward priorities.

currently discussing the development of a project to address issues in care for children and young people with one of the commonest gastro problems – constipation. These service and clinical development problems do not go away.

Opportunism. The Police Forces jn England were handed the lead, with a share of a small national pot of funding, on Sexual Assault Referral Centres (SARCs). PiP had been working on services for child sexual abuse services for children for four years by this time, producing a multi-agency pathway, associated standards of service and a model of service provision that was as close to sustainable quality as the working group could devise. This involved, essentially, children's SARCs. The clinician leading the project was tipped the wink and PiP gate-crashed the first meeting at Police HQ to make the case for a children's door into the Referral Centre and for dedicated children's services. The model of services that PiP had proposed had also involved a network of practitioners supporting services at one or two shared, central facilities. PiP was invited to join the planning team and remained closely involved as the Police established a SARC to serve Staffordshire[35] completing involvement in 2011. Sadly, handover, even to safe hands, doesn't guarantee sustained quality[36].

CONCLUSION.

PiP started as an experiment – the proposition was that there was a different way of organising available resources and claiming new resources to redress inequalities in services for children. But such initiatives, Peter Marris argues "*… characteristically lack any powers to change the established institutional structure …. It does not matter much, I think, what these experiments try to do…. So long as whatever happens tests the responsiveness of the governmental structure to new ways of representing people's needs…and at the same time, tests the ability of the structure to comprehend and act upon problems as a whole, irrespective of judicial boundaries. Nor does the value of the experiment depend on achieving success…..*" (Marris, 1974: 256-7).

For seven reasons, I have suggested PiP, as a voluntary association, has been able to claim and sustain a legitimate role as a facilitator of collaborative working among members, and as a mechanism by which paediatric services could achieve a stronger, collective voice to push for intelligent change. If it has escaped direct threat of dis-establishment, it has certainly had to navigate 'crises' in order to survive. Perhaps both 'grit' AND luck have been required (Liu, 2021). But where it has found itself in turbulent waters, or becalmed, there has been sufficient 'capital' banked and 'hope value' for the future that PiP remains a work-in-progress. Ensuring that paediatric services are able to provide safe, high quality and accessible care for children undoubtedly will remain a major challenge and the continuing question for PiP's members is how PiP can most usefully help them to meet that challenge.

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[35] See updates in PiP Annuals Reports Year Seven (2005), 2008/09; 2011, and 2012-14 when it is reported that PiP is supporting the Designated Professionals' (Safeguarding Children) Network across the West Midlands. PiP continues, as of 2023, to provide support to that group.

[36] https://www.theguardian.com/society/2023/aug/06/two-thirds-of-sexual-assault-support-centres-in-england-branded-inadequate

ANNEX A.

Theories of Organisational Survival (and Failure): a brief survey.

PiP is an association that exists for its members' mutual benefit. Members – in this case, organizations - join voluntarily and decide on the activities that they, collectively, will support. Ahrne and Brunsson (2008) argue that associations of organizations like PiP (which they term 'meta-organizations') will, *once established*, tend to persist. The cost of membership is very low (relative to their resources), and the opportunities for influence within the association are significant, so there are no compelling reasons for members to leave. Their's is a theory of 'the herd', and, broadly, of organisational stability. But they do note some ways in which the survival or continuity of such an association may be imperilled – if it fails to achieve a sustainable size, if it fails to attract the membership that would be expected, especially high status members and a high proportion of those in the 'target category' of organizations; if it doesn't maintain a distinctive role as a gathering ground, and if it can't handle differences in interest among members.

Though they say less about this, Ahrne and Brunsson (2008) also suggest that survival will depend on the context in which the association is set, and the way external forces affect it. These might be severe 'shocks' and 'jolts', but it could simply be the nature of the 'sector' in which the organization sits. For example, is competition among members extreme? Are there pressures towards scale and concentration, so reducing the pool of members and the need to associate? Is there a singular source of influence, or power, that shapes the sector – a regulator, or a policy centre with mandated authority to govern the sector? Are there other associations – there or emerging - to which members might defect?

The ability of an association to prevent and respond to problems is also crucial. Catastrophic crises of culture and behaviour (eg the recent problems of the CBI[37] and, say European and Spanish football) may arise from arrogant, complacent or tarnished governance. Problems of conduct and values can overshadow the benefits members receive. Ahrne and Brunsson's argument pinpoints the association's function in strengthening member identity and status and if this is so, there will be an overriding emphasis on work to maintain the association's symbolic worth – its legitimacy and standing – both to members and to external interests. Any scandal or failure that reflects weaknesses in governance is likely to be immensely challenging to any association.

Others would argue that the 'material value' the organization produces through its 'products, and the activities that lead to them is what is most important, especially in responding to external change. Rod Sheaff and colleagues' (2010) study of the resilience of clinical networks in the face of health sector reform concludes that it is the judicious adjustment of 'network artefacts' – the things the networks produce – which enables successful network adaptation to new operating conditions[38]. A failure to adjust and adapt may well be a problem. A first issue is securing a mandate from members. Sustaining member involvement in governance is a well-recognised problem for associations (Blau and Scott, 1966) – there is a tendency, once it is established, to let the enthusiastic few to run things….until, that is, the step too far outside the established frame. Ahrne

[37] https://www.theguardian.com/business/2023/sep/17/cbi-seeks-3m-from-members-within-days-to-avoid-financial-oblivion?CMP=Share_iOSApp_Other

[38] *"…changes in networks' core practical activity are what stimulate changes in other aspects of network macroculture. The most powerful way of using network macroculture to manage the formation and operation of health networks therefore appears to be by focusing managerial activity on the ways in which networks produce their core artefacts."* (Sheaff et al., 2010: from Abstract)

and Brunsson's discussion of associations suggests that change, from the set of agreements among members that is initially negotiated, is hard to achieve. They also come close to suggesting that 'performance' doesn't actually matter, except (as noted above) in terms of keeping the association's nose clean. Although 'permanently-failing organizations' may be commonplace (Meyer, 1979), it is unlikely that the culture of high accountability for performance that holds in the NHS would allow this in PiP's case.

In claiming their value to members, the association has to balance expectations. To encourage members to commit time and energy, it needs to highlight the benefits – potential or actual - of the association's activity. But, against the association's resources, organizing capacity and demands of getting the activity up, running and producing benefits, it may be easy to 'overreach', to try to do too much, and to misjudge a commitment. This can endanger the organization as a whole (Wilson, Hickson and Miller, 1999). Equivalent lines of thought can be found in Staw's (1976) analysis of escalating commitment that may leave an organization 'knee-deep in the big muddy'; and van Oorschot et al's (2013) discussion of decision traps in complex projects. There may also be a special case of 'lock-in' when an association becomes obligated to or dependent on particular organizations inside or outside the associational framework. At the heart of all of these are a) failures of information flow and sensemaking that reinforce decision makers' 'blinkers' on strategic concerns, and b) problems of effective governance when responsibility is either highly distributed or highly concentrated.

Resilience and vulnerability may also be understood in terms of stages of the life course. Ahrne and Brunsson's argument that a sort of membership inertia quickly sets in depends on getting through the process of establishment, but particular '**liabilities of newness' and liabilities of adolescence**' (there is a debate about whether these reference the same or different points in the emergence of an organization) can bedevil the transition from the idea of the organization to its operation beyond initial investments and endowments. Yang and Aldrich (2016) suggest that such liabilities can be mitigated. So "*most new businesses begin with meager funding and mundane objectives. However, entrepreneurs are less likely to terminate their emerging businesses if they can accomplish a great deal with whatever it is available to them, especially when they are fully committed to their business. New ventures are not stuck at the start with whatever they have assembled. …* ***Those who pursue external resources, make time to create routines and standards, and undertake activities that bring organizational boundaries into sharper relief can substantially increase the likelihood that their emerging ventures persist long enough to achieve a stable existence.***" (p49). Yang and Aldrich suggest "*startup teams that already have joint experience working together*". (p39) and that "*acceptances by well-established institutions may be particularly influential for new organizations because they signal new organizations' credibility, legitimacy, and competence*" (2016: 49). Perhaps a dollop of good fortune or luck, helps too, whatever luck might mean! (Liu and de Rond, 2016).

As well as dangers at the point of start-up, then, there may also be **liabilities of maturity,** including problems of sustaining aspects of performance eg innovation, adaptation, and problems of 'drift'. When faced with challenge and adversity, uncertainty and blight, members, Ahrne and Brunsson argue, may find it hard to agree on change – there is a tendency simply to continue. For sure, the longer an association runs, the more chance that new differences will appear among members' interests or that external jolts and shocks will occur. A loss of agility because of internal differences, or the decay of established routines can also leave an organization open to greater risk of failure to meet expectations, or even to define 'hope value' – what the association intends to do for its members - in a coherent and plausible way. With each of these 'syndromes', members may then feel that their interests and membership entitlements are compromised and vote with their subscriptions. We can say that clear-sighted leadership, bundles of energy, vigilant governance and wise choices about member-benefit activity are crucial. Though the association can become valued –

by members and other interests alike – nevertheless, constitutionally, there is an endemic anxiety and fragility to the form.

REFERENCES.

1. Goran Ahrne and Nils Brunsson (2008) *Meta-organizations*. Cheltenham: Edward Elgar
2. Al Aynsley-Green (2019) *The British Betrayal of Childhood: Challenging uncomfortable truths and bringing about change.* London: Routledge
3. Albert Aynsley-Green, Maggie Barker, Sue Burr, Aidan Macfarlane, John Morgan, Jo Sibert,
4. Tom Turner, Russell Viner, Tony Waterston, and David Hall (2000) Who is speaking for children and adolescents and for their health at the policy level. *BMJ*, 321:229–32
5. Sue Barrett and Laurie McMahon (1990) Public Management in Uncertainty: a micro-political perspective of the health service in the United Kingdom. *Policy and Politics, 18*: 257-68
6. Kevin Cox (1998) Scales of dependence, spaces of engagement and the politics of scale, or: Looking for local politics. *Political Geography, 17*: 1-23
7. Nigel Edwards and Helen Buckingham (2020) Strategic Health Authorities and Regions: Lessons from History. London: Nuffield Trust
8. Chengwei Liu (2021) Don't estimate the power of luck when it comes to success in business. Harvard Business Review. 14..6.21
9. Chengwei Liu and Marc de Rond (2016) Good night, and good luck. *Academy of Management Annals, 10*: 409-451
10. Steve Cropper (2001) Changing institutional frameworks: Formalisation as a means of institutionalising collaborative activity among health care providers. pp82-105 in Lynn Ashburner (Ed) Organisational behaviou and organisational studies in health care: Reflections on the future. Houndmills, Basingstoke, Palgrave.
11. Steve Cropper, Angela Hopper, and Andy Spencer (2002) Managed Clinical Networks: multi-lateral collaboration as a basis for the future organisation of paediatric services? *Archives of Disease in Childhood, 87*, 1: pp1-5
12. Clarence Lo (1992) Communities of Challengers in Social Movement Theory. pp224-248 in (Eds) Aldon Morris and Carol Mueller. *Frontiers in Social Movement Theory*. New Haven: Yale University Press.
13. Danny Mackinnon and Jon Shaw (2010) New State Spaces, Agency and Scale: Devolution and the Regionalisation of Transport Governance in Scotland. *Antipode, 42*: 1226-1252
14. Peter Marris (1974) Experimenting in Social Reform. pp245-259 in Eds) David Jones and Marjorie Mayo. *Community Work One*. London: Routledge and Kegan Paul.
15. George Miller (1956) The magical number seven, plus or minus two: Some limits on our capacity for processing information. *Psychological Review*, *63*: 81–97
16. Natalie Papanastasiou (2017) The practice of scalecraft: Scale, policy and the politics of the market in England's academy schools. *Environment and Planning A: Economy and Space*, 49: 1060-1079
17. Calum Paton (2023) The NHS in the UK at 75: On life support or death watch?: It's the politics, stupid (to misquote Bill Clinton). *International Journal of Health Planning and Management*, pre-print DOI: 10.1002/hpm.3699
18. Simon Pemberton (2016) Statecraft, scalecraft and local government reorganisation in Wales. *Environment and Planning C: Government and Policy, 34*: 1306-1323
19. Andy Spencer, Carol Ewing and Steve Cropper (2013) Making sense of Strategic Clinical Networks. *Archives of Disease in Childhood: 98*, 843-5, doi: 10.1136/archdischild-2013-303976
20. Rod Sheaff, Lawrence Benson, Lou Farbus, Jill Schofield, Russell Mannion, and David Reeves (2010) Network resilience in the face of health system reform. *Social Science & Medicine 70*: 779–786
21. RCPCH (2012) *Bringing networks to life: An RCPCH guide*. London, RCPCH. March
22. Barry Staw (1976) Knee-deep in the big muddy: A study of escalating commitment to a chosen course of action. *Organizational Behavior and Human Performance, 16*: 27–44.
23. Kim Van Oorschot, Henk Akkermans, Kishore Sengupta, and Luk Van Wassenhove (2013)
24. Anatomy of a Decision Trap in Complex New Product Development Projects. *Academy of Management Journal, 56*: 285–307
25. David Wilson, David Hickson, and Susan Miller (1999) Decision Overreach as a Reason for Failure: How Organizations Can Overbalance. pp35-50 in H.K. Anheier (Ed) *When Things Go Wrong: Organizational Failure and Breakdowns*. London: Sage

26. Tiantian Yang and Howard E. Aldrich (2017) “The liability of newness” revisited: Theoretical restatement and empirical testing in emergent organizations. *Social Science Research 63*: 36-53.

Partners in Paediatrics: From the Archive.

Annual Reports x13: Year 1 (1998), Year 2 (1999), Year 3 (2000), 2001-02, Year 4, Year 5, Year 6, Year 7, Year 8, 2008/09, 2010, 2011, 2012-14

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