

# Working together for better oncological care

A diagnosis of the governance of the haematology network collaboration as part of Oncologienetwerk Oost using structure theory combined with network theory

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# Abstract

This study aims to make a structure-based diagnosis of the governance of the haematology network collaboration in Onco Oost. More specifically, this thesis examines whether there is a potential gap between the desired governance structure that realises the goals of the network and the actual governance structure. The primary goal of the network is to collaborate on giving patients with a haematological disease the best possible care.

To help achieve this goal the governance structure needs to realise three subgoals of governance: setting goals, designing conditions and operational regulation. A structure that can realise these operates best when it scores low overall on the used design parameters: functional concentration, separation, specialisation of regulatory activities and specialisation of operational activities. In that case, the structure is not a cause of disturbances and it has enough regulatory potential disturbances.

The governance structure that is discovered matches the desired governance structure pretty well. The network is governed by a network administrative organisation, which fits the network well. There are some gaps, but for the most part, the values on the design parameters are as low as possible considering the context. The specialisation of regulatory activity is now too low, there are no tasks defined in the board of the network. The board just handles what it faces, so no goals are being set or tracked in the network. Defining tasks and setting goals are points of improvement for the governance of the network. Concluding, the governance structure fits the network well and it helps them achieve the goals of the network.

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# Introduction

Cancer is one of the most problem-causing diseases in our day and age, and in the coming years, the number of patients who are suffering from cancer will increase (*Rapport Oncologienetwerken in Beeld*, 2022). Care for these patients is becoming continuously more expensive due to more specialized care for the individual patient and their situation, and the overall improving quality of the oncological care (*Rapport Oncologienetwerken in Beeld*, 2022). The complexity of procedures while treating cancer is increasing, and this combined with the ageing of the population creates pressure on the oncological care centres (*Rapport Oncologienetwerken in Beeld*, 2022). Hospitals that try to cure every type of disease create high overhead costs that make healthcare unnecessarily expensive. Relocating patients to specialised institutions can be a strategy to realise a reduction in healthcare costs (Christensen et al., 2000), and healthcare networks can help facilitate this. That is why from 2014 onwards there have been oncology networks in the Netherlands (*Rapport Oncologienetwerken in Beeld*, 2022).

The main idea of the oncology network is to only focus on doing what a certain hospital is good at, and outsourcing tasks that can be done better or more efficiently at other hospitals (Oncologienetwerken, 2023). This requires a good governance system that makes sure the different regulatory tasks are being executed (Achterbergh & Vriens, 2009). Network governance can be defined as “the use of institutions and structures of authority and collaboration to allocate resources and to coordinate and control joint action across network as a whole” (Provan & Kenis, 2008, p. 230). The governance structure needs to make sure that goals are set, conditions for operating are designed, and problems within the primary process are dealt with (Achterbergh & Vriens, 2009, 2019). However, since healthcare networks are a relatively new way of working several problems are occurring within the governance systems of healthcare networks. There is a realisation within the oncology network that governance is something that needs improvement (Oncologienetwerken, 2023). The main challenge for the coming years as regards governance will be to realise a governance model for oncology networks in which administrative control becomes more integrated (*Rapport Oncologienetwerken in Beeld*, 2022). This problem of organising the governance of the haematology network will be the problem within the network collaboration that this thesis focuses on.

In the Netherlands seven oncology networks together cover the country. These networks are further divided into subnetworks, based on the type of tumor the patient is suffering from (*Oost-Nederland | Regionale Oncologienetwerken*, n.d.). This thesis will look at the governance of the subnetwork of Oncologienetwerk Oost which specialises in haematology. In this thesis, the haematology network will be diagnosed based on the structure of the network and its governance system. The structure of the network and its governance will be analysed to discover how this affects the network collaboration because the way the structure is organised can say something about effectiveness (Achterbergh & Vriens, 2009).

Healthcare networks are a novel topic in research. There is research done into the effectiveness of healthcare networks (Dias-Santagata et al., 2022), which demonstrates specifically in care for cancer patients that healthcare networks get patients the best treatment and that the networks improve the standard of care across partner sites. The main benefits that can come from healthcare networks are clear, care organisations think that by joining a network the quality of care will be improved while the costs are reduced (Yan et al., 2024). However, there is not a lot of literature on how the governance of these networks can be improved. This thesis will use organisational structure theory and its design parameters (Achterbergh & Vriens, 2009; de Sitter, 1994), to look at how the governance of a network collaboration, in this case, the haematology network, can be optimised. Structure theory can be used to look at the improvement of the performance of an organisation, or in this case network collaboration. The design parameters of structure theory describe how the operational and regulatory tasks are performed in an organisation, so this will be used as a tool to describe and diagnose the governance system (Achterbergh & Vriens, 2009, 2019), to see how this can be optimised.

Research has been done into network collaborations in the past, more specifically into Social Network Analysis (Popp et al., 2013), which is an analysis based on certain characteristics like density, centrality and the existence of cliques (Provan et al., 2005). These characteristics can say something about how a network operates. However, structure theory and its design parameters haven't yet been used to assess network collaboration. Since these parameters can say something about the effectiveness of an organisation or in this case network, that is what this thesis will focus on. Research has also been done on the governance of networks. In the literature, different ways of organising the governance system of a network are described (Provan & Kenis, 2008). Within the oncology network, there is the realisation that governance has to improve (Oncologienetwerken, 2023). Every region needs to create a governance system

that provides the conditions for the network to work optimally. The fit between the network and the governance type chosen is key in order to optimise network effectiveness (Popp et al., 2013). The types of governance structures (Provan & Kenis, 2008) and how these work in the oncology networks will be further discussed in the conceptual model.

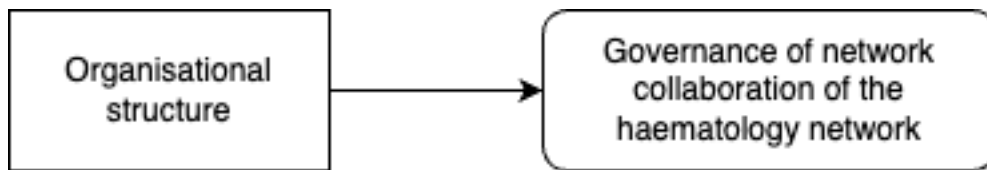
This thesis is theoretically relevant by creating new knowledge in the existing literature about healthcare networks (Yan et al., 2024; Dias-Santagata et al., 2022) and inter-organisational networks in general (Popp et al., 2013; Provan et al., 2005). More specifically it adds to the literature about the governance of healthcare networks (Provan & Kenis, 2008). The most innovative part of this research comes from the combination of network theory and organisational structure theory (Achterbergh & Vriens, 2009; de Sitter, 1994). These haven't been used together before, and structure theory can provide new insights into improving network collaborations. This thesis creates new knowledge by creating a starting point for looking further into how these two combined can create a better understanding of inter-organisational networks.

This thesis is practically relevant because the knowledge generated can be used to optimize the governance structures of healthcare networks and more specifically within Oncologienetwerk Oost. By creating and improving healthcare networks, patients can receive the best possible care by going to more specialized hospitals within the healthcare network, and this can help to bring the costs of healthcare down (C. M. Christensen et al., 2000). The knowledge is also practically relevant to practitioners in other kinds of networks to learn how to deal with problems regarding governance in networks.

The goal of this thesis is to make a structure-based diagnosis of the governance of the network collaboration of subnetwork haematology within Onco Oost. To accomplish this goal a set of subquestions is created that need to be answered to complete the structure-based diagnosis:

- What is network governance and how is it organised in the haematology network?
- What are the desired structure and corresponding values of the design parameters of the governance of the haematology network?
- What are the actual structure and corresponding values of the design parameters of the governance of the haematology network?

- What is the difference between the desired and actual structure and its corresponding values of the design parameters?



*Figure 1 - Base model*

In order to answer these questions and make the structure-based diagnosis a qualitative study will be done. In this qualitative study, first documents of the haematology network will be studied to create an overview of the primary process of the network, to get insights into the actors in the network, and to examine the selected governance structure. This will happen in the second chapter, so here the first two subquestions will be answered. The diagnosis in this thesis is based on the guidelines of Verschuren et al. (2010) about how to do a structure-based analysis. The first two subquestions are part of the preliminary research which is described in the book. This preliminary research will be mostly based on the documents. Next, semi-structured interviews and an observation will be used to gain better insights into the governance problems of the haematology network. A further explanation of the methods used in this thesis and the argumentation for the choices can be found in the methods section.

This thesis consists of six chapters. In this first chapter, the introduction, the central idea of the research along with the research problem and general approach to this problem are explained. In the second chapter, the conceptual model, the most important theories are introduced and some preliminary research about the haematology network is presented. In this chapter, the desired governance structure is also outlined. The third chapter is the methods section, where the methodological choices are explained and arguments for choices are provided. In the fourth chapter, the results are presented, and the sub-research questions are answered. The fifth chapter is the conclusion where the results are summarised and the answer to the research problem is provided. In the sixth chapter the discussion is presented, where the results are interpreted, the limitations of the research are discussed, the implications of the research are presented and there will be recommendations for further research. After this final chapter, the reference list and the appendices can be found.



# Structure of the governance of the haematology network:

## Conceptual model

As explained in the introduction, the goal of this thesis is to make a structure-based diagnosis of the governance of the network collaboration of subnetwork haematology within Onco Oost. In this chapter, a conceptual model will be made based on the base model in the introduction (Figure 1). First, this chapter will delve into the concept of network collaboration, as a starting point. Next, this chapter will look at theories regarding the governance of network collaborations, covering why governance is important within network collaborations and which types of governance systems there are for network collaboration. Finally, this chapter will go into organisational structure theory. From this theory, the four most prominent design principles will be explained (Achterbergh & Vriens, 2019), and then the two most important design parameters regarding governance will be delved into. These are separation and specialisation of regulatory activities. These parameters are most important because they can have a direct influence on the governance of network collaboration, while the other design parameters can have an indirect influence.

The design parameters will be used in this thesis as variables in the gap analysis, this gap analysis will be performed according to the guidelines explained in Achterbergh & Vriens (2019). In a gap analysis, for certain variables, called diagnostic variables, norm values are determined. These are values on the variables where the structure is performing as desired. The actual values on these diagnostic variables can be determined, and when these are far apart there is the 'gap'. The next step is a cause analysis, where the influences on these diagnostic variables are determined, and with these, solutions to the gap can be made.

In this chapter, the current situation of the network collaboration and its governance system is discussed, along with the goals that are set for both of these. Also, this chapter will delve into what the literature describes as a desired situation for the structure of the network collaboration, and why this is. This chapter ends with the completed conceptual model which also shows the desired governance model for the haematology network.

## Network theory

There are many differing definitions of networks, but Popp et al. (2013) describe how all the definitions come down to a certain foundation: “the concept of networks consisting of the structure of relationships between actors (individuals and organizations), the nature of the links between actors, and the meaning of those relationships” (Popp et al., 2013, p. 10). When organisations engage in network collaboration, representatives of the different organisations work together to achieve common goals (Britto et al., 2018). The most important aspect of a network to achieve these common goals is trust (Popp et al., 2013). In healthcare collaborative networks are used to combat rising healthcare prices and to improve the quality of healthcare (*Rapport Oncologienetwerken in Beeld*, 2022). Networks here are used to achieve something that can’t be done by a hierarchical organisation on its own. One of the most important benefits of working in a network is knowledge diffusion (Hartley & Benington, 2006). So, for the haematology subnetwork, this means sharing knowledge about new treatments in studies. The specific goals of the subnetwork will be discussed later.

Network theory and Social Network Analysis have become more popular since 1980 (Borgatti & Ofem, 2010) to get an understanding of how networks operate. Network theory offers insights into the structures of these networks, by looking at different network characteristics (Provan et al., 2005). In Social Network Analysis multiple characteristics of network collaborations are used to describe and compare networks. In this thesis, the focus is on organisational structure theory, but it is also useful to understand network characteristics to compare networks with each other.

Three characteristics of networks will be discussed here. Provan et al. (2005) discuss many more characteristics, but these three show the most important information about the social relations between the organisations that are engaging in the network. The article by Tabassum et al. (2018) discusses statistical measures that can be used to compute the levels of these characteristics. These statistical measures won’t be used in this thesis but are useful to understand the characteristics better. The first characteristic is the density of a network. The density of a network explains the general level of connectedness within a network (Popp et al., 2013). This can be calculated by “the proportion of edges in the network relative to the maximum possible number of edges” (Tabassum et al., 2018, p. 8). This value can range between 0 and 1, the higher the value the more densely connected the network is.

The second characteristic used is the centrality of the network. There are multiple different forms of centrality, but the most commonly used and standard form is degree centrality (Tabassum et al., 2018). The degree centrality is “a measure of the immediate adjacency and the involvement of the node in the network and is computed as the number of edges incident on a given node” (Tabassum et al., 2018, p. 5). The most important information this provides is the level of importance of a node, so which organisation is most central in the network (Popp et al., 2013; Provan et al., 2005).

The third characteristic used is the existence of cliques in the network. A clique is a subgroup of three or more fully interconnected organisations within the structure (Provan et al., 2005). Intensive collaboration through the form of cliques can help with network effectiveness (Provan & Sebastian, 1998). However, that does not mean that complete integration across a whole network is desirable, there is a limit to what point the level of integration boosts the effectiveness of a network.

### **The haematology network collaboration**

The haematology network is a subnetwork of Oncologienetwerk Oost, which is a collaboration between eight hospitals in the eastern part of the Netherlands, centred around Nijmegen. Based on the FTE spent on haematology the Radboud UMC is also the biggest actor within the network. In internal documents of the network, the goals of the haematology are stated. The primary goal of the network is to collaborate on giving patients with a haematological disease the best possible care.

There are three subgoals related to this. The first is to try to give patients the care they need as close to home as possible, to minimize the inconvenience for the patients. The second is that the network tries to focus on the more complex cases or care where certain expertise is needed, as to not focus on the regular cases that can be treated with a standard treatment plan. The final subgoal is to focus on studies within the cases that are treated, which means that for these cases there is research into how the treatment can be improved.

## **Governance in networks**

Much of the literature on governance is focused on governance in organisations, little attention is paid to governance in networks. The most obvious reason to explain this is that networks are a form of collaborative endeavours, so comprised of autonomous organisations (Provan & Kenis, 2008). Since the collaborative network is not a legal entity, the legal imperative for having an organised governance system is lacking. Governance in networks is needed to solve conflicts and provide steering for the network (Maron & Benish, 2022). It needs to make sure that the needs and activities of multiple organisations are accommodated and coordinated (Provan & Kenis, 2008). Governance makes sure “that participants engage in collective and mutually supportive action, that conflict is addressed, and that network resources are acquired and utilized efficiently and effectively” (Provan & Kenis, 2008, p. 230). These goals are also prevalent in structure theory. Here the goals of the governance system are setting goals for the organisation, designing conditions for distributing resources, and operational regulation, which is addressing conflicts (Achterbergh & Vriens, 2009). These types of regulation will be further discussed later in this chapter.

Provan and Kennis (2008) describe three forms of governance that are prevalent in networks and can help to accomplish the aforementioned goals. The first is participant-governed networks, in some forms also called shared governance (Milward & Provan, 2006), where the members themselves govern the network. In this form, there is not a separate entity that is responsible for governing the network, but it is governed by the members themselves. When this is done decentralised and all participants are engaged in governance, that is when it is called shared governance. The second is lead organisation-governed networks, where one of the participants is responsible for governing the network. The final form is with a network administrative organisation, here a separate administrative entity is created to govern the network. These three are pure forms, but recently there has been more recognition of the fact that in practice the governance model used is most often a hybrid form instead of one of these three pure forms (Lemaire et al., 2010).

Which of these three configurations is most relevant for a specific network depends on four structural and relational contingencies: trust, size, goal consensus and the nature of the task (Provan & Kenis, 2008), but it is mentioned that in healthcare networks the form of a network administrative organisation is most prevalent (Provan et al., 2007). However, Provan & Kenis

(2008) mention that the lead organisation model is often used in healthcare, due to a core provider being prevalent in the network, that “assumes the role of network leader because of its central position in the flow of clients and key resources” (Provan & Kenis, 2008, p. 235). The chosen governance model needs to balance power and authority (Hoberecht et al., 2011). Network leaders and managers need to be aware of the fact that the context and needs of the network are changing and that the form of governance also might need changing (Popp et al., 2013). In the table below from Popp et al. (2014) certain characteristics of networks are operationalised to assess the fit between the network and the chosen governance structure. In the section ‘governance of the haematology network’ the structure used is described, and in the results section the actual structure will be compared to what a good fit should be according to the literature.

<b>Governance structure</b>	<b>Distribution of trust</b>	<b>Number of participants</b>	<b>Goal consensus</b>	<b>Need for network level competencies</b>	<b>Decision making</b>
<u>Shared governance</u>	Widely distributed	Few (i.e., < 6-8)	High	Low	Decentralized
<u>Lead organisation</u>	Narrowly distributed, occurring differentially within individual dyads or cliques	Moderate number	Moderately low	Moderate	Centralized
<u>Network administrative organisation</u>	Moderately distributed, NAO monitored by members	Moderate to many	Moderately high	High	Mixed

Figure 2 - Predictors of good fit between a network and a governance structure (Popp et al., 2014)

### **Structure theory on governance**

Structure theory also provides information about the governance model. Achterbergh and Vriens (2009) describe several goals that a governance model needs to achieve to ensure the organisation can achieve its goals. The first subgoal is setting goals. This entails establishing clear and achievable objectives that the network can work towards. Measuring progress towards these goals is also part of this. The second subgoal is designing conditions, this entails the creation of the structural conditions necessary for achieving the set goals. Here the structure is made where roles and responsibilities are defined. Next to this resources need to be allocated in a way that supports the goal achievement. In healthcare networks, there are no real resources but patients and studies need to be divided between the hospitals that take part in the network. The third and final subgoal is operational regulation which is the monitoring and regulating of operations. There needs to be power within the operational process to deal with disturbances if the operational process is not in line with the goals set and the conditions designed. By focusing on these three subgoals, the network can ensure that it is well-positioned to achieve its objectives and can work towards long-term success (Daft, 2016).

### **Governance of the haematology network**

In the internal documents of the haematology network, it is stated that the network works according to the lead-organisation model as explained by Provan and Kennis (2008). However, the network is still in the transition to this model, until 2023 they had been working in a shared governance model (personal communication, May 6<sup>th</sup> 2024). In the proposed lead-organisation model, Radboud UMC is the leading organisation in the governance structure. They are also responsible for managing the treatment protocols within the network. The Radboud UMC has this role because they tried to start the collaboration between the hospitals. The network coordinator mentioned that they started because they felt the hospitals collectively felt the need for collaboration, which is why the network was started in a bottom-up process. That is why they started with a shared governance model, which is often the case with emerging networks (Popp et al., 2013). This collaboration started in 2011, and the more formal network was started seven years later in 2018.

In the internal documents, there are plans to change the governance structure. The proposal they have in the most recent documents about meetings they propose a structure where they form a sort of network administrative organisation, composed of a network coordinator, a president, and a representative from every participating hospital. The representatives are the first point of contact for regional cases and are responsible for communication within the hospital as part of the network.

There are no clear goals for this governance structure or argumentation for why this way of organising the governance structure was chosen. However, in the documents there is a focus on improving the way information is shared regarding treatments of patients and updates in the ways hospitals are working, so this is the most logical reason for choosing a network administrative organisation comprised of members of all of the participating hospitals. The documents also mention plans to create a formalised communication process, but this hasn't been worked out yet.

## **Organisational structure theory**

Organisational structure theory is a perspective on how organisations can optimise their structure to work towards two goals, which are quality of work and quality of organisation (Achterbergh & Vriens, 2009). In this theory, structure is defined as the way tasks are defined and related into a network of tasks (de Sitter, 1994). These structures are called adequate structures when they score low on a set of ‘design parameters’. The four design parameters used in this thesis will be discussed briefly and then they are compared with design principles from network theory. Also, it will be explained why two design parameters are especially important for this thesis.

The first design parameter is functional concentration, which is the degree to which operational tasks are related to all different types of orders. The second design parameter is separation, which is the degree to which operational and regulatory activities are separated, so if they are assigned to different tasks. The third and fourth design parameters are about the specialisation of regulatory and operational activities, so the degree to which these tasks are divided into small tasks or cover a larger part of the process (Achterbergh & Vriens, 2009). Organisational structure theory describes how the values on these parameters should be low because then the structure has a low probability of causing disturbances while simultaneously having enough regulatory potential to deal with these disturbances (Achterbergh & Vriens, 2019).

Two of these design parameters are especially relevant for this thesis because they say something about how the structure of the organisation influences governance. These are separation and specialisation of regulatory activities. Separation is important because it says something about how much of the regulatory power is within the operational tasks, in other words, how big the distance is between the governance system and the operations of the network (Achterbergh & Vriens, 2019). Specialisation of regulatory activities says something about the division of regulatory activities, so also governance, into different smaller tasks. Three types of regulation need to be organised within the governance structure (Achterbergh & Vriens, 2019). The first type is operational regulation, which deals with problems that arise within the primary process of the network. The next type of regulation is strategic regulation where goals are set for the network. The final type of regulation is the designing of conditions. Here the infrastructure of the network is designed, which consists of human resources, technology and the task structure (Achterbergh & Vriens, 2009, 2019).



The literature on organisational structures explains the optimal structure is the one with the lowest possible values on the design parameters in that specific case, so limited by possible circumstances (Achterbergh & Vriens, 2009, 2019; de Sitter, 1994). For this thesis, the focus will be on the two design parameters described above because they have a direct effect on the governance system of the haematology network. The other two design parameters, functional concentration and specialisation of operational activities will also be discussed in the results section because they can have an indirect effect on the governance structure.

Low values on the parameter's separation and specialisation of regulatory activities creates a network that has a lot of regulatory potential within the operational tasks, and this regulatory potential is not split up into tiny differing parts but covers big parts of the total. Both of these create a situation where there is a good overview of the complete process, which means a lower probability of disturbances occurring. So, the desired situation is a situation where separation is low, so the people who are responsible for governing the network aren't too distanced from the operational process. Next to this, the desired situation is a structure in which the regulatory tasks aren't too specialised, so as an example, people responsible for operational regulation should also be involved with other types of regulation so that they can keep an overview of the complete picture, which is needed for making correct decisions for the network.

### **Link between network theory and organisational structure theory**

With low design parameters, organisational structure theory recommends a decentralised structure to keep the interdependence between nodes low (Achterbergh & Vriens, 2019). The literature on network theory also states that centralisation negatively impacts the way the network is able to manage potential systemic risks (Carboni & Milward, 2012). However, it is also stated overall centralisation leads to higher effectiveness of the network (Popp et al., 2013), especially in networks that are stable and have been in existence for at least three years (Raab et al., 2015). This means that for the haematology network, some centralisation can be beneficial in organising the governance structure.

Low design parameters also give information about density. Low values on the design parameters mean that the connectedness between nodes is as low as possible, to create the lowest probability of disturbances (Achterbergh & Vriens, 2009). Network theory doesn't give specific recommendations on whether low or high density is better. High density can be beneficial when a lot of communication between nodes is needed (Newman, 2003). On the other hand, low density can be good when a lot of flexibility is needed, because then nodes have fewer direct connections. This is also beneficial when nodes have highly specialised tasks, this allows nodes to focus on this task without being disturbed by an overwhelming amount of connections (Newman, 2003). Within the haematology network, a lot of communication is needed so the density needs to be relatively high. However, hospitals still run their operation completely interdepend so this does not increase the probability of disturbances (Achterbergh & Vriens, 2009).

The same idea of low connectedness between nodes due to low values on the design parameters also means that organisational structure theory does not recommend the existence of cliques because these increase the interdependence between nodes. If cliques are needed, they should be as small as possible to keep the variability of relations low (Achterbergh & Vriens, 2009). When structure theory does recommend a form of cliques is when they are used to realise parallel product flows, in that case, they are beneficial. Based on these arguments it becomes clear that there are differences in how network theory recommends the structure of a network to work and what organisational structure theory recommends.

## **Desired governance structure**

The desired governance structure needs to be organised to realise three main parts of governance: the setting of goals, designing of conditions, and operational regulation (Achterbergh & Vriens, 2009). Network theory provides three types of governance structures to organise this system: shared governance, lead organisation and network administrative organisation (Provan & Kenis, 2008). Based on Figure 2 and the characteristics of the haematology network the best fit for the governance structure is the network administrative organisation (NAO). In the results section, this decision compared to what the network actually does is explored more deeply.

For setting goals, there must be a goal consensus (Popp et al., 2013), which at the start of the network was the case as it was built from the ground up (personal communication, May 7<sup>th</sup> 2024), but as the network develops declines as each of the hospitals has its own interests. These interests differ because the hospitals are in other regions, differ in size, and have differing clientele. So, the NAO makes sure that all the members are involved in decision-making (Provan & Kenis, 2008) because the board structure involves members of all participating hospitals. For the designing of conditions, the most important goal for the governance structure should be to make a procedure for distributing the studies of new treatment procedures among the hospitals, this seems to be the part of distributing resources that causes the most problems within the network (personal communication, May 7<sup>th</sup> 2024). Finally, the desired governance structure needs to provide for operational regulation, which is done by having all member organisations represented on the board with equal rights.

To accomplish this governance structure, the network structure needs certain values on the design parameters described in this conceptual model. An important note from structure theory is that values should be as low as possible in the context of the organisation (Achterbergh & Vriens, 2009), so they shouldn't be low in all cases. For the haematology network functional concentration can't be as low as possible because hospitals need to collaborate on treatments of patients to realize the main goal of the network, providing high-quality care. However, the network should try to keep functional concentration as low as possible within this context given, by creating parallel care flows across different MDOs. So, the desired value for functional concentration is low. Specialisation of operational activities should be a moderately low value, the process of dealing with haematology patients is so complex that haematologists

need to be part of the whole process. The only specialisation there should be is with facilitating healthcare experts like lab experts.

Now for the two design parameters that have a direct influence on the governance structure. First, separation should be as low as possible. Haematologists need to be part of the governance structure, they know best what should happen with the network to accomplish the goals of the network, so they should be part of the regulatory process. For the specialisation of regulatory activities, the parameter should be of a moderately low value. There should be some specialisation so that all three forms, which are the goals of governance in Figure 3 below, are taken into account. The decision-making power should be within the management group made up of the representatives of the hospitals, but responsibility for these goals can be distributed within this group.

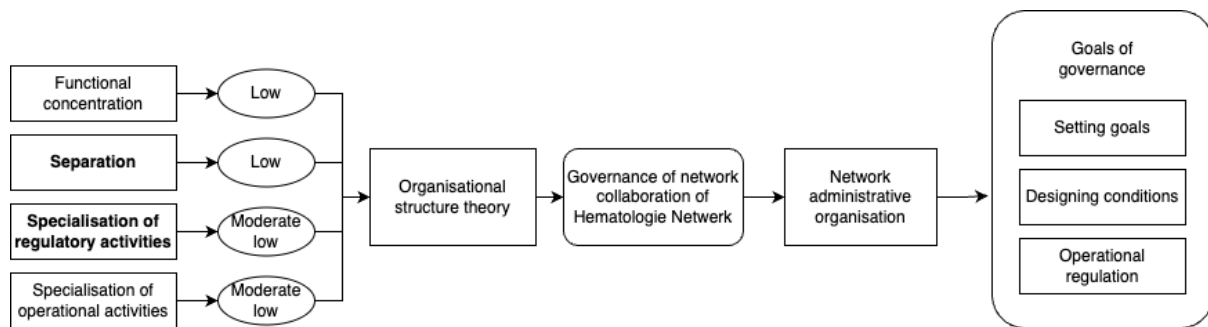


Figure 3 - Conceptual model of the desired governance structure of the haematology network

# Methods section

## **Qualitative research method**

This thesis is a structure-based diagnosis of the governance of the network collaboration of the haematology subnetwork that is a part of Oncologienetwerk Oost. This diagnosis is based on a qualitative approach. The subject that is studied in this thesis is relatively new, especially the combination of network theory and organisational structure theory, and qualitative research is particularly appropriate when limited research has been done on the topic (Boeije, 2014). Qualitative research methods also allow researchers to draw from existing literature and simultaneously allow for new insights to be found based on data collection and analysis (Corbin & Strauss, 2014). This again makes qualitative research a logical option because there is already much literature on the separate topics of organisational structure theory and network theory. Qualitative research in this case serves to collect data about the gap in how these concepts relate to each other. Next to this, qualitative research methods are useful because this thesis is focused on network collaboration which is a social phenomenon. In a social phenomenon, qualitative research enables the discovery of meanings and interpretations within the phenomenon (Boeije, 2014). Participants of the network might have differing perspectives on network collaboration, especially because network collaboration is such a complex and diverse concept. Qualitative research methods allow the researcher to better understand the social phenomenon due to the differing perspectives of respondents (Boeije, 2014).

The structure-based diagnosis is based on the principles of a gap and cause analysis as described in Achterbergh and Vriens (2019). First, in the conceptual model, the desired situation of the organisational structure of the haematology network collaboration is described, and it is explained why this is desired. In this part, the current goals of the network and its governance structure are also described. This is all part of the preliminary research as described in Verschuren et al. (2010). This preliminary research also uses some data from the interviews, so that is why there are references to personal communication in the conceptual model. In the results section, the gap analysis will be completed by describing the current situation of the structure and the values of the design parameters will be described. Next, this thesis will look at the differences between the actual and desired situation, so the gaps, and will look at the causes for possible gaps. Here the thesis will also look at possible better structures for the haematology network, those will be worked out in the discussion chapter.

## **Document analysis and semi-structured interviews**

To answer the questions that this thesis tries to answer, first multiple documents will be analysed and those will be followed by multiple semi-structured interviews (Bleijenbergh, 2015). Next to this, an observation during an MDO meeting of the network will be used to get a better understanding of what the haematology network is doing. The documents that will be analysed will create a better understanding of the network collaboration and how it operates while the semi-structured interviews will create a more in-depth understanding of how the people working in the network think it operates and how the governance of the network can be improved. The documents that will be analysed are provided by the participants of the haematology network and will be presentations that are used internally in the network and reports about meetings that happened within the network. Documents often provide insights into what is expected or should be happening in an organisation (Bleijenbergh, 2015), or for this thesis in the network collaboration. The interviews can also be used to see if the employees see the same things happening or if they think that the talk of the network is differing from its actions. The documents will be mainly used for the preliminary research part (Verschuren et al., 2010) of the conceptual model.

For the interviews, an interview guide will be made to make sure there is a plan for the interviews. This guide will use the principle of a topic list. This list shows all the topics that need to be covered in the interview with some example questions but is not a complete guide for how the interview should go. So within the guide, there is a lot of room for further questions, following the principle of semi-structured interviews (Boyce & Neale, 2006). The interview guide can be found in the Appendixes. Each interview will start with an introduction to set expectations on content and how much time the interview will consume. Also, here permission to record the interview is asked. Next to this confidentiality and responsibility regarding the data that is collected are ensured in this introduction. The interviews will be prepared and held together with a research partner, who is also studying the haematology subnetwork of Oncologienetwerk Oost but is focussing on the MDO, a meeting where all parties work together on the best treatments for patients, rather than the problems in the governance of the network.

The interviews will be recorded because if the researcher is focused on making notes during the in-depth interview, it is hard to get all the details of the information that the interviewee provides (Boeije, 2014). Also, a lot of non-verbal information about the behaviour of the

interviewee will be lost. With the use of recordings, the researcher can focus better on the interview itself and the recording also captures a lot of extra information about intonation and for example, laughs in the interview (Bleijenbergh, 2015). The recordings of the interviews will be transcribed so that they are ready for data analysis.

## **Data analysis procedure**

The data used in this thesis, so the documents and the transcripts of the interviews will be analysed in a deductive manner (Bleijenbergh, 2015). This will be done based on the terms that are used in the conceptual model. For organisational structure theory, functional concentration, separation, specialisation of regulatory activities, and specialisation of operational activities will be looked at, with a focus on separation and specialisation of regulatory activities, as explained in the chapter ‘Conceptual Model’. Based on these design parameters combined with a network governance model, a desired governance structure is described in the conceptual model. A coding scheme will be made based on these concepts from the conceptual model and the transcripts of the interviews will be coded according to this coding scheme. This scheme can be found on the next page with the operationalisation (Figure 5). Coding and analysing data is an iterative process that goes back and forward between the data and the coding schemes (Bleijenbergh, 2015). The final filled-in codebook with the open codes from the transcripts can be found in the appendixes.

## **Operationalisation**

The theoretical definitions presented in the conceptual model will be used for coding the transcripts of the interviews, but before the coding can start these concepts need to be operationalised (Bleijenbergh, 2015). To operationalise the concepts indicators are described. When coding the transcripts codes that match these indicators will be placed under the pre-defined concepts that are used as the a priori codes in this thesis. These open codes can be found in the codes book in the appendixes under the concepts that they are assigned to. In Figure 4 below the pre-defined concepts and the matching indicators can be found.

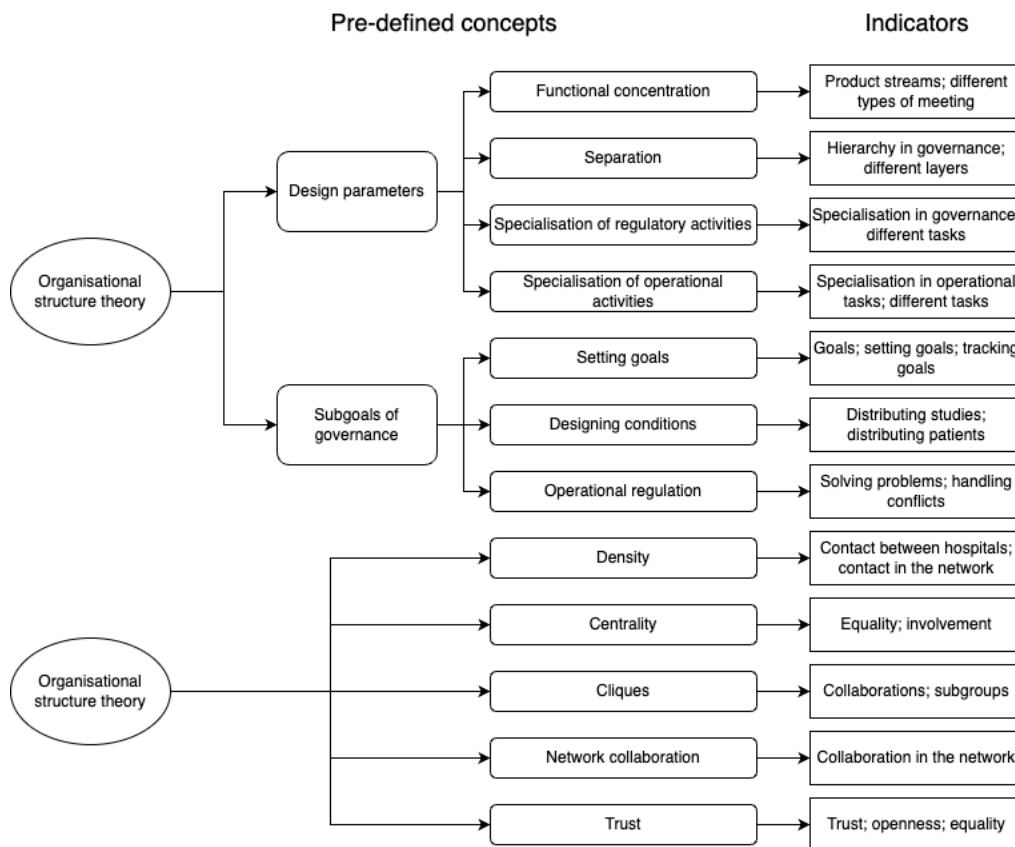


Figure 4 - Operationalisation of the pre-defined codes

## Qualitative research criteria

In qualitative studies, the trustworthiness of scientific research is usually assessed by three metrics: generalisability, internal validity and reliability (Bleijenbergh, 2015). These metrics and what they mean for this thesis are discussed here. First generalisability. This thesis is a diagnosis specifically performed concerning one organisation, so generalisability is not the focus. However, the results of this study can be used by other healthcare networks for insights into their own governance structure. Internal validity ensures that a study measures what it intended to measure (Boeije, 2014). To ensure this data triangulation is used. Documents of the network are studied, an observation of a meeting is used and interviews with members of the network are conducted. The use of these different research methods increases internal validity. Finally, reliability is the degree to which other researchers will acquire the same results when they perform the same study. Reliability is increased by clearly describing the steps taken during the gathering and analysis of data (Bleijenbergh, 2015). Also, the use of a clear topic list with multiple questions on the same concepts helps increase reliability, which is done for this thesis (Baarda et al., 2007).



## **Research ethics**

While conducting research, a researcher must be aware of the role he or she has and the influence he or she has on the research process. Ethics and the impact of the role must be taken into consideration during all steps taken during the process of the research (Guillemin & Gillam, 2004). During the research process, the researcher will be transparent with the respondents and participating parties about the intentions of the research. The participation of respondents in the interview is voluntary, they can quit at any time during the interview and they don't have to answer questions if they don't want to, this is mentioned in the introduction of the interview. The collection of data will be anonymous, so names are not mentioned in this thesis.

# Results

## **What are the actual structure and corresponding values of the design parameters of the governance of the haematology network?**

In this chapter, the results of the interviews will be presented. In the first subquestion, the structure of the haematology network will be outlined based on interviews. In the second subquestion, the differences between the actual structure and the desired structure will be outlined. This first subquestion starts by looking at the chosen governance model for the haematology network and how this has changed in the last few years. Next, it will delve into how this governance structure tries to accomplish the different goals that are presented in the conceptual model. Finally, the values on the design parameters of structure theory will be determined.

### **Chosen governance structure**

From the interviews, it becomes clear that the governance structure has changed a lot in the last year. The network coordinator of the haematology network mentioned (personal communication, May 7<sup>th</sup> 2024) how the structure has changed:

*“From November onwards we started working with a network management team. This entails that we have a representative of every hospital. With a chairman and a supporter, the policy advisor in this case.”*

Before this time the network was led by a single haematologist, who came from Radboud UMC. They were happy with this system but realised things needed to be upgraded for the network to improve itself. One of the reasons for starting this new governance structure was the better distribution of patients and studies:

*“With the new format we all have to get used to, so to speak, distributing the tasks within the region and the patients within the region more fairly”* (personal communication, May 7<sup>th</sup> 2024)

This is important because in the network collaboration everybody wants to work together, but they also have to keep their own organisation running, so they have a financial interest in doing as much as possible in their hospital:

*“And then you notice that, although haematologists strictly speaking would like to collaborate, it is not always possible because there are financial interests, which means they will never be completely transparent”* (personal communication, May 7<sup>th</sup> 2024)

The network coordinator said in an interview (personal communication, May 7<sup>th</sup> 2024) that the governance structure is based on a lead organisation and that this is the only possible way of organising:

*“It is a leadership organisation model. You can’t avoid that. Because the Radboud also has those consultative functions. They need to facilitate the MDOs. They also have the resources to conduct the studies. The more complex patient care is also here. But it is also mainly the idea that the hospitals around us can also achieve their ambitions and take on a role where possible.”*

This is tied to the financial structure of the network. At the moment Radboud UMC is financing the network collaboration, contradictory to other networks that are part of OncoOost where all participating hospitals are paying for the network (personal communication, May 7<sup>th</sup> 2024). The haematology network isn’t fully integrated in OncoOost at the moment, but a haematologist mentioned that when they do, this might change things in the power and governance structure:

*“Yes, I think that OncoOost will ensure that ... because all hospitals are also financially participating, so that our network will also do that. Until recently, the regional network was mainly managed by Radboud UMC. And I think that will change with the arrival of OncoOost.”* (personal communication, May 7<sup>th</sup> 2024)

However they say that they are operating according to a lead organisation model, this is stated in the interviews but also in documents of the network, the governance model is organised like an NAO when the structure is compared to the literature. The Radboud UMC is paying for the network collaboration, but all of the hospitals have equal rights within the network. Within the board, every hospital has one vote and all votes are equally important. In a lead organisation model, “all major network-level activities and key decisions are coordinated through and by a single participating member, acting as a lead organization” (Provan & Kenis, 2008, p. 235) and this is clearly not the case in the haematology network. If the three governance models of Provan & Kenis (2008) are compared to the haematology network a shared governance model would also look like a fit because all the hospitals participate in governance, but the chosen model differs from this in the fact that there is a separate board that controls the network.

Although this board is made up of a representative from every hospital, this does not make it a shared governance model.

When compared to the table in Figure 3 choosing for the NAO governance model is also an obvious choice, because the haematology network matches on a lot of the criteria. Network members mention that goals consensus is moderately high within the network, the overall goal is the same but every hospital does have its own subgoals that it is working towards, also coherent with the size of the hospitals. The need for network-level competencies is also high in healthcare networks. Within the haematology network the overall trust in the network is good, mention the participants, but of course, it also still needs to grow. The network coordinator mentioned:

*“The difficult part is that you have to work together. And working together means that you need to take but also give. This means that when get something you will have to give something back”* (personal communication, May 7<sup>th</sup> 2024)

He mentions that not everyone is always pleased to do so. Especially for smaller hospitals it can feel like a threat to their right of existence when they have to stop providing particular forms of care.

### **Goals for the governance structure**

In the conceptual model, it was explained that the governance structure needs to organise for three goals. The first was ‘setting goals’. From the interviews, it seems that the haematology network is not actively setting goals and tracking them.

*“No, there are no concrete goals set yet. Only various intentions”* (personal communication, May 7<sup>th</sup> 2024)

There are the main goals of the network that are described in the conceptual model, but apart from that they are not making goals time-specific goals. A respondent mentioned that this is a point of improvement for the network:

*“Yes, but not really very concrete. It could be more concrete. So that you actually create a timeline. Yes, in five years and in ten years we want to be at this point. Actually we haven’t really gotten to that yet.”* (personal communication, May 8<sup>th</sup> 2024)

The second goal for the governance structure is ‘designing conditions’. There are not really resources that need to be shared in the network, but they do need to organise a system for

distributing patients and studies across the hospitals in the network. According to the interviews they do this by simply looking at what is fair to everyone and trying to make an equal distribution of patients across the members.

*“There isn’t a specific rule for it, but in such cases, you try to balance what is reasonable and what is not, considering how things have been handled before. This way, you can also see who is next in line and who is best suited.”* (personal communication, May 7<sup>th</sup> 2024)

Respondents also said that the new board is a good tool for improving this process because all of the hospitals are represented on the board. Designing conditions also includes the designing of processes and systems. Respondents mention that there is a blueprint for MDOs from Onco Oost with guidelines on how to organise MDOs, but that they have found their own way of organising these and don’t adhere to the blueprint. The haematologists in the network have the power themselves to design the conditions, this also says something about the design parameters.

The final goal for the governance system is ‘operational regulation’. When problems occur the respondents mention a similar approach as with distributing resources, they try to work together and find a fair solution:

*“If one does not want this and does not want that... what is possible then? So then you look at what compromises are available”* (personal communication, 7<sup>th</sup> May 2024).

The power for operational regulation is all within the operational process, the haematologists themselves can solve the problems they encounter, at least if they can be solved and are not an effect of the environment. However, the board is also a good tool for when a problem can’t be solved by the haematologists mutually. An example of operational regulation in the network is the lack of time the haematologists have for the MDOs:

*“So let’s say that we need to be somewhere else for any reason, then there can always be someone who stays behind to ensure that the MDO goes well”* (personal communication, May 8<sup>th</sup> 2024)

The haematologists have the power to change up the MDO if one of the haematologists needs to be somewhere else. The respondent also mentioned that it is not uncommon for the MDOs to last longer than the planned time and that they then often continue past working hours in their own time (personal communication, May 8<sup>th</sup> 2024. This is not desirable, but this is also a form of operational regulation.

## **Values of the design parameters**

Before starting with the discussion of the values of the parameters the possible values need to be discussed. To start, there are two extreme scenarios: if values are low, they are as low as possible and are optimal. The other extreme is high, then the values on the parameters are so high that they cause problems for the network. Moderately low is also used in this thesis, then the value is not as low as possible, it could be lowered, but it is not so high that it causes problems for the network. Based on those definitions, the values of the parameters will be determined.

### Specialisation of regulatory activities

Within the NAO there is a representative of every hospital, a chairman and a policy advisor, but apart from this, there is no clear division of tasks. This is a starting point for looking at the design parameters of structure theory. Based on this division of tasks the first parameter that will be discussed is specialisation of regulatory activities. The value on this parameter is low, there are no specified tasks within the regulatory body of the network and so there is no specialisation. The network coordinator mentioned that they don't have a planning with what the board needs to do, but *"it is more about what comes our way that we respond to"* (personal communication, May 6<sup>th</sup> 2024). This is the case because this way of working is still fairly new:

*"Also because we haven't been working on this part for very long. I mean, it's been two or three meetings"* (personal communication, May 7<sup>th</sup> 2024).

### Separation

The value on the parameter separation is low. Within the governance system of the network, there is almost no distance between the operational tasks and the regulatory power. The board of the network is comprised of haematologists, except for the network coordinator, and haematologists who are not on the board can also speak up about for example problems they are facing at any moment. Some haematologists are afraid that with the arrival of Onco Oost, this will change, but the network coordinator mentioned in the interview that this is not the intention:

*"That is not the intention of Onco Oost. Onco Oost actually wants those networks to set their own agendas. So they don't want those networks to be forced into a straitjacket"* (personal communication, May 7<sup>th</sup> 2024)

Also within the MDOs, there is a low value on separation. The only separation is that there is a leader of the meeting, but he or she is only responsible for guiding the meeting:

*“Every haematologist, whose patient it is, brings in their own patient so that the most information is available. And the person who is the chair ensures that the advice given is properly recorded and ultimately also signs the letter.”* (personal communication, May 8<sup>th</sup> 2024)

### Functional concentration

Functional concentration is moderately low in the haematology network. This is done by creating a form of flows with the different types of MDOs which are used in the network. Three types of MDOs are used (personal communication, May 7<sup>th</sup> 2024). First, there are local MDOs which are done internally in a hospital and are mostly used to deal with straightforward cases, that can be approved without much discussion. Next, there are regional MDOs where sub-groups of hospitals come together to talk about the different patients and their treatment plans. These are organised by the hospitals themselves and the Radboud UMC attends as the consulting hospital. Finally, there is an MDO that is focused on one particular clinical picture, which is acute myeloid leukaemia (AML). This clinical picture is so complex that they dedicated this entire MDO to only patients within this clinical picture. The MDO is organised by the Radboud UMC and all other hospitals join. An important goal of this AML MDO is also the development of the haematologists:

*“There is also a lot of intuition, knowledge, and experience involved. Yes, well, other doctors also hope to gain something from that. So, I think that is also a very important goal”* (personal communication, May 8<sup>th</sup> 2024).

Respondents also mentioned that this is one of the problems when trying to improve efficiency, that this room for the development of the doctors goes away.

### Specialisation of operational activities

The final design parameter is specialisation of operational activities, the value on this parameter is moderately low. There is some specialisation, but this is inherent to the use of MDOs in the network. The main purpose is to get the different disciplines, so specialists, together in one meeting. The process of treatment in the care for cancer patients is just too complex and the haematologists need help from different specialists that are also working in the hospitals. Between the haematologists there is only some specialisation during the MDOs, there is one

haematologist who is appointed as the leader of the MDO but besides this, there is no specialisation. Within the network, there is some specialisation but this is based on norms that are set for the hospitals by national guidelines and so the network has no control over them. Certain hospitals can give certain treatments based on their classification:

*“Within haematology, we have stratification. We are an echelon-A hospital, which allows us to perform stem cell transplants and certain treatments. And then you have ABCD ... So there are various forms”* (personal communication, May 7<sup>th</sup> 2024)

Concluding this section the values on the design parameters are presented in the table below.

<b>Specialisation of regulatory activities</b>	Low
<b>Separation</b>	Low
<b>Functional concentration</b>	Moderately low
<b>Specialisation of operational activities</b>	Moderately low

*Figure 5 - Actual values on design parameters*



## **What is the difference between the desired and actual structure and its corresponding values of the design parameters?**

Based on the desired situation that is described in the conceptual model and the actual governance model depicted in the first part of the results chapter, this section will delve into the differences between the actual and the desired situation based on the design parameters. These will be discussed in the same order as the previous section, starting with the two parameters that have a direct influence on the governance structure followed by the two parameters that have an indirect influence. Next, the gap in the realisation of the subgoals of governance will be discussed.

### *Specialisation of regulatory activities*

Starting with specialisation of regulatory activities. In the desired governance structure, the desired value on this parameter was specified as moderately low, because some specialisation can be useful to make sure that the separate goals of the governance model are met. This is not done in the actual structure, there are no clear tasks defined and so there is no specialisation within the regulatory activities.

### *Separation*

Separation is the next parameter that has a direct influence on the governance structure. In the desired governance structure separation is as low as possible. This is accomplished in the actual structure, the board of the network is comprised of mostly haematologists who are in the midst of the operational process, except for the network coordinator, who works as the policy advisor. But separation is indeed as low as possible.

### *Functional concentration*

For functional concentration, the desired governance specified how creating flows could make sure that the functional concentration is as low as possible for the network. This is realised by creating three different types of MDOs that are used in the primary process of the network. In the network, the network coordinator confirmed that functional concentration is in this situation as low as possible, by saying the following about creating even more flows:

*“In the future you could try to create all different MDOs for different clinical pictures. But that would cost us even more time. Because you will be sitting together with the whole group of hospitals every time. And that is just not an option.”* (personal communication, May 7<sup>th</sup> 2024)

*Specialisation of operational activities*

The final design parameter is specialisation of operational activities. In the desired governance structure, the desired value was low because of the complexity of procedures, in the actual situation this is described as moderately low. However, the actual value is as low as possible in this context, the goal of the MDOs is to bring different disciplines together that are all specialised in a certain part of the treatment procedure, so this is inherent to the process. So, concluding this part of the results section and finishing the gap analyses it can be said that there are only minor differences between the desired governance structure based on structure theory. The most noticeable difference is in specialisation of regulatory activities, here the desired value was moderately low, and the actual situation is as low as possible. For the other three design parameters, there are no real differences between the desired and actual situation.

Concluding the differences between the values on the design parameters in the desired and actual structure, the values are summarised in the table below.

	<u>Desired structure</u>	<u>Actual structure</u>
<b>Specialisation of regulatory activities</b>	Moderately low	Low
<b>Separation</b>	Low	Low
<b>Functional concentration</b>	Low	Moderately low
<b>Specialisation of operational activities</b>	Moderately low	Moderately low

*Figure 6 - Differences between values on design parameters*

## **Differences in achieving goals for governance**

### Setting goals

For the first subgoal, there is a big gap between the desired situation and the actual situation. From the quotes in the first section of the results section, it can be learned that the haematology network is not actively setting goals, there are just lots of intentions. The structure to start doing this is in place however, the use of an NAO ensures that there is a goal consensus, which is the first step. They agree on the main goals of the network as outlined in the conceptual model, but they are not making time-specific goals that they can work towards.

### Designing conditions

For designing conditions, the governance structure needs to realise a system for distributing patients and studies between the different participating hospitals. There are national guidelines for distributing studies but these are not always sufficient:

*“There is a national process for this, but outside of that national process, coordination within the region can be requested”* (personal communication, May 7<sup>th</sup> 2024)

The network does not have a procedure for doing this, but from the interviews, it seems like they do a good job of distributing these without a formalised process.

### Operational regulation

Operational regulation is organised similarly to designing conditions. There are no procedures for operational regulation but the members of the network have the power to solve problems themselves.

*“There are no rules for it, we try to manage it as best as we can mutually”* (personal communication, May 7<sup>th</sup> 2024).

So for the haematology network, it seems like they don't need the formalisation to organise operational regulation.

Concluding this segment it can be concluded that the network is achieving the subgoals of designing conditions and operational regulation, although they do not do this consciously. But, thanks to the relatively low values on the design parameters and the size of the network this works. The network does not achieve the subgoal of setting goals, here there is a gap between the desired situation and the actual situation, so this is a point of improvement.

## Conclusion

The goal of this thesis is to make a structure-based diagnosis of the governance of the network collaboration of subnetwork haematology as a part of Onco Oost. To accomplish this, it is first determined what governance is in the haematology network. Next, a gap analysis is executed which means that a desired structure and corresponding parameters are compared with the actual structure and corresponding parameters.

The desired governance structure is a structure where overall the values on the design parameters are as low as possible in the context of the haematology network. This is done so that the structure is not a cause of disturbances and has enough regulatory potential to solve these disturbances. For the haematology network, the desired governance structure is one with a moderately low value on specialisation of regulatory activities, a low value on separation, a low level on functional concentration and a moderately low level on specialisation of operational activities.

The actual structure that is described in this thesis is one with a low value on specialisation of regulatory activities, a low value on separation, a moderately low value on functional concentration and a moderately low value on specialisation of operational activities. The discrepancy between the desired and actual level of functional concentration is not relevant, in this context, the functional concentration is as low as possible. For specialisation of regulatory activities, some specialisation or at least the definition of tasks could remove this discrepancy. The governance is organised in the network by a network administrative organisation, although the network itself states that it is governed by a lead organisation. When compared with the literature a network administrative organisation is a good fit for the haematology network.

With this governance structure, they accomplish two of the three subgoals of governance, designing conditions and operational regulation. The haematologists have the power to organise these thanks to the low values on the parameters of separation and specialisation of regulatory activities. Setting goals is a point of improvement for the network, the members of the network agree on the main goals, but no goals are being set that the network can work towards.

Because of the relatively small size of the network and the trust they have in each other and in the network collaboration, the governance structure they use has been a good solution for them. The structure-based diagnosis concludes that the haematology network has, without consciously trying to implement this, created a governance structure with design parameters that are in the context of the network mostly as low as possible.

## Discussion

In this chapter first, the results of this thesis will be interpreted. Next the implications of these results will be discussed. Then the limitations of this thesis will be discussed, and it will end with suggestions for further research based on this thesis. First, the interpretation of the results. The results of this thesis are not in line with the expectations beforehand. The haematology network is a group of organisations that started working together because of a need that they all felt but was not deliberately planned as an organised collaboration. Because of this, it is surprising that the structure of the network is so well aligned with the theory about the design parameters of structure theory (Achterbergh & Vriens, 2009; de Sitter, 1994). In the conceptual model, a desired governance structure was described based on structure theory combined with literature about the governance of networks (Provan & Kenis, 2008). The actual governance structure described in this thesis matches the desired model pretty accurately. Not only on structure theory but also on what literature in network theory describes as the right governance model out of the three forms described in Provan & Kenis (2008), so working with a network administrative organisation. Although they call it a lead organisation, the NAO seems a good fit based on the literature.

Where there was a discrepancy between the desired situation and the actual situation is in the specialisation of regulatory activities. At the moment, the board of the network does not have deliberate goals and has no tasks defined. This could be a point of improvement for the board, as setting goals can make plans more deliberate and can also help motivate employees to work towards goals when these goals are communicated (Christensen et al., 2021). Next to this, specifying tasks makes sure that the subgoals of governance are achieved, by making deliberate who is responsible for these tasks. The other parameters which are used in this thesis can not be further optimized, so lowered, based on discussions with the respondents in this thesis. Separation is already as low as possible, and specialisation of operational activities and functional concentration can not be lowered further because this would have a negative impact on the quality and efficiency of MDOs which are used in the network. It can be concluded that the governance structure of the haematology network is working well, it helps in achieving the main goal of the network which is to give the best possible care, as close to home as possible for the patients and to use studies to improve the treatment methods by using studies.

In the coming years, the governance structure of the haematology network might be subject to changes by the arrival of Onco Oost. Although Onco Oost says that it doesn't want to push the subnetworks into a straitjacket and wants to let the subnetworks work in their own preferred way, the arrival of Onco Oost does add another layer in the governance hierarchy for the subnetworks. This can have an impact on the power of the haematologists and can influence their decision power on the processes of their network since the overarching Onco Oost can have the effect of formalisation on the processes of the subnetworks. Time will have to tell if this is the case or if the haematology network can keep governing itself in the way it has been doing.

Next the limitations of this thesis will be discussed. The first limitation has to do with the perspective that is chosen as 'success' of the haematology network. In the conceptual model, it is mentioned that organisational structure theory is a perspective on how organisations can optimise their structure to work towards two goals. In this thesis, the focus is on the quality of organisation as a goal, because this resonates with the main goals of the network. However, the quality of work is not taken into account in this thesis. As an example to show how this is impacted, a form of operational regulation is that haematologists have to do preparation for MDOs in their own time and if the MDOs take longer than expected this extra time also comes from their own time. The MDOs also add to the already big work pressure that haematologists experience. All of this is not taken into account in this thesis but would be very interesting and important to study in further research.

The next limitations have to do with the interviews which are conducted for this thesis. For this thesis, only three interviews were conducted, because of the limited availability of the employees of the hospitals. This negatively influences the reliability of this thesis. Next to this, two of the three respondents were employees of the Radboud UMC which is the biggest actor in the network, so this might have a negative influence on the validity of this thesis. What also is a limitation tied to this is that the researchers are part of Radboud University, so this might affect the answers of the respondents. So, a suggestion for further research to build further on the knowledge created in this thesis would be to have more interviews and have them with more employees of the smaller hospitals that are partaking in the network, to get a different perspective.

Another limitation of this thesis is that it is beyond the scope of this thesis to measure causality. It is beyond the scope of this thesis to measure if the organisational structure influences how well the haematology network is operating. To try to measure this a suggestion for further research could be to use a quantitative study using surveys to collect data on employee perceptions of organisational structure and their effects on outputs of the network.

Another limitation of this thesis is that is focused on one healthcare network, the haematology network which is a relatively small network. This has as a result that the results of this thesis can not be generalized. Recommendations for further research are to examine the structures of multiple healthcare networks so that these can be compared. In the future it can also be interesting to look at the influence of Onco Oost on the subnetworks that are a part of it, but before that Onco Oost first needs to develop further.



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# Appendixes

## Appendix 1: First version of interview guide (in Dutch)

Goedemorgen/middag,

We zullen onszelf kort voorstellen. Wij zijn Daan van de Wijgert en Wiebe van der Vlist, studenten aan de Radboud Universiteit en wij zijn bezig met de master Organizational Design and Development. Voor onze master thesis doen wij onderzoek naar de invloed van structuur op de effectiviteit van het Hematologie netwerk.

### Waarom dit onderzoek?

Het onderzoek bij het Hematologie Netwerk maakt deel uit van een onderzoek naar de invloed van de structuur op de effectiviteit van zorgnetwerken dat de Faculteit der Managementwetenschappen onlangs samen met het Rmuc is gestart.

Als onderdeel van het onderzoek willen wij enkele interviews afnemen met deelnemers van het Hematologie netwerk om te achterhalen hoe zij het werken in MDO's ervaren, hoe zij de governance van het netwerk ervaren en wat zij mogelijk als verbeterpunten zien.

**Anonimiteit:** Het is belangrijk om te vermelden dat deelname aan het interview volledig anoniem is. Met de informatie verkregen uit het interview wordt vertrouwelijk omgegaan. Uw naam en functie worden niet in het onderzoek vermeld of bekendgemaakt aan anderen. Dan willen we nog graag benadrukken dat dit interview geheel vrijwillig is, u kunt op elk moment het interview stoppen.

**Resultaten van het interview:** Als deelnemer krijgt u inzicht in het (uitgeschreven) gegeven interview (en de mogelijkheid dit aan te passen) en wordt u op de hoogte gebracht van de resultaten van het gehele onderzoek.

Mocht u na afloop van het interview nog vragen hebben, dan kunt u altijd contact met ons opnemen.

Voordat we het interview starten, wil ik u vragen of u akkoord gaat met het opnemen van dit gesprek. En of u zou willen tekenen voor akkoord met het afnemen van het interview onder de genoemde voorwaarden.

Als er tijdens het interview vragen of concepten zijn die niet duidelijk zijn, horen wij dat graag van u. Heeft u verder nog vragen voorafgaand aan het interview?

### Introductie respondent

- Zou u zich kort even voor kunnen stellen en vertellen waar u werkt en wat uw taken zijn/rol is binnen hematologie?

### Algemene netwerk vragen: 5-10 min

1. Doelen van het netwerk (*setting goals*) a. *Worden deze doelen behaald?*
2. Welke rollen zijn er binnen het netwerk? (*functional concentration, specialisation*)
3. Hoe worden taken gespecialiseerd en verdeeld over deze verschillende rollen?

*(specialisation)*

4. Wat gaat er goed binnen het netwerk?
5. Wat gaat er minder goed binnen het netwerk? Wat zijn uitdagingen? Waar zie je

graag verbetering?*(problems)*

### **Deel Governance: 25 min**

1. Hoe is de governance structuur op dit moment vormgegeven? *(designing conditions)* a. Hoeveel en welke mensen zijn hierbij betrokken? *(functional concentration)*

2. Wat zijn de doelen van de governance structuur, wat wordt er beoogd bereikt te worden met deze governance structuur? *(setting goals)*
3. Wie stelt de doelen voor het netwerk? *(setting goals)*
  1. Hoe zijn de verschillende ziekenhuizen hierbij betrokken? *(designing*

*conditions)*

2. Op welke manier worden de doelen die gesteld worden gemonitord?

*(regulation)*

4. Wat zijn de problemen waar jullie bij de aansturing van het netwerk tegenaan lopen?

*(problems)*

5. Draagt deze manier van governance organiseren bij aan het bereiken van de doelen?
6. Hoe is het vertrouwen tussen de ziekenhuizen binnen het netwerk? *(trust)*
7. Hoe is het contact georganiseerd tussen de ziekenhuizen, kan je elkaar goed en snel

spreken? *(density of network)*

8. Hoe is het operationeel regelen (oplossen van problemen) georganiseerd?

*(operational regulation)*

9. Hoe worden taken gealloceerd aan mensen? *(designing conditions)*
10. Hoe worden middelen binnen het netwerk verdeeld? *(designing conditions)*

### **Deel MDO: 25 min**

1. Hoe ziet het MDO eruit binnen hematology? Hoe ziet het proces eruit, wie zijn er betrokken bij het MDO en hoe ziet de samenwerking eruit? *(structure)*

a. Zijn de betrokkenen altijd hetzelfde of verschilt dit?

2. Welke specifieke taken en verantwoordelijkheden hebben verschillende deelnemers met betrekking tot het MDO?
3. Wat zijn de doelen voor de MDO's? *(setting goals)* Hoe worden deze doelen gerealiseerd? *(monitoring)*
4. Draagt deze manier van werken (vormgeving/structuur van MDO) bij aan het realiseren van de doelen van het MDO?

5. Hoe dragen de doelen van het MDO bij aan de doelen van het netwerk?
6. Welke uitdagingen ervaar je? Wat zou beter kunnen binnen het MDO?
7. Hoe zijn de taken verdeeld binnen het MDO?
8. Hoeveel tijd is er beschikbaar voor het uitvoeren van een taak en is dit voldoende? I
9. Is deze verdeling van taken efficiënt volgens u?
10. Hoeveel patiënten worden per keer in het regionale MDO besproken?

a. Hoe wordt er bepaald wie er besproken wordt?

11. Als er zich problemen voordoen tijdens de multidisciplinaire overleggen, hebben jullie dan de mogelijkheid om deze zelf op te lossen, of moeten andere individuen of instanties worden ingeschakeld?

Hematologie valt niet onder SONCOS en IZA, er is wel vanuit NVvH / HOVON wel sturing op regionalisatie: Hoe ziet deze sturing eruit?

## Appendix 2: Second version of interview guide (in Dutch)

### Topiclist / Interview Guide - MT Haematology network

Goedemorgen/middag,

We zullen onszelf kort voorstellen. Wij zijn Daan van de Wijgert en Wiebe van der Vlist, studenten aan de Radboud Universiteit en wij zijn bezig met de master Organizational Design and Development. Voor onze master thesis doen wij onderzoek naar de invloed van structuur op de effectiviteit van het Hematologie netwerk.

#### Waarom dit onderzoek?

Het onderzoek bij het Hematologie Netwerk maakt deel uit van een onderzoek naar de invloed van de structuur op de effectiviteit van zorgnetwerken dat de Faculteit der Managementwetenschappen onlangs samen met het Rmuc is gestart.

Als onderdeel van het onderzoek willen wij enkele interviews afnemen met deelnemers van het Hematologie netwerk om te achterhalen hoe zij het werken in MDO's ervaren, hoe zij de governance van het netwerk ervaren en wat zij mogelijk als verbeterpunten zien.

**Anonimiteit:** Het is belangrijk om te vermelden dat deelname aan het interview volledig anoniem is. Met de informatie verkregen uit het interview wordt vertrouwelijk omgegaan. Uw naam en functie worden niet in het onderzoek vermeld of bekendgemaakt aan anderen. Dan willen we nog graag benadrukken dat dit interview geheel vrijwillig is, u kunt op elk moment het interview stoppen.

**Resultaten van het interview:** Als deelnemer krijgt u inzicht in het (uitgeschreven) gegeven interview (en de mogelijkheid dit aan te passen) en wordt u op de hoogte gebracht van de resultaten van het gehele onderzoek.

Mocht u na afloop van het interview nog vragen hebben, dan kunt u altijd contact met ons opnemen.

Voordat we het interview starten, wil ik u vragen of u akkoord gaat met het opnemen van dit gesprek. En of u zou willen tekenen voor akkoord met het afnemen van het interview onder de genoemde voorwaarden.

Als er tijdens het interview vragen of concepten zijn die niet duidelijk zijn, horen wij dat graag van u. Heeft u verder nog vragen voorafgaand aan het interview?

#### Introductie respondent

- Zou u zich kort even voor kunnen stellen en vertellen waar u werkt en wat uw taken zijn/rol is binnen hematologie?

#### Algemene netwerk vragen: 5-10 min

1. Doelen van het netwerk (*setting goals*) a. Worden deze doelen behaald?

2. Welke rollen zijn er binnen het netwerk? (*functional concentration, specialisation*)
3. Hoe worden taken gespecialiseerd en verdeeld over deze verschillende rollen?

(*specialisation*)



4. Wat gaat er goed binnen het netwerk?
5. Wat gaat er minder goed binnen het netwerk? Wat zijn uitdagingen? Waar zie je graag verbetering?(*problems*)

### **Deel Governance: 25 min**

1. Hoe is de governance structuur op dit moment vormgegeven? (*designing conditions*) a. Hoeveel en welke mensen zijn hierbij betrokken? (*functional concentration*)

2. Wat zijn de doelen van de governance structuur, waarom is er gekozen voor deze manier van organiseren? (*setting goals*)

3. Wie stelt de doelen voor het netwerk? (*setting goals*)

1. Hoe zijn de verschillende ziekenhuizen hierbij betrokken? (*designing conditions*)

2. Op welke manier worden de doelen die gesteld worden gemonitord?

(*regulation*)

4. Wat zijn de problemen waar jullie bij de aansturing van het netwerk tegenaan lopen?

(*problems*)

5. Draagt deze manier van governance organiseren bij aan het bereiken van de doelen?

6. Hoe is de hiërarchie van regulering georganiseerd? Denk aan landelijk, misschien OncoOost en dan hematologie netwerk? (*separation*)

a. Is er wrijving tussen deze verschillende lagen?

7. Hoe is het vertrouwen tussen de ziekenhuizen binnen het netwerk? (*trust*)

8. Hoe is het contact georganiseerd tussen de ziekenhuizen, kan je elkaar goed en snel

spreken? (*density of network*)

9. Zijn er binnen het netwerk subgroepjes van ziekenhuizen die meer samen werken of

is dit ongeveer gelijk? (*cliques*)

10. Hoe is het operationeel regelen (oplossen van problemen) georganiseerd?

(*operational regulation*)

11. Hoe worden taken gealloceerd aan mensen? (*designing conditions*)

12. Hoe worden middelen binnen het netwerk verdeeld? (*designing conditions*)

## Deel MDO: 25 min

1. Hoe ziet het MDO eruit binnen hematology? Hoe ziet het proces eruit, wie zijn er betrokken bij het MDO en hoe ziet de samenwerking eruit? (*structure*)

a. Zijn de betrokkenen altijd hetzelfde of verschilt dit?

2. Welke verschillende mdo's zijn er

a. Waarom is deze verdeling gemaakt?

3. Welke specifieke taken en verantwoordelijkheden hebben verschillende deelnemers met betrekking tot het MDO?

4. Wat zijn de doelen voor de MDO's? (*setting goals*) Hoe worden deze doelen gerealiseerd? (*monitoring*)

5. Draagt deze manier van werken (vormgeving/structuur van MDO) bij aan het realiseren van de doelen van het MDO?

6. Hoe dragen de doelen van het MDO bij aan de doelen van het netwerk?

7. Welke uitdagingen ervaar je? Wat zou beter kunnen binnen het MDO?

8. Hoe zijn de taken verdeeld binnen het MDO?

9. Hoeveel tijd is er beschikbaar voor het uitvoeren van een taak en is dit voldoende? I

10. Is deze verdeling van taken efficiënt volgens u?

11. Hoeveel patiënten worden per keer in het regionale MDO besproken?

a. Hoe wordt er bepaald wie er besproken wordt?

12. Als er zich problemen voordoen tijdens de multidisciplinaire overleggen, hebben jullie dan de mogelijkheid om deze zelf op te lossen, of moeten andere individuen of instanties worden ingeschakeld?

Hematologie valt niet onder SONCOS en IZA, er is wel vanuit NVvH / HOVON wel sturing op regionalisatie: Hoe ziet deze sturing eruit?

### Appendix 3: Code book

Functional concentration	Separation	Specialisation of regulatory activities
<p>En in het rijnstate heb je vier hematologen. Dan komt ede nog aansluiten met twee of drie hematologen. En dan heb je weer van ieder andere specialisme een erbij</p>	<p>nee, dan hebben we weer een bemoei structuur</p>	<p>dus niet dat ieder centrum exact hetzelfde doet</p>
<p>regionaal heb ik... ik heb een keer in het ... zeg maar, ik heb een mdo met doetinchem, ik heb een mdo met rijnstate, ede</p>	<p>dus dat is het enigste ziektebeeld waar echt op gestuurd wordt, landelijk ook</p>	<p>we hebben sinds kort een overlegstructuur waarbij inderdaad van alle centra een hematoloog en van radboud twee, waaronder de voorzitter. En ik</p>
<p>er is een mdo met cwz. Dan is er nog een mdo, dat doet een collega van mij, met den bosch - bernhoven. Dan hebben wij wekelijks onze eigen mdo hier</p>	<p>maar die snapt de hematologie niet. Hoe wij op de structuur werken. Dus die kans ook niet goed vertegenwoordigen</p>	<p>die makkelijker in onze takenpakket zijn te versleutelen dan in een perifere kliniek</p>
<p>binnen de hematologie heb je verschillende niveaus van zorg. Dat heet echelon a tot en met d. d is de basiszorg</p>	<p>ik heb dan meer de coördinerende rol, de ondersteunende rol</p>	<p>in een stafvergadering, wie wil. En aangezien ik al heel wat regionale taken, dan is het natuurlijk dat ik dat doe</p>

<p>je hebt eigenlijk twee verschillende soorten mdo's in het netwerk. De ene is ziektespecifiek ... daar sluiten alle ziekenhuizen bij aan. Dat is eigenlijk ook de enige ziektespecifieke die we hebben</p>	<p>ik heb de tijd om dingen uit te voeren en dingen op te pakken. Specialisten zijn in de regel erg druk. Het gaat er mij om dat er gewoon gedragen beleid is</p>	<p>iedere hematoloog is wat dat betreft gelijk</p>
<p>we hebben ook regionale mdo's. dat zijn mdo's die niet door het radboud georganiseerd worden, maar door verschillende ziekenhuizen</p>	<p>maar zo professioneel zijn we nog niet. Ik denk dat er met de nieuwe structuur binnen onco oost.... Wel meer gaat komen</p>	<p>netwerkcoördinator, coördineerder van regionale samenwerking voor de hematologie</p>
<p>naast die regionale mdo's heb je trouwens ook lokale mdo's</p>	<p>het is op landelijk niveau veel georganiseerd</p>	<p>hematologne, ze behandelen, denken ook wel mee over het beleid</p>
<p>het lokale mdo is bijvoorbeeld vooral bedoeld om die hamerstukken te doen</p>	<p>dat is NVVH-beleid. En die schrijven voor dat er in een mdo minimaal drie hematologen moeten deelnemen</p>	<p>in november zijn we gaan werken met een netwerkbestuur. Dat houdt in dat we een vertegenwoordiger per ziekenhuis hebben. Plus de voorzitter en de onderstuener, de beleidsadviseur in dit geval</p>
<p>je kunt op een gegeven moment voor allemaal ziektespecifieke mdo's gaan zorgen. Maar dan ben je nog meer tijd kwijt. Want dan zit je elke keer met de hele club van ziekenhuizen. En dat gaat hem niet worden</p>	<p>ook vanuit HOVON. HOVON is de wetenschappelijke vereniging voor de hematologie. En de nederlandse NVVH is de beroepsgroep voor de hematologie</p>	<p>het is een leiderschapsorganisatie model. Daar ontkom je ook niet aan. Want het radboud heeft ook die consultverlenende functies</p>

<p>het voordeel van zo'n regionaal mdo is dat er gewoon veel in een korte tijd besproken kan worden</p>	<p>dat is niet de intentie van onco oost. Want onco oost wil juist dat die netwerken zelf hun eigen agenda bepalen. Dus die willen niet dat die netwerken in een gedwongen keurslijf zitten</p>	<p>eerst hadden we een voorzitter. Dat is een hematoloog van hier. En dat was het eigenlijk</p>
<p>zie ik eigenlijk alle AML behandelaren, grotendeels alle AML behandelaren, aansluiten aan dat overleg</p>	<p>er zijn ook best wel vel overstijgende dingen. De manier hoe je met patientenvoorlichting omgaat. Privacy issues. Wetenschappelijk onderzoek ... en daar kun je gewoon beter overstijgend aanpakken</p>	<p>op dit moment is er niet echt een specifieke taakverdeling</p>
<p>oke, maar dan heb je dus twee mdo's. dus het mdo aml, waar jullie bij zitten. Dat is echt totaal verschillend georganiseerd</p>	<p>netwerkondersteuner</p>	<p>ja dat is de negende. Oke, dus acht ziekenhuizen, voorzitter. Ja acht ziekenhuizen. Maar dan heb ik nog een onderdeel aan het maken van het bestuur, ik heb geen stemrecht</p>
<p>dat worden regionale mdo's genoemd en daarnaast hebben we ook nog een lokaal mdo ... dus het mdo aml en het mdo, het regionale mdo</p>	<p>op dit moment zat onco-oost er nog niet. Dat is heel vers van de pers, die samenwerking. De NVVH en de HOVON, de studies komen vanuit de HOVON</p>	<p>maar op zich, binnen dat netwerk, zijn we wel allemaal gelijk</p>
<p>alle ziektebeelden in dat regionale mdo. Met uitzondering dus van aml mdo</p>	<p>eerder was het zo dat de HOVON contacten zocht via de tumorwerkgroepen van verschillende ziektebeelden</p>	<p>op dit moment is het, denk ik, dat het radboud ziekenhuis, als het enige academische ziekenhuis van de regio, wel in de lead is. Dus dat klopt. En dat het systeem dat vanuit oudsher zo ontstaan is</p>

<p>ja, complexiteit. Dus als het recht toe recht aan is ... dan kunnen wij dat rustig lokaal afhandelen. Is het wat complexer, dan moet het in een regionaal mdo</p>	<p>consultverlenend ziekenhuis ja</p>	<p>ook omdat zo lang zijn we nog niet bezig met dit stukje. Ik bedoel, het zijn twee of drie vergaderingen geweest</p>
<p>ja 1 keer per 2 weken. En het mdo aml is wekelijks</p>	<p>als neutrale partij of zo. Ik denk, het lijkt me wel goed om daar iets over af te spreken</p>	<p>als ik naar mezelf kijk, dan vind ik het een positieve ontwikkeling. Ik vind het een goede stap voor de toekomst</p>
	<p>dat is ten eerste gewoon een eisen. Dus dat is een eisen die geformuleerd is ... ik denk vanuit het NVVH</p>	<p>Ja, onco-oost gaat, denk ik, zorgen dat ... omdat alle ziekenhuizen ook financieel participeren, dus dat nu wordt. Tot voor kort werd het regionale netwerk met name aangestuurd vanuit het radboud umc. En ik denk dat daar wel verandering in gaat komen door de komst van onco-oost</p>
	<p>ja, dat is dus omdat het in de behandelrichtlijn staat van zo'n bepaald ziektebeeld, dat dat moet. Dus doordat die behandelrichtlijn is, dus als je dit doet, dan zijn dit de voorwaarden waaronder je dat mag doen</p>	

Specialisation of operational activities	Setting goals	Designing conditions
we hebben allemaal een subspecialisatie	name samenwerking en dat de zorg die wij hier in de regio leveren, dat iedereen dezelfde zorg krijgt en kwaliteit van zorg	dus dan moeten we samen tot een compromis komen van wat is strikt noodzakelijk en wat is hobby
binnen de hematologie hebben we echelonering. Wij zijn een echelon-a-ziekenhuis, waardoor wij stamceltransplantie mogen, bepaalde behandelingen mogen doen	allemaal in dezelfde richtlijnen gaan	denk bestuurlijk, dan heb je gewoon het centrum voor oncologie en daar vallen wij onder en waarschijnlijk gaan wij straks ook onder het onco-oost vallen
ja, en dan heb je een ABCD en dan heb je nog een C-HIC en een C-SCT. Dus je hebt allerlei vormen	nee, er worden nog niet hele harde doelen gesteld. Allerlei intenties	dan hebben we overleg en dan is meestal vanuit ieder centrum een hematoloog die die afdeling hematologie vertegenwoordigt
je moet minimaal vijf jaar hematoloog zijn en daarna mag iedereen het doen. Maar sommige passen gewoon niet in hun takenpakket	het is meer wat er op ons afkomt waarop gereageerd wordt	vroeger ging dat landelijk en dan was het veel vriendjespolitiek met degenen die de studie initieerden

de dokter die de patient kent, die brengt de patient. En daar worden we over gediscussieerd	ja ik denk dat het gaat om te zorgen dat de kwaliteit van de zorg overal hetzelfde is	dus dat in de acht regio's die er zijn, dat het allemaal ongeveer evenveel centra
taken is om allemaal goed voor te bereiden. En verantwoordelijkheden..., ja ik ben adviserend	het netwerk heeft nog niet zo'n hoge doelen he	gewoon omdat de financiële structuur zo is
je moet een goede voorzitter hebben en hier in het ziekenhuis ben ik zelf de voorzitter	best mogelijk zorg kunt bieden waar het kan dicht bij huis en verder weg waar het moet	de voorzitter heeft geen stemrecht
en zijn verantwoordelijk voor de studies die ze uitvoeren en de behandelingen die ze uitvoeren	zoveel mogelijk mensen in studies behandelen. Want dat geeft mensen toegang tot de nieuwste geneesmiddelen	dus heel veel van die oncologie regels die vallen buiten ons zicht
dus wat wij willen is dat de patienten die echt in de ziekenhuizen in de regio behandeld kunnen worden, ook zoveel mogelijk daar laten behandelen	in dat gremium proberen we ook gewoon meer met elkaar na te denken over waar we naartoe willen, hoe we invulling geven aan beleid	die hebben niet de autoriteit, denk ik



<p>zodat we zelf onze handen vrij hebben voor die complexe zorg, die je niet zomaar in de regio kunt verlenen</p>	<p>en die personen zijn dan weer verantwoordelijk... om dat binnen hun eigen organisatie af te stemmen. Dus dat is ook een belangrijk doel</p>	<p>de drempel van ons, van perfier naar hier, is niet zo groot omdat academisch, dus dat is voor patienten uit te leggen</p>
<p>dus we zijn niet van het centraliseren, wel van het verdelen</p>	<p>op dit moment hebben we geen jaarplan... of geen doelstellingen met een einddatum. Vaak zijn met de dingen waar we mee bezig zijn</p>	<p>nee voorbereiding doe ik vaak in mijn eigen tijd</p>
<p>het kan ook zijn dat bijvoorbeeld het jeroen bosch ziekenhuis of het cvz of rijnstade zeggen van wij focussen ons daarop. En dat is ook iets waar we gewoon steeds meer naartoe willen werken</p>	<p>een doel dat we op dit moment bijvoorbeeld hebben... is dat elk ziekenhuis deelneemt aan studies... voor nieuwe behandelmethoden, nieuwe middelen</p>	<p>maar het lastige is dat bij standardiseren ga je denk ik meer bespreken. Want dan moet je aan de veilige kant gaan zitten</p>
<p>het zijn hematologen hematoloog in opleiding. Laboratorium specialisten, dat kan heel breed zijn</p>	<p>het andere doel is nu ook om met de patientenvereniging wat meer aansluiting te zoeken</p>	<p>eh, vast wel. Maar daar we als dockters heel slecht in. Geld vind heel vervelend. Om daarover te moeten praten</p>
<p>dat heeft te maken met de structuur van academsich versus perifieer</p>	<p>het wordt wel bij de vergaderingen... wordt wel elke keer een update gegeven... van waar we mee bezig zijn</p>	<p>ja, maar er is wel het een en ander over vastgelegd. Maar wat je ziet is dat de ziekenhuizen zelf heel breed willen blijven qua zorg</p>

<p>dus enerzijds, je kunt efficiëntie zoeken, maar dat gaat wel ten koste van de inhoud van je vak</p>	<p>en dan kun je altijd terugzien wat je eerder hebt geadviseerd. Dat is ook een stukje kwaliteitsborden</p>	<p>er is een landelijk proces voor, maar buiten dat landelijke proces kan gevraagd worden om binnen de regio onderling af te stemmen</p>
<p>ja, daar zit een onderscheid in. Dus niet elk ziekenhuis kan hetzelfde doen</p>	<p>daar zit ook een hoop gevoel, kennis en ervaring bij. Ja goed, daar hopen andere dokter ook nog iets uit te halen. Dus dat is denk ik ook wel gewoon een heel belangrijk doel</p>	<p>er is niet een bepaalde regel voor, maar je probeert in soort gevallen wel even een gelijk te maken van wat is redelijk, wat is niet redelijk, hoe is het eerder gegaan. Zodat je ook een beetje kijkt van wie is er nu aan de beurt, wie past het goed</p>
<p>maar dat type ziektebeeld wordt meer onderverdeeld. En je gaat meer op moleculair niveau, dus op een heel klein niveau, ga je je behandelingen toespitzen</p>	<p>elkaar ondersteunen en uniformiteit binnen de hele regio</p>	<p>de studies onderling zo evenredig mogelijk te verdelen</p>
<p>dus het radboud umc is het consultverlenend ziekenhuis voor heel veel mdo's in de regio</p>	<p>patienten dezelfde protocollen volgen en ook hetzelfde doen</p>	<p>maar omdat jij als eerste benaderd wordt, is het wel zo dat jij die studie ook mag doen binnen de regio</p>

<p>zit er altijd een klinisch chemicus bij en soms ook een patholoog. En ook van andere ziekenhuizen kan het iemand van de cytogenetica zijn of een klinisch chemicus</p>	<p>ja, maar niet echt super concreet. Het zou wel concreter mogen. Dus dat je echt een tijdsparade maakt</p>	<p>en welke ziekenhuizen gaan erin participeren? En dus eerder was het zo dat dat eigenlijk altijd via die tumorwerkgroepen werd aangestuurd</p>
	<p>ja over vijf jaar en over tien jaar willen we zover staan. Eigenlijk daar zijn we nog niet helemaal aan toegekomen</p>	<p>wij participeren in al die tumorwerkgroepen. Dus wij krijgen veel sneller die studies verwezen</p>
		<p>en dat je daar dus probeert, dus dat het niet altijd de grote ziekenhuizen zijn, maar dat je studies die bijvoorbeeld in kleinere ziekenhuizen gedaan kunnen worden dat je die het ook kunt</p>
		<p>dus als de een het ene krijgt, dan moeten andere het andere krijgen... globaal</p>
		<p>de werkdruk is te hoog</p>

Operational regulation	Density	Centrality
<p>ik denk toch proberen te praten en het lastige is ook omdat iedereen een eigen toko heeft, ik heb niks te zeggen over rijnsstaat. Dus als wij ruzie hebben, of ruzie, maar als wij woorden hebben over het een of ander, uiteindelijk kunnen zij alles doen wat ik niet wil</p>	<p>maar op een dagelijkse basis werken we heel nauw met alle hematologen in de regio</p>	<p>het lastige is dat ieder ziekenhuis is een eigen bedrijf</p>
<p>ja niet. Ik denk niet dat dit problemen zijn</p>	<p>nou ik denk inderdaad de laagdrempelijkheid van elkaar vinden</p>	<p>om meer gelijkwaardigheid in de netwerkorganisatie te krijgen. Het is vooral niet de bedoeling dat het radboud bepaalt</p>
<p>nou, op het algemeen zijn er meerdere wegen naar rome</p>	<p>iedereen kent elkaar in de regio</p>	<p>en betrokkenheid is vanuit alle partijen</p>
<p>ja, tot nu toe is het nog niet heel veel veranderd</p>	<p>ik ben veel met andere ziekenhuizen in contact. Bijna dagelijks heb ik wel een of twee hematologen uit de periferie die ik aan de telefoon heb voor vragen over patienten of andere dingen</p>	<p>iedereen heeft ook altijd nog z'n eigen belang. En zeker voor de kleinere ziekenhuizen is dat soms heel lastig, om mee te komen met de ziekenhuizen die veel groter zijn</p>

<p>dat is heel wisselend. Soms zoek je actief naar een oplossing. Soms blijf je een beetje om de pot heen draaien...</p>	<p>je en daarna wordt er wat sociaal gebabbeld</p>	<p>het is wel zo dat vergaderingsverzoeken, dat gaat nu nog allemaal via het Radboud UMC</p>
<p>als men dit niet wil en men wil dit niet... wat is er dan wel mogelijk? Dus dan kijk je welke compromissen er zijn</p>	<p>maar we hebben wel bewust gekozen voor een groep waarin elk ziekenhuis vertegenwoordigd is</p>	
<p>er zijn geen regels voor, we proberen dat allemaal in zo goed mogelijk een stand te houden</p>	<p>en de intentie is om de ziekenhuizen zoveel mogelijk aan boord te krijgen</p>	
<p>ook bij het verdelen van zo'n studie, dat is ook iets wat je onderling probeert te doen. De ene keer gaat het makkelijker, de andere keer gaat het moeilijker</p>	<p>er ook om makkelijker te kunnen schakelen tussen de ziekenhuizen</p>	
<p>je probeert daar wel onderling een zo goed mogelijke oplossing voor te vinden</p>	<p>ja, dat is heel verschillend. De arsten spreken elkaar regelmatig in mdo's. die zijn een keer in de week, een keer in de twee weken</p>	

<p>dat is allemaal eluk bedacht, maar dat is niet altijd haalbaar</p>	<p>dus die hebben veel contact. We hebben vijf keer per jaar een verdaring van het netwerk</p>	
<p>dat kan met degene die aanwezig is vanuit het radboud. Dat kan met degene die het mdo in het ziekenhuis organiseert. Dat kan zelfs in een regionaal overleg. Dat is maar net wat het probleem is</p>	<p>wij bezoeken de ziekenhuizen, dat doe ik samen met (naam) of met een andere hematoloog</p>	
<p>maar ik denk dat het dan allereerst wordt besproken op een van die vergaderingen. En dat we dat onderling proberen op te lossen. Maar iedereen is gelijkwaardig. Dus het is soms best heel lastig om dan dingen op te lossen</p>	<p>ja, er is veel contact op allerlei niveaus</p>	
<p>dus ja, inderdaad, als het uitloopt, dan gaat het mdo voor. Zo is het nu geregeld</p>	<p>her is ten eerste goed dat je elkaar kent in de regio. Dus de onderlinge contacten, dat is al heel erg belangrijk</p>	
<p>dat hebben wij nu zo georganiseerd dat we dat dus voorkomen</p>	<p>zeker, ten eerste, je ziet dezelfde mensen wat waker</p>	

	<p>dus door dat mdo aml en doordat je ook al is met een videoverbinding, heb je wel het idee dat je elkaar vaker ziet</p>	
	<p>binnen het netwerk is het alleen die bestuursvergadering. Ja, en je ziet elkaar natuurlijk op hovondagen en congressen</p>	

Cliques	Network collaboration	Trust
er zijn mensen die meer bellen en er zijn mensen die wat meer zelf regelen	door meerdere, door alle centra gevoed	en dan merk je dat, hoewel ze ,hematologen, strikt genomen graag willen samenwerken, het niet altijd kan omdat er financiële belangen zijn waardoor ze nooit helemaal open kaart zullen spelen
dat kunnen ook groepjes van ziekenhuizen zijn. Dat zijn slingeland, die hebben een eigen mdo. Rijnstaat samen met gelderse vallei	gewoon praktisch werken wij veel samen en dan zijn wij denk ik wel de spin in het web die met doetinchem, rijnstate enzo werken	maar dat ze niet helemaal open kaart spelen
dat zal met name voor het jeroen bosch ziekenhuis met het radboud umc zijn	uitwisseling en ook van patienten	ja, ik denk dat vertrouwen wel goed is
nou, die zijn er natuurlijk wel. Wij werken wat intensiever met bernhoven samen	wij zijn al veel verder met het organiseren	maar dan zeggen ze; nee, dat kan niet. Dan moet ik hem erop vertrouwen, en dat vertrouw ik hem



wij hebben met bernhoven heel veel contact omdat in ons mdo, dus er is een groot verschil tussen het mdo aml	dat we niet beter een hematologie landelijk kunnen	je moet gewoon vertrouwen
dus over de patienten van het jeroen bosch ziekenhuis en die van bernhoven. En dus hebben wij het consulterend ziekenhuis uitgenodigd	dus doordat de kwaliteit beter wordt, dat levert in principe geen geld op voor de ...	maar ze zien het mogelijk ook als een bedreiging dat ze bepaalde zorg kwijt kunnen raken
dus je hebt eigenlijk een paar groepjes in de regio, het radboud umc zit er wel altijd bij	omdat wij een hele andere overlegstructuur hebben	daar twijfel ik eigenlijk bij geen enkele partij aan. Je ziet gewoon dat iedereen... wat dat betreft hetzelfde doel heeft
	want ons groepje is veel kleiner. En wij hebben elkaar veel harder nodig. Daarom lopen we voor	ik denk ook dat het vertrouwen er ook zeker is. Ik denk ook het vertrouwen in elkaar. Zeker als het gaat om het leveren van zorg
	dat zien we als een probleem. Of dat een probleem wordt, weten we natuurlijk helemaal niet	dus ik denk om echt een langetermijnplanning te maken, moet je eerst elkaars vertrouwen hebben

	<p>een regionaal samenwerkingsplan geschreven waar privacy issues die opgelost moesten worden. Beleid in aanzien van studies</p>	<p>ik denk dat dat heel erg moet groeien</p>
	<p>het lastige in het netwerk is dat je samenwerkt. En samenwerken dat is geven en nemen. Dat betekent dat als je iets krijgt je er ook iets voor terug moet geven</p>	<p>we moeten er met z'n allen aan gaan wennen, zal maar zeggen, dat we de taken binnen de regio en de patienten binnen de regio wat eerlijker gaan verdelen</p>
	<p>ja, als je kijkt naar de oprichting van onco oost... is hematologie al heel ver. Dat zal ook voor een of twee andere netwerken zo zijn</p>	<p>en dat vertrouwen moet er dus wel zijn</p>
	<p>het is ook een vorm van scholing</p>	<p>maar als je elkaar daar onderling in wilt gaan vertrouwen. En dat dus zo eerlijk mogelijk wil doen, wat denk ik wel beter is</p>
	<p>tegenwoordig het regionaal hematolgoei bestuursnetwerk</p>	<p>en het lastige is, dan moeten wel al die ziekenhuizen daar ook hun vertrouwen in uitspreken, dat die persoon dat gaat doen</p>

	<p>dat is ook een van de voordelen van het netwerk, dat we gaan samenwerken bij studies</p>	<p>dus ook met vertrouwen te maken</p>
	<p>zijn dat je toch patienten naar de verschillende centra verwijst</p>	
	<p>ik denk dat een van de aanleidingen voor het netwerk wel de studieverdeling was</p>	
	<p>dat het wel helpt dat elke keer gestructureerd overleggen, om elkaar beter te begrijpen, en hopelijk om ook te zien het grote verband, de reden waarom we dit allemaal doen</p>	

	dus er is meer gedeelde smart dan vroeger	
	nou ja, ik denk dingen die de rest van de regio niet aangaan	
	dat is van alle ziekenhuizen samen. Dus dat is los van het radboud umc	
	ja, dat loopt nog niet helemaal soepeltjes	