

## WHY SERVICE LEVEL AGREEMENTS? AN OVERVIEW OF THEIR ORIGINS AND BEST PRACTICE

**Shane Godbolt**

*Based on presentations to the IFMH study day 'Service level agreements: straitjacket or positive management tool?' 28 January 2003. This presentation has been summarised by Susan Mottram, University of Leeds*

Service level agreements (SLAs) date from the 1960s and have their origin in the need of organisations to manage relations with IT and computing services. SLAs have developed as a tool to manage the complexity of organising service delivery between different stakeholders who may have competing interests but who need to find common ground and to recognise their interdependence. Where there is willingness to work in partnership there is huge scope to explore the creative potential for service development and for synergy from collaborative working.

In the late 1980s following the culture change brought about by the recommendations of the Griffiths report (Griffiths, 1983) SLAs became a recognised tool. They were used in the NHS to negotiate a wide range of services provided by computing

departments and other facilities providers and more recently this business-focused approach has embraced libraries.

Partnerships may also need to be agreed externally as well as internally and cross sectorally. For example, collaborative working is emphasised in the *Statement of Strategic Alliance for Health and Social Care* (Department of Health and HEFCE, 2002),

"In recognising the interdependency of teaching, research and patient care, the DH and HEFCE... recognise the importance of ensuring that each partner is well informed of the other's priorities. The Strategic Alliance further strengthens the commitment of both organisations to partnership working, providing the framework for building upon existing arrangements for liaison, consultation and representation."

SLAs have an important role to play in supporting such partnerships.

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### Characteristics of SLAs

As defined by Ashcroft (1993),

" Service level agreements ...[are] the means by which two parties communicate to each other their commitments in relation to the resourcing and provision of services to a given level, over a given period."

An SLA is similar to a contract in that it represents collaborative working between two or more parties, contains a statement by the commissioner of what is required and a statement by the provider of what is feasible within existing resources.

The SLA describes what the customer needs by providing a service statement. It also shows the mechanics and processes which need to be put into place in order to fulfil those needs. It gives a clear picture of the volume of work involved, quantifying levels of service, costs and service delivery, including a realistic timeframe. It defines quality, standards and types of service and how these can be monitored and measured. It outlines the nature of the agreed services in such a way that it is precise enough to act as an agreement but not so prescriptive that it prevents service development or precludes negotiated change in order to improve services. The negotiated agreement between customer and provider must be formal but flexible in its enforcement and it is unlikely to be viewed as a strictly legally binding document.

### Key points of good practice

SLAs should

- Describe the scope and level of service provision to the community served
- Define the resources available to support this
- Clarify understanding and agreement of all parties on what the community expects
- Provide realistic service expectations
- Be simple and free from complex language
- Focus tightly on business needs
- Concentrate on important issues (e.g. on user needs and satisfaction rather than

on producing complex reports)

- Encourage partnership working so that the commissioners collaborate with providers to facilitate service delivery within their community
- Establish strategic ownership and a forum for discussion and negotiation

It must be remembered that SLAs do not maintain themselves but require constant vigilance. They respond to environmental change and the way services are used. Customer requirements may evolve and there needs to be constant discussion and sometimes re-negotiation. Developing SLAs is an on-going learning experience and it is recommended that the people responsible undergo appropriate training.

References see page 7.



# Public service agreements: costing and linking SLAs to business planning processes.

**Lorraine Cooper,**  
**The Larian Consultancy**

*Based on presentations to the IFMH study day 'Service level agreements: straitjacket or positive management tool?' 28 January 2003.*

*Lorraine Cooper, having been involved in lending on the Euro-currency market in banking, changed career - and set up her own consultancy, The Larian Consultancy 15 years ago. For the last 11 years she has regularly worked with library and information professionals through her involvement with CILIP and undertakes training and consultancy projects with Libraries in all sectors, centring on the development of business skills.*

## **Keynote introduction**

Having been asked in this article to summarise some of the key messages in my presentations at the recent IFM Healthcare study day *Service Level Agreements - Straitjacket or Positive Management Tool?* I challenged myself whether to address some of the issues I set out in my keynote speech. On reflection, I feel this is where I should place emphasis as no summary article of this nature could cover the technical details of the other sessions presented. The reasons for engaging and developing those technical skills need however to be fully taken on board by any library professional wanting to engage with modern information provision in such a key service as the NHS. So I start this article by trying to raise your enthusiasm

and explain the rationale behind taking on some wider management skills, which traditionally have not formed part of the skills set within library and information management provision.

The world has become more businesslike in recent years with customers taking pride of place in all business decision making. We live in customer led and customer-driven times where customers have higher expectations than ever before and are better informed about those expectations. In summary, customers want better, more and cheaper services, delivered to where they want it, at exactly the time they need it and at a price they can not only afford but are prepared to pay, a factor particularly relevant in a cost challenged health service. So if the world has become more businesslike should library and information units in the health service follow like sheep? Well sheep perhaps is not the best word! But certainly these days many charities perceive themselves as businesses but still deliver their charitable aims. If a business is a collection of individuals whose role it is to fulfil clear aims for its customers or users, and deliver clear standards for them within a costing structure they can afford, and in doing so make a positive impact upon their customers' lives, then library and information units should certainly strive to be businesses.

## **Public service agreements**

The NHS is a public sector organisation managed within the government framework. The current government was elected and re-elected partly for its mandate to improve public services. One of its first acts was to undertake a comprehensive spending review of all public sector spending, resulting in three-year forecasts of medium term aims and consequent funding needs, as well as the introduction of Public Service Agreements. Public Service Agreements are agreements between the Treasury and the public sector delivery units that set out medium term aims, objectives and performance measures the Treasury expects those units to deliver, in exchange for the funding it receives. That framework is undoubtedly a business planning framework by any other name. The particular public service agreement for the NHS trusts is freely available on the Department of Health website. It includes, unsurprisingly, targets to ensure reduced waiting times for out-patient appointments and in A&E departments, the ability for patients to obtain appointments with their local GPs within 48 hours and other primary care trust professionals within 24 hours. For other targets please see *"2002 Spending Review: Public Service Agreements July 2002"*. Within that framework the establishment of service agreements between the commissioning Confederations and local library and information providers is unsurprising and a natural move towards clarity of expectations and real accountability for delivering to those expectations.

There is increasing acceptance of private sector processes and approaches being used within the NHS, private finance initiatives and the purchasing of surplus capacity from private hospitals being clear examples. Evaluation of performance is becoming the norm across most public sector organisations with independent inspection to examine the evidence of performance maintained in provider units and identify underperformance and business risks within the process. The process usually concludes with the report being made public

on a government website and a label being given to the unit inspected such as a "Three-Star Hospital", "Accredited College", "Beacon Council", and "Excellent School". Whether or not you like that way of working there is no sign that this approach will diminish.

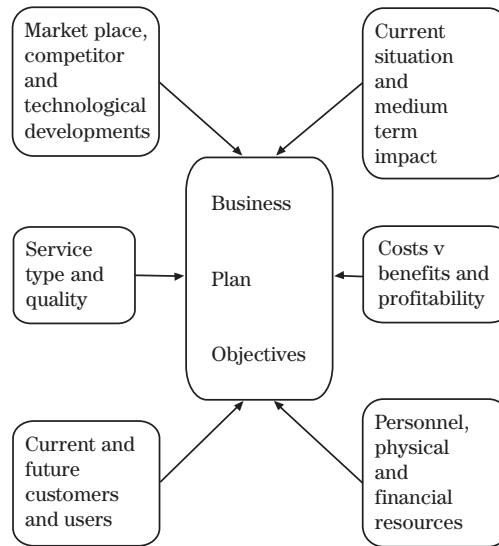
### Objectives and performance targets

So how can we use those private sector rigours and processes sensitively in public sector organisations concerned with people's health? I believe it is entirely possible to do that if we make sure we have a shared vision that focuses on end outcomes for patients. That picture needs to be delivered through clear aims, managed locally with SMART objectives. This will lead to every day functions and tasks being channelled in the direction of achievement of objectives, aims and ultimately the vision to improve people's health. In order to do that, people must be accountable for delivering those objectives and service agreements underline the seriousness with which we must rise to the challenge of improving patient care. The essential components of a good service agreement are covered ably by my colleague Shane Godbolt in her article. It is none the less worthwhile reiterating that service agreements should encompass the following broad categories: -

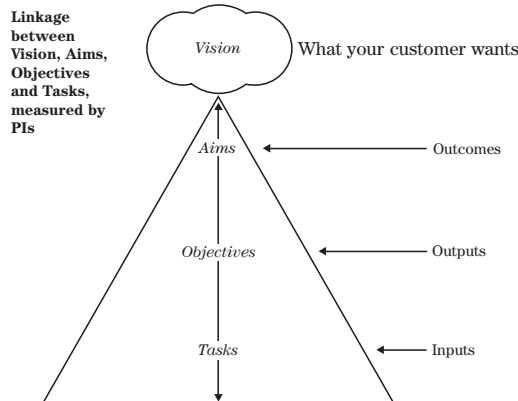
- The **type of service** on offer, its quality and quantity to be used and methods of providing the service
- The **period** of the agreement
- The **frequency or timing of delivery** of the service/product.
- **Re-negotiation clauses** which indicate events which require adjustment to the basic agreement, e.g. rises in inflation and/or rises in demand for the service.
- **Review dates.**
- **Arbitration arrangements.**
- **Price**

### Linking SLAs to business planning

So, in order to deliver to clear standards and shared understanding for the benefit of patients service agreements are best developed within a robust business planning framework. This framework seeks to evaluate issues around the main headings outlined below and from those set SMART objectives to deliver our vision.



In the process of setting Business Plan Objectives, it is vitally important that we stay focused on delivering the vision. In setting, managing and monitoring performance against business plan objectives the best organisations can immediately see the linkage between everyday tasks and objectives and the aims and vision of the organisation. Equally, strategic management must be able to be confident that their vision is being delivered locally through carefully developed objectives and day-to-day work plans.



A well-managed organisation will find that their inputs in the form of tasks work towards the achievement of their outputs in the form of objectives and deliver outcomes for the customers in the aims. If that process works well achieving the organisational vision is a piece of cake!

For me business planning is the ultimate management tool. Staff management skills are needed to enable us to motivate staff towards delivery of objectives. Tasks need to be delegated so that they are done at the lowest appropriate skills levels, freeing up high-level skills for more imaginative and creative work. We need performance management skills, with real accountability and objectives introduced into staff appraisals for clarity and transparency purposes. Inevitably staff development must be sound both for the organisation and for individuals if we are to be able to assume high levels of performance in staffing skills.

The moment we've got the staff sorted out we can start serving customers well. A positive customer interface that meets customer expectations and hopes and is able to deal with customer disappointment and complaints in open-minded ways is essential. Organisations must be able to benefit from negative customer feedback in positive ways for business development purposes. If that's in place we're well on the way to excellence but we must be very self-challenging and ensure that we are looking at service development issues for customers as well. As providers we must be able to deliver to customers what they want for the future not what we think they should have. Beauty is in the eye of the beholder and if your customer perceives your service is not for them, their perception is your reality!

### Financial aspects

And if you think I've now nearly covered all the management skills you'll need to think again. Financial control skills are essential for any library and information manager these days. You will be required to provide your services under your service agreements at agreed costs. The customer will want to get what they pay for and pay for what they get. Your organisation will not want you to commit to an agreement or contract that you

cannot afford to deliver. That being the case, you need refined financial control skills that include skills around budget setting management and controlling, costing and cost efficiency contract management and charging realistic prices that your customers can afford.

Once you've done that you're nearly there. The real test is when you undertake some business evaluation within a robust benchmarking framework that looks at methods of service delivery, cost and quality thresholds as well as the service range. Your business evaluation skills need to bring about a situation where you ensure delivery of a modern effective and relevant service, achieving and maintaining a good reputation for your service. That probably means not repeating what you have always done in the past. Business planning should be an innovative process and library and information managers need to become innovative to survive and succeed. Otherwise Confederations are likely to choose to purchase library services from an alternative provider to ensure that support for patient care is at a cutting edge level. Confederations will be focused on outcomes and outcomes only. If the customers will get a better deal by choosing to do things differently my best bet is that Confederations will take those decisions in time.

So challenging traditional ways of working is essential.

- There must be something new you can do for your customers
- There must be something old you can stop doing without the customers noticing
- There must be some administration you could stop doing without anybody noticing!
- If your customers don't like it stop doing it Even if it's your favourite thing
- If the customer doesn't notice you're doing it stop doing it!
- There must be something other providers are doing that you're not. Start doing it quickly

- If you haven't thought about changing something this week you haven't earned your salary
- If you haven't implemented something new this month you haven't earned your salary

#### Aspects of costing services

And finally, this article would be incomplete if I didn't also include an element about the costing issues you need to face. Most library and information professionals in the public sector have grown up with a public service ethos that focused on service delivery without considering the cost implications. That atmosphere is now dead indeed. All public sector organisations are required to bring cost conscious decision making to their skills set and inevitably that means we need to know exactly what our costs are. Costing services is a complex issue, which is why a cost accountant is a professional in their own right That being the case I can barely give you more than an injection in this article about costing issues but I'm afraid it will bring precious little immunity! The library and information manager of the 21st century must develop financial and other costing skills and embed them as core competences.

There are different reasons for costing services but for the most part they fall into these broad categories

- Setting prices for operating under contracts, service agreements or for determining budget funding levels
- Informing pricing reviews and negotiations
- For control of costs to within previously agreed levels so that contracts and agreements do not run into deficit
- Benchmarking comparison with other providers. The absence of costing data when benchmarking makes a nonsense of the whole benchmarking work, since quality and cost are two sides of the same coin

As I said earlier, purchasers should pay for what they get and

get what they pay for, so it is essential to cost your service agreements. Costing service agreements enables you to assess your ability to deliver service quantity and quality thresholds within the price the purchaser can afford to pay. Further, when there are issues around the purchaser wanting more than the value they are prepared to commit in the price they want to pay, costing issues can help to prioritise the purchaser's needs. No doubt you have heard the expression appreciating the worth of everything and the value of nothing. Costing services does not mean that we only understand the worth. Cost and quality are two sides of the same coin and the purchasers will use the price you set in your agreement to evaluate the worth and value for their customers - patients. Inevitably this will mean that there will be some decisions that will cause cost and quality compromises to be discussed.

There are some key steps in costing approaches as follows: -

- An assessment of chargeable or non chargeable time or, if you prefer, productive and non-productive time –Time is money
- Calculation of the hourly rates of people who contribute to the service agreement
- Identification of equipment and materials needed to deliver the agreement
- Decisions on how to apportion shared costs across different service activity areas Calculation loading on individual services

Once costing services has been completed, the unit costs derived from the costing processes can be used to cost up the particular agreement as follows: -

## Theoretical costing examples

Cost Type	Document Delivery	Electronic Resources	Issues
Staffing	£125000	£60000	£40000
Materials	£40000	£100000	£400000
Overheads	£41000	£30000	£110000
Total Cost	£206000	£190000	£550000
Driver & Numbers of Units	Documents delivered 15000	Searches 200000	Loans 125000
Average Unit Cost	£13.73	£0.95	£4.40

CUSTOMER GROUPS	SERVICE TYPE	UNITS OF ACTIVITY	UNIT COST	CHARGE
Training doctors	Enquiries	Hours: 500	£40	£20000
Graduate nursing students	Enquiries	Hours: 200	£40	£8000
Graduate nursing students	Document Delivery Requests Satisfied	Number of items: 6000	£13.73	£82380
Training doctors	Document delivery Requests Satisfied	Number of items: 3500	£13.73	£48055
<b>TOTAL</b>				<b>£158435</b>

If the customer in the particular service agreement concerned estimated their potential needs for document delivery at say 2000 documents, then the price for that part of the contract would be  $£13.73 \times 2000 = £27,460$ .

I hope the illustration above clarifies the need to undertake some varied thorough costing of services before pricing up agreements. Often this is left too late and customers can be led into an unrealistic expectation that the costs of services are lower than they are. If for instance you had already been providing document delivery services at £8, having plucked that figure out of the air, your customers will not understand when next year, having undertaken a professional costing of your services, you now need to increase the price by such a large amount. It is for precisely this situation that robust costing of services needs to be undertaken before decisions are taken around quantity and quality thresholds to be included in particular contracts. Understanding costing structures is also very important. A library in its present structural format incurs higher levels of fixed-costs for buildings, minimum materials and minimum

professional staffing levels. Those costs need to be incurred before you can call yourself a credible library - or do they? High levels of fixed costs in library units, taken together with the immense moves towards electronic provision, makes the arrival of the virtual library inevitable. And why couldn't that virtual library be situated in India serving every NHS trust in the country? For unless you get your hands dirty by costing your services and realising the medium term implications your costing structure imposes upon you, you will not have the opportunity to take remedial action. Thus remote electronic provision of information might well be provided from Delhi as is already the case with software support these days.

But perhaps most of all the reason to cost services is that without understanding costs, you cannot sell yourselves to the full. Once you understand what your hourly rate is for information search skills, or that a document delivery item can be provided at the miniscule cost of £13.73, then you have the opportunity to make statements as follows: -

*"If the consultant had searched for this it would have taken them at least one hour; it took us a quarter-of-an-hour. The consultants hourly rate is £200, ours is £40. You received this information for £10 instead of £200. What's more, our information search skills mean we won't select information for you as a consultant that's only appropriate for a nurse and we will search worldwide. We bring wider access and higher quality to information searching, for less cost".*

How could anyone fail to appreciate the value of library and information provision if you can make statements like that?

### Conclusion

So in answer to the question posed by the title of the study day Service Level Agreements - Straitjacket or Positive Management Tool?, I don't have a shadow of a doubt that if used positively and properly service agreements can be the positive management tool that will defend you from attack. What other service is there in the world that could be relevant to every single person in the population, provide quality outcomes with positive personal impact in such cost efficient ways? Service agreements should not be feared they should be welcomed!

*Note: Any figures provided in this article should not be taken as a useful benchmark. They are illustrative only and chosen for ease of calculation and communication and do not represent the costs of any particular library and information unit.*

# KEY COMPONENTS OF SERVICE LEVEL AGREEMENTS

Shane Godbolt

*Based on presentations to the IFMH study day 'Service level agreements: straitjacket or positive management tool?' 28 January 2003. This presentation has been summarised by Susan Mottram, University of Leeds*

An SLA should be a short, formal document and should contain

- Definitions of the user groups to be covered
- Pricing schedule/list of charges and terms
- List of services to be provided including levels of service
- Details of monitoring mechanisms (what output measures and how data will be collected and evaluated)
- Length of the agreement and notice to quit
- Key responsibilities of all parties
- Arrangements for re-negotiation
- Arrangements for the resolution of disputes

## Negotiating SLAs

There are no hard and fast rules and much will depend on the setting and what parties are involved. Senior management will probably establish the strategic context, will perhaps nominate the negotiators and should be supportive of the process. The negotiators will have a good understanding of user needs and will have defined these. They will have a thorough knowledge of the service and will have the authority to make decisions. They will also be aware of the local political environment, will be good at partnership working and will have an overview of the objectives and agendas of both (all) involved parties.

The process of developing an SLA will initially involve the commissioner (purchaser / client) drawing up a specification. This will require a disciplined review of the alternatives and an awareness of the whole range of available provision. The provider will then address the specification and a dialogue will develop to consider needs and the level of provision required.

There are 10 key steps in the SLA development process

- Assess whether an SLA is appropriate
- Get management commitment
- Designate SLA managers
- Educate the parties involved about SLAs
- Assess current services
- Gather customer feedback
- Ensure agreement about the agreement; create a draft
- Solicit feedback
- Complete pre-implementation activities such as establishing tracking mechanisms and conducting pilots
- Implement and manage the SLA

The SLA will need to be embedded into practice and clear lines of responsibility should be established so that all parties know who to turn to for advice and guidance. Good communication is essential to identify and resolve problems and differences of opinion as well as to share information.

## Judging success

Some questions to ask in order to assess the success of the SLA could include:

- Does the outcome satisfy the need?
- Do the parties feel they had an effect on the outcome?
- Are the stakeholders willing and able to implement the agreement?
- Does the agreement produce joint gains for all?
- Were communications between the parties increased and the working relationships improved?
- Has the agreement held up over time? Was the process efficient in terms of time and resources?
- Does the solution conform to available objective standards?
- Do all the parties perceive the procedures to have been fair?

A successful collaboration will satisfy most, if not all, of these criteria. A collaboration that produced a fair and lasting agreement would be judged a success even if the process of achieving may have seemed gruelling and inefficient at the time.

The key lessons learnt from developing work in this area are

- Recognise and understand interdependence of parties especially in the educational/ library context
- Recognise cultural and value differences and avoid making assumptions; become skilled at active listening, summarising and checking out with partners

## References and further readings

Ashcroft, Margaret. Provision of library and information services to nursing professionals : NURLIS phase II : management guidelines. London : English National Board for Nursing, Midwifery and Health Visiting, 1993. p. III:10

Department of Health and the Higher Education Funding Council for England. *Statement of strategic alliance for health and social care*. London: Department of Health. p. 1 Available at:

<http://www.doh.gov.uk/research/documents/strategicallianceapril2002.doc> [25 March 2003]

Griffiths, Roy. *NHS management inquiry*. London : Department of Health and Social Security, 1983.

Fisher R, Ury W. *Getting to yes: negotiating agreement without giving in*. 2nd ed. Houghton Mifflin 1991.

Gray B. *Collaborating: finding common ground for multiparty problems*. Jossey-Bass, 1991.

Sheila Pantry, Peter Griffiths. *The complete guide to preparing and implementing service level agreements*. Library Association 1997.

Fisher R., et al. *Getting it done: how to lead when you are not in charge*. Harper Business, 1998.

# SERVICE LEVEL AGREEMENTS (SLAs): RESOURCES GUIDE

**Bertha Yuen Man Low;  
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"A service level agreement (SLA) is an agreement between the provider of a service and its customers which quantifies the minimum quality of services which meets the business needs." -- Hiles AN. Service level agreements: panacea or pain? *The TQM Magazine* 1994;6(2);14-16.

The concepts of value for money, the competitive marketplace of the information industry, and the ever changing NHS structure demand cost-effectiveness and create new ways of working among service providers and customers; and SLAs are often used to define such working relationships. As a support service, libraries have the chance to be involved in SLAs as either a service provider or as a customer. This short guide lists resources introducing the basics of SLAs and the skills involved in drafting them.

## **SLA Basics ...**

Sheila Pantry, Peter Griffiths. *The complete guide to preparing and implementing service level agreements*. Library Association 2001. -- covers practical, step-by-step guidance to constructing and implementing an SLA and gives a SLA outline.

Larson KD. The role of service level agreements in IT service delivery. *Information Management & Computer Security* 1998;6(3);128-132. -- introduces the concept of service level agreements in IT service provision, especially in the case of outsourced service provision.

Parish RJ. Service level agreements as a contributor to TQM goals. *Logistics Information Management* 1997;10(6);284-288. -- illustrates how the adoption of SLAs can assist an organization in its drive to achieve Total Quality

Management (TQM) goals.

Pratt KT. Introducing a service level culture. *Facilities* 1994;12(2);9-15. -- explores how to convert the organisation's customer needs into a menu of quality, volume and cost, and how to establish service level information from the point of view of project management.

## **Service Costing ...**

Cooper, Lorraine. How much should it cost?: an introduction to management use of costing information. *Health Libraries Review* 1997;14(4):209-217. -- discusses the various reasons for costing services and how costing information can influence our management decision making; and covers considerations in cost control, comparison of costs with other providers, setting prices, and forecasting cost levels.

Snyder, Herbert. *Costing and pricing in the digital age: a practical guide for information services*. Library Association 1997. -- introduces cost allocation, cost accounting and charging for services.

McKay D. *Effective financial planning for library and information services*. Aslib 1995. -- introduces budgeting, service costing, financial report and accounting.

Roberts SA. *Cost management for library and information services*. Butterworths 1985. -- discusses service cost structure and gives a checklist of cost study process.

## **Negotiation Skills ...**

Drawing up SLAs involves negotiation. The following references introduce the craft of negotiating mutually satisfactory agreements, especially in difficult situations.

Fisher R, Ury W. *Getting to yes: negotiating agreement without giving in*. 2nd ed. Houghton Mifflin 1991.

Ury W. *Getting past no: negotiating with difficult people*. Century Business 1992.

#### Examples of SLA ...

City University Library and Information Services  
<http://www.city.ac.uk/library/using/slas/sla.htm> -- these service level agreements set out key service targets to be achieved by the Library, Information Services (LIS) for the benefit of customers of the City University; and give an example of specifying the quality of service and monitoring mechanisms.

Service level agreement between colleges and learning resource centres, other client groups, and the Bibliocentre  
<http://biblioweb.cencol.on.ca/ServiceLevelAgreement3.HTML> -- this service level agreement is between the Ontario colleges Bibliocentre and the colleges and clients in Ontario to whom the Bibliocentre provides services; and presents a different format of SLA.

# SIDELINES

**Compiled by Su Golder, Kate Light, Lisa Mather, Vickie Orton, and Kath Wright of the Centre for Reviews and Dissemination, University of York.**

*Crystal ball gazing features largely in this issue. The future of scientific communication and publishing is provoking widespread debate and some interesting suggestions are presented for your consideration. This issue also looks at the impending impact of recent Data Protection and Freedom of Information legislation. And as always there are papers on the impact of the Internet on use of and access to health information!*

**LaPorte RE, Linkov F, Villasenor T, Sauer F, Gamboa C, Lovalekar M, Shubnikov E, Sekikawa A, Sa ER. PowerPoint to PowerPoint (P 2 P): metamorphosis of scientific communication. BMJ 2002;325:1478-1481.**

LaPorte and his colleagues investigate the possibility that the traditional forms of scientific communication, as represented by the journal system, are about to change. They suggest that the obvious successor is the PowerPoint presentation, since it can be made to fit the criteria of scientific communication, is easy, relatively cheap, fast and controlled by scientists themselves.

The article suggests the change will happen in the following stages.

- Stage 1: A move from the complex style of journal articles to the straightforward style of PowerPoint presentations.
- Stage 2: The removal of the journal as middleman, to allow direct peer-to-peer communication.
- Stage 3: PowerPoint templates, such as those currently used in training sessions, will dictate the structure of the content. This would replace the current pattern (introduction, methods,

results, discussion) that the authors argue may not be an optimal method of communication.

- Stage 4: Peer review will give way to a scientifically appraised method of quality control.
- Stage 5: Cost reduction.
- Stage 6: The ability to reach populations with special needs.
- Stage 7: The speed of scientific communication will increase.

The article concludes with a call for an evidence-based evaluation of all systems of scientific communication.

**Delamothe T. Is that it? how online articles have changed over the past five years. BMJ 2002;325:1475-1478**

This is a brief review of developments in electronic journal publishing over the last five years, with predictions for the future. In particular, the authors comment on how web publishing now often precedes publishing in print, allows for the inclusion of additional material, has made peer review and copy editing less important, and enables linking to other articles. While the researcher may access journals via the Internet rather than visiting a library, she or he use downloaded copies in the same way as copies made from printed journals.

**Abbasi K, Butterfield M, Connor J, Delamothe T, Dutton S, Hadridge P, Horgan A, Smith J, Smith R, Walford E, Williamson A. Four futures for scientific and medical publishing. BMJ 2002;325:1472-1475**

Abbasi and colleagues envisage four future scenarios for publishing that are illustrated using the four characters in the Simpsons cartoon family! In the

Homer model, publishers adapt technology and continue to publish research while in the Lisa model publishers are replaced with a global network enabling researchers to communicate with each other directly. The other possible scenarios outlined are the Marge model where academics begin to publish directly on the web and the Bart model where mainly companies provide information and traditional publishing is redundant.

**Welburn B, McNally N, Kerrison S. Get in on the act. Health Service Journal 2002;5 September:18-19.**

The process of reaching full compliance with the Data Protection Act of 1998 takes time and effort. This paper summarizes work carried out at the University College London Hospitals Trust (UCLH) on developing an information security policy in relation to patient data for research to comply with the legislation.

The development of the policy at UCLH involved an audit of recently completed research in the Trust and consultation with researchers via interviews, the circulation of a draft document and lunchtime seminars. The consultation process identified three key elements.

Firstly, where information given by the patient is to be used for more than their immediate care written consent must be sought. A checklist produced at UCLH is then summarised.

Secondly, the "data controller" and the "data owner" must be clearly defined. The data controller, in this case UCLH, has responsibility for providing policies, guidance and training for staff to aid the implementation of the Act, whereas the data owner is responsible for the security of their study data.

Thirdly complications may arise when research is being carried out in collaboration with third parties. Written agreement between parties needs to be sought even in the case of teaching hospitals and universities despite sharing staff, offices and equipment. Those working with collaborators in the US should work with members of the voluntary Safe Harbor

framework. Although missing much of the detail of the policy at UCLH this paper would be of interest to researchers or research departments using patient information.

**Jones D, Miles C. Licence to look. Health Service Journal 2002; 5 September:20.**

This article outlines the ways in which NHS organisations will be expected to comply with the Freedom of Information Act when it is fully enforced in January 2005. The Act changes the focus from everything being secret unless otherwise stated, to the reverse - that everything is public unless it falls into specified cases.

The two main responsibilities for NHS bodies will be a requirement to produce a 'Publication Scheme', and to deal with individual requests for information.

Publication Schemes set out the types of information an authority publishes, the form in which it is published and whether a charge will be made. Members of the public can then request this information. NHS organisations will have to conduct a full audit of all information they produce, and sound records management procedures will need to be put in place.

From January 2005, individuals will be able to access all types of personal and non-personal data held by a public body, including third-party information, although the Data Protection Act may apply to some personal information. Access will not be restricted, and anyone - including the media - may apply.

Codes of practice are currently being produced offering guidance to authorities on implementing the Act.

**Fritsche L, Greenhalgh T, Falck-Ytter Y, Neumayer H-H, Kunz R. Do short courses in evidence-based medicine improve knowledge and skills? Validation of Berlin questionnaire and before and after study of courses in evidence based medicine. BMJ 2002;325:1338-1341.**

The Berlin questionnaire is a series of questions designed to evaluate knowledge and skills

relating to evidence based medicine. It was tested on experts in evidence-based medicine, and a control group of third year medical students who had no previous exposure to evidence based medicine. It was also tested on a group of students participating on an evidence based medicine course, but who had little previous exposure to evidence based medicine. The test results distinguished accurately between the three groups.

This instrument was then used to assess the effects of a three-day course in evidence-based medicine. The course was aimed at doctors with high motivation but little previous knowledge of evidence based medicine. The test was administered on a before and after basis and detected a significant increase in the skills and knowledge of the participants.

The authors noted that their tool had been designed only to test short term learning and that more research is needed to assess the impact of teaching on long term clinical behaviour.

**Cooke A, Gray L. Evaluating the quality of Internet-based information about alternative therapies: development of the BIOME guidelines. Journal of Public Health Medicine 2002;24(4):261-267.**

BIOME is a collection of gateways to selected and evaluated health/life sciences resources on the Internet. There are currently five main databases in total, including OMNI and NMAP. BIOME uses a set of resource evaluation guidelines to identify high quality web sites for inclusion in any of its databases.

The aim of this study was to develop additional guidelines that were suitable for the evaluation of information relating to alternative medicine. Guidelines were drafted by an expert committee, and were tested on 20 sites covering the topic of alternative therapies for cancer already on the BIOME databases. Current BIOME content providers carried out the evaluations.

All content providers selected one site out of 20 as being suitable for inclusion in BIOME, and all agreed that a further nine should be excluded. However, there were

discrepancies on the remaining ten resources, indicating that further development of the BIOME guidelines on selecting alternative therapy resources is required.

**Mead N, Varnam R, Rogers A, Roland M. What predicts patients' interest in the Internet as a health resource in primary care in England? Journal of Health Services Research and Policy 2003;8(1):33-39.**

This study assessed why the uptake of a free, guided Internet service provided to patients in one inner city general practice in Manchester had been very low.

To assess some of the factors that influence patients' interest in Internet-based health resources, questionnaires were distributed to the patients in the inner city practice. The questionnaire was also administered to patients from a suburban practice with a relatively affluent population.

660 questionnaires were analysed from the survey. Internet use appeared to be influenced by motivational factors, such as patients' belief that the Internet would help them to deal better with their health, previous use of health websites, confidence in the use of technology, social deprivation, and having school-age children at home. As suggested by the low use of the service provided by the general practice in Manchester, although access is important, it is not the only factor influencing the uptake of Internet-based health information. Motivational issues seem more important, and these need to be addressed if the use of digital health information is to become more widespread.

**Rhodes SD, Bowie DA, Hergenrath KC. Collecting behavioural data using the world wide web: considerations for researchers. Journal of Epidemiology and Community Health 2003;57:68-73.**

The use of the Internet for collecting research information is nothing new. This paper, however, examines the advantages and challenges of questionnaire surveys online. The authors draw

on their own experiences and emphasise their key points in relation to obtaining social behavioural data. Numerous advantages of electronic surveys are listed:

- the minimisation of error via pull-down menus and selection lists
- flexibility in making adjustments to the survey
- being able to document the length of time taken to complete the survey
- reaching respondents across geographical and cultural boundaries
- lower costs of mailing, and shorter time for postage
- access to previously hidden populations
- prevention of error from survey administration, interview interpretation and data entry
- people are willing to share information and experiences on sensitive topics electronically
- the cost of data collection is reduced due to automated data entry and questionnaire administration
- fewer training needs for interviewers
- a reduction in paper, printing postage and paper storage.

The challenges, on the other hand, include sampling issues, unknown response rates, multiple submissions, access to the web, literacy, anonymity and confidentiality and informed consent. Although this paper does give some food for thought regarding survey methods, a comparison of electronic surveys with paper surveys and interviews via telecommunications and face-to-face interviews might have been more appropriate.

**Abbott S, Florin D, Fulop N, Gillam S. The meaning of 'health improvement'. Health Education Journal 2002;61:299-308.**

This paper reports on the results of 107 semi-structured interviews

with key health professionals and personnel. The aim of the study was to ascertain how those working in and with Primary Care Organisations (PCOs) understand the term 'health improvement'. Three categories of meanings for the term emerged from the analysis of the interviews. Firstly, a broad philosophical definition, secondly, 'health improvement' as a national government policy and lastly as a local activity. The authors report on the overlap of these definitions and look at the differences between responses from different professional groups, different sites and the Government's definition and those found in the study.

**Fone D, Hollinghurst S, Bevan G, Coyle E, Palmer S. Information for clinical governance: analysis of routine hospital activity data in Wales. Journal of Public Health Medicine 2002;24 (4):292-298.**

The authors explored how information on variations in hospital admission rates can provide useful information for clinical governors. A cross sectional analysis of hospital activity data was undertaken for the 22 Local Health Groups (LHG) in Wales and 101 general practices in Gwent Health Authority.

The research found considerable variation in standardized hospital admission ratios between the LHGs in Wales and practices in Gwent. Despite issues surrounding the quality and availability of data the authors suggest that the research provides potentially useful local information on variation to primary care decision makers and can contribute to the process of reducing medical practice variation. Further research is planned to evaluate the impact of the tool.

**Gulliford MC. Availability of primary care doctors and population health in England: is there an association? Journal of Public Health Medicine 2002;24(4):252-254.**

It was recently reported by Shi et al that in the United States there was an ecological association between low access to primary care and higher population

mortality. This paper examines whether the same relationship can be found in England, which has a different political environment and health care system.

Relevant data from 99 health authorities in England on initial analysis indicated that there was lower hospital utilization from acute or chronic conditions, and lower teenage conception rates in areas with higher general practitioner (GP) supply. However, further factors need to be taken into consideration as GPs in more affluent areas generally have better facilities, provide more services and offer longer consultations with higher quality of care.

The authors conclude that need and outcome cannot be distinguished in cross-sectional data; future studies require longitudinal data collected at both the individual and the area level. The authors feel their research indicates the continuing need to reduce inequality in the supply of GPs and to increase the effectiveness of primary care services in deprived areas. They also suggest that the geographical allocation of resources for hospital and primary care services should be linked.

# NeLH UPDATE

**Alison Turner;**

**Library Partnerships Co-ordinator, NeLH**

*If you thought 2002 was a busy year for NeLH, you ain't seen nothing yet! 2003 is going to be a very busy year for the whole of NeLH. The year has started with a flurry of activity around preparation of the Full Business Case for NeLH and the complex process of procuring a range of resources and services. At the time of writing, the Full Business Case has passed three crucial milestones: it has been approved by the Programme Board, by the NHS Information Authority Board and the project has passed OGC Gateway 3 (investment decision) with a green light. The remaining stage for the business case is approval by the Department of Health as soon as possible.*

The Library itself will undergo considerable change over the coming year, thanks to gradual improvements to look and feel, navigation and search facilities. Virtual Branch Libraries will be re-badged as Specialist Libraries which may help to avoid some of the confusion which users have felt in the past. Major changes will be flagged in the NeLH Updates distributed via the list-medical and nelh discussion lists. Alternatively, you can visit the About Us pages on NeLH to access these newsletters online.

In terms of procuring Library resources and services, this was well underway at the time of writing. The suppliers for content and for Specialist Libraries have been selected. A further procurement, for a Health Information Environment has also begun.

## **News from January - February 2003**

- **150 new Guidelines** were added to the Guideline Finder database – following a survey of Specialist Library requirements. Non-UK guidelines will now be added and look out for future changes in news features for guidelines.
- **Development of the new Resource Management**

**System** for NeLH has started. Child Health, Coronary Heart Disease, Musculo-skeletal Diseases and Communicable Diseases will trial the system during Feb/March together with the Guidelines Finder and NSF Zones. The URL for the prototype system will be shared with other Specialist Libraries and evaluation will lead to a full working version for April/May this year. Specialist Library content will migrate to the new system over the coming year and there will further development of enhanced functionality during this time.

- **NeLH Emergency Care** launched an emergency care leads toolkit. This resource has links to all sorts of documents and evidence around emergency healthcare modernisation. [www.nelh.nhs.uk/emergency](http://www.nelh.nhs.uk/emergency)
- **NeLH Record-Breaking Usage.** NeLH recorded 3.8 million hits in January, equalling its previous record month of November 2002. NeLH now has 54,000 users a month, which has doubled over the last 12 months.
- **NeLH will be using “Web Trends live”** for reporting statistics and will in future be reporting page impressions as an indicator of use along with unique hosts.
- **The NeLH Communication Plan** for 2003/6 has been completed. Key elements are to have 200,000 unique hosts accessing the library per month by 2006 together with 300 strong network of facilitators working with clinicians to firstly raise awareness of the library then raise standards of searching and finally help users integrate

know how and knowledge with practice.

- **Review of Training & Promotional materials.** All NeLH items are being reviewed and updated in the next two months in collaboration with stakeholders. There are still promotional items at [www.nelh.nhs.uk/publicity](http://www.nelh.nhs.uk/publicity) and posters are available for download. Orders for new materials are being taken on 08453 660066.
- **A series of events** are being arranged for trainers and librarians in a master class format. At these events delegates will be able to access detailed training of the major resources and have an opportunity to join the NeLH network. Details will be released in March on [www.nelh.nhs.uk/librarian](http://www.nelh.nhs.uk/librarian)
- **F.O.L.I.O** (Facilitated Online Learning Interactive Opportunity). During January, around 200 health librarians across the UK took part in the first 3-week online course on project management. The course (the first of three run by Andrew Booth of ScHARR), run as pilot as part of the NeLH Librarian Development programme, was free to NHS Librarians (including academic and charities). The second course, "Evaluating Your Service", began in February with around 150 participants. The third course, on evidence-based librarianship, will be delivered via the evidence-based-libraries list and will be opened up to international participants. The whole programme will be evaluated to feed in to future training developments.
- **Networking with NeLH :** a mini conference for NHS library staff. To be held on the 10th March, the day is designed to update library staff on the latest developments and to give library staff a chance to feed in their ideas, comments and suggestions. Notes and presentations from the day will be made available via the Librarian Portal [www.nelh.nhs.uk/librarian](http://www.nelh.nhs.uk/librarian).

# IFM HEALTHCARE COMMITTEE NEWS

January 2003 saw a number of committee member changes. We bade farewell to Steve Rose of Oxford University, who had served on the committee for over seven years, most recently as Chair of IFMH. Thanks for all your hard work Steve. Maria J Grant ([m.j.grant@salford.ac.uk](mailto:m.j.grant@salford.ac.uk)) of Salford University has become our new Chair, and is joined by Karen Macpherson (NHS Quality Improvement Scotland - [kmacpherson@htbs.org.uk](mailto:kmacpherson@htbs.org.uk)) as Secretary of IFMH. Meanwhile, Susan Mottram (University of Leeds - [s.j.mottram@leeds.ac.uk](mailto:s.j.mottram@leeds.ac.uk)) has joined Alison Brettle (University of Salford - [a.brettle@salford.ac.uk](mailto:a.brettle@salford.ac.uk)) as Joint Study Day Co-Ordinator, whilst Pat Spoor (University of Leeds - [p.a.spoor@leeds.ac.uk](mailto:p.a.spoor@leeds.ac.uk)) is in the newly formed post of Web Site Editor. Watch out for the relaunch of our web site later this year!

**For more information on IFMH  
visit our Web site at:  
[www.york.ac.uk/inst/crd/ifmh](http://www.york.ac.uk/inst/crd/ifmh)**

## Managed Clinical Networks

<p><b>What are... Managed Clinical Networks?</b></p>	<p>There are many definitions of managed clinical networks, both within the UK and other countries. One definition often quoted is that from a Management Executive Letter Circular released by the Scottish Office Department of Health as the result of an Acute Services Review by the Scottish Office in 1998<sup>1</sup>.</p> <p>This circular defined managed clinical networks as “linked groups of health professionals and organisations from primary, secondary and tertiary care working in a co-ordinated manner, unconstrained by existing professional and existing [organisational] boundaries to ensure equitable provision of high quality, clinically effective services.”</p>	<p><b>What are... Managed Clinical Networks? Why are they important? What do I need to do? What are the benefits? Whom can I contact? Where can I find examples of good practice? Resources References Comments</b></p>
<p><b>Why are they important?</b></p>	<p>The <u>NHS Plan</u>, <u>National Service Frameworks</u>, <u>Action On</u> and <u>Collaborative</u> programmes all represent initiatives which often involve more than one organisation.</p> <p>Managed Clinical Networks are one way of ensuring that organisations within a locality can work together to jointly improve the service provided to patients and their relatives. In particular they can mean improvements in the quality of the service, access to the service and seamless care across the primary, secondary and tertiary interfaces.</p> <p>Managed Clinical Networks also represent the opportunity to achieve this within a multidisciplinary forum.</p> <p>With recruitment difficulties and the need to sustain appropriate levels of clinical skills and expertise as well as the increasing sub specialisation amongst the medical staff, managed clinical networks are considered to provide the opportunity to overcome these potential problems.</p> <p>In 1999 Dr Boon in discussing cardiac services concluded that “the concept of managed clinical networks hopes to address the dilemma by concentrating specialist activity while dispersing the expertise through the medical community”<sup>2</sup></p>	
<p><b>What do I need to do?</b></p>	<ul style="list-style-type: none"> <li>• Contact the <u>NHS Confederation</u> for their discussion paper on Clinical Networks (see <i>Whom Can I Contact?</i>)</li> <li>• Find out who has responsibility for clinical networks and their development within your Strategic Health Authority area, PCT or NHS Trust.</li> <li>• Ascertain what specialties currently have or are forming networks within your area of work and consider what value they can offer</li> <li>• Reflect on the national and local initiatives for the specialty under consideration and consider whether a managed clinical network could be of practical value</li> </ul>	

	<ul style="list-style-type: none"> <li>• Ensure that you also gain awareness of the potential difficulties with managed clinical networks and the requirements to ensure their successful implementation</li> <li>• Read <i>Managed care networks: principles and practice</i>, ed. R James &amp; A Miles<sup>5</sup>.</li> </ul>	
<p><b>What are the benefits?</b></p>	<p>The South East Regional Office in England suggests that “the development of managed clinical networks can add value to service provision and help solve difficult clinical issues. There is significant potential for breaking down the traditional barrier between primary, secondary and tertiary care and between health and social care”<sup>3</sup>. Nigel Edwards, policy director for the NHS Confederation writes in the <i>BMJ</i> that “Networks offer a way of making the best use of scarce specialist expertise, standardising care, improving access, and reducing any ‘distance decay’ effects that can result from the concentration of specialist services in large centres”<sup>4</sup></p>	
<p><b>Whom can I contact?</b></p>	<ul style="list-style-type: none"> <li>• The <u>NHS Confederation</u> has produced a discussion paper on Clinical Networks and looks at what a network is, what issues they can be expected to deal with, how success might be defined, how they can be managed and commissioned and considers some of the possible opportunities and risks.</li> </ul>	<p>Management Briefings are short briefing papers produced by experienced health management librarians &amp; other professionals. Their purpose is to provide a brief introduction to topics of current concern.</p>
<p><b>Where can I find examples of good practice?</b></p>	<ul style="list-style-type: none"> <li>• <u>Dumfries &amp; Galloway Managed Clinical Networks for Coronary Heart Disease.</u></li> <li>• <u>South West London HIV &amp; GUM Clinical Services Network</u></li> </ul>	
	<p><b>Resource Sites</b></p> <ol style="list-style-type: none"> <li>1. Review the <u>South Eastern Regional Office</u> paper on Managed Clinical Networks.</li> <li>2. Visit the <u>Health Services Management Centre, Birmingham</u> website.</li> <li>3. See also related Management Briefings on <u>Change Management</u>; <u>Workforce Planning</u>; and <u>National Service Frameworks</u>; also the <u>NeLH Web site</u></li> </ol>	<p>Information is obtained from the HMIC database and from desk-based Web research. Readers are advised to consider further information before acting on information contained in Management briefings</p>
<p><b>References</b></p>	<ol style="list-style-type: none"> <li>1. The Introduction of managed clinical networks within the NHS in Scotland. Management Executive Letter Circular MEL (1999)10. The Scottish Office Department of Health; 1999.</li> <li>2. Boon NA. Cardiac services: bigger is better but managed clinical networks are best. <i>Scottish Medical Journal</i> 1999; August 44(4):101-2</li> <li>3. NHS South East Regional Office. Managed clinical networks. 2000</li> <li>4. Edwards N. Clinical networks. <i>British Medical Journal</i> 2002; January 324(7329): 63.</li> <li>5. James R, Miles A, eds. <i>Managed care networks: principles and practice</i>. London: Aesculapius Medical Press, 2002. ISBN 1903044278</li> </ol>	
<p><b>Comments</b></p>	<p>Please address all comments, suggestions or ideas for improvement to the compiler, <u>Jane Bushby</u>.</p>	<p>This briefing will be reviewed and updated in June 2003</p>

