Fostering participation, collaboration and working well together across systems to meet the shared challenges for our future healthcare

Analysis of the results of the on-line survey April 2016

This report has been produced by Wellsteed Associates on behalf of the NHS London Leadership Academy (LLA) and HEE Kent, Surrey and Sussex Leadership Collaborative (KSSLC).

Background

An online survey was conducted by LLA and KSSLC with key stakeholders in London, Kent, Surrey and Sussex during April 2016. The aim of the survey was to identify the key challenges of system working, the current engagement in systems and the level of interest in a supported Community of Practice approach. The survey was open for a short period and there were 73 responses.

The Survey

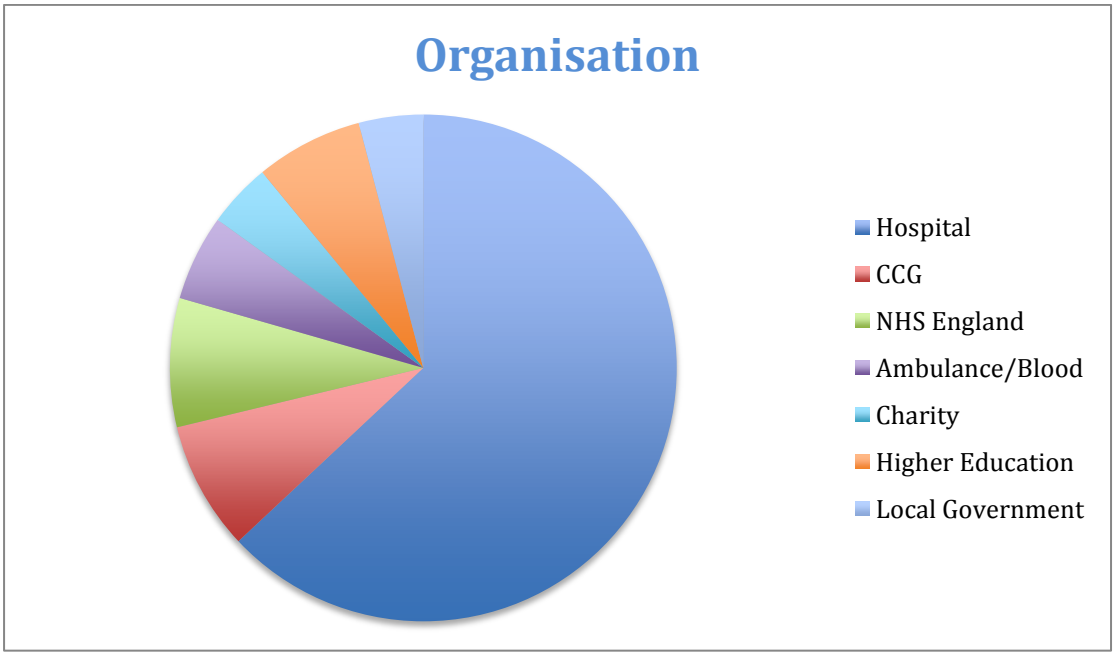
Respondents were asked to provide their name, job role, job title, function and organisation. They were also asked to provide their email address so that they could be contacted if they expressed interest.

The following open-response requests/questions were asked in the survey:

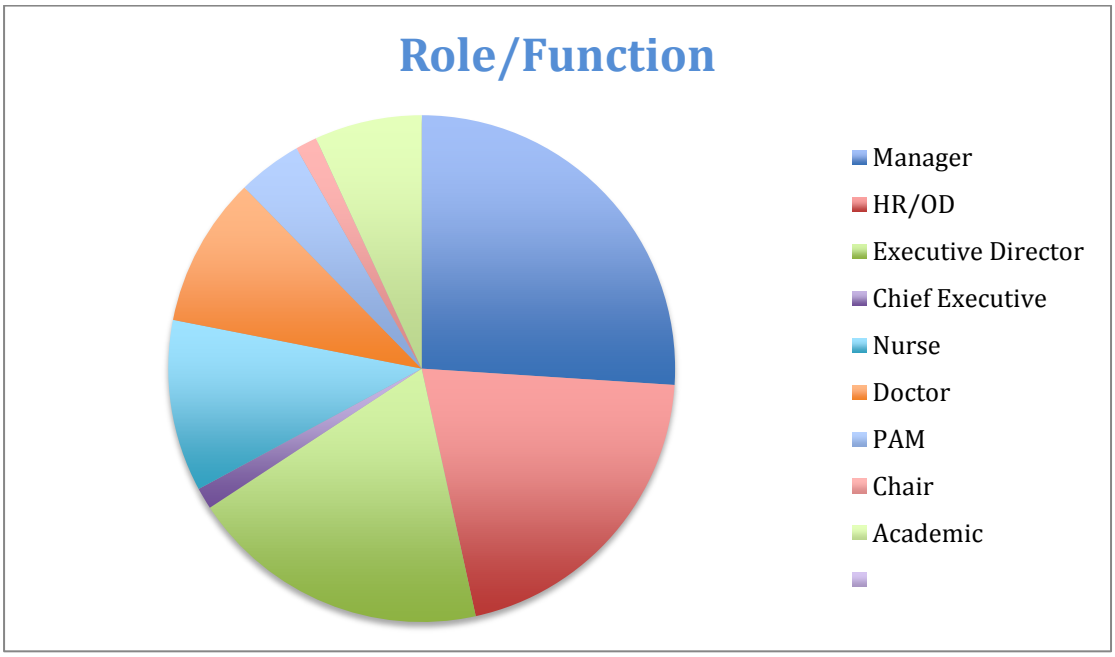
1. Share three examples of systems you work in.
2. What are the systemic issues or challenges that you are faced with?
3. If you were leading the system, as a system, what would this look or feel like?
4. What would be different as a result?

They were then asked to rate their level of interest in working on any of the issues they mentioned. There was a 7-point rating scale, with one being 'not very interested' to 7 being 'extremely interested'.

The Respondents



62 of the 73 respondents work in the NHS and the largest group of respondents (46) work in a hospital setting. There are only 3 respondents who work in local government settings.



Respondents are from a wide-range of roles across health and social care. 18 of the 73 respondents are in a clinical role. Whilst there is only one response from a Chief Executive, 14 Executive Directors responded. These include 5 Directors of Nursing, 3 Directors of Strategy, a Director of Adult Social Care and Public Health, a Director of HR, a Director of Finance, a Medical Director, a Scientific Director and a Director of Corporate Development and Assurance. The largest and most diverse group of respondents are those in managerial roles (19). There were 15 responses from those who work in HR or OD and 5 from those in an academic role.

Question 1: Examples of systems

Practice-based

- Libraries across NHS England
- National Orthopaedic Alliance
- Federation of Specialist Hospitals
- 'Great Expectations' project, working with local women and networks to improve experiences and quality of care
- Nursing leadership and quality performance across the south
- Digital health adoption across health and social care
- KSS community discussing ways to engage, deliver and facilitate organisational development
- Working with other acute providers to provide specialist cancer surgery with an access framework

Local

- Central London STP
- Network of GP Practices serving 170,000 + patients
- A mental health partnership of 4 organisations delivering a primary care mental health service

- A GP federation based in Brighton and Hove
- Surrey STPs
- Partnerships with local authority and education to enhance healthcare workforce through equality and diversity
- London Scientific and Diagnostic Network
- Work on Person Centred Outcomes, crossing boundaries of healthcare, social care and community assets

Organisational

- Complaints and patient safety
- Internal coaching and mentoring network
- Operating theatre systems

This question was intended to determine the respondents' understanding of 'systems' in this context and to help them to focus on the questions that followed. The covering email attempted to explain the intention. However, it was evident that for a small number of respondents the word 'system' was not understood. Many answers were very general, for example, 'acute hospital trust', 'urgent care', 'Hampshire, Surrey and Berkshire', 'inpatient wards', 'health and social care integration'. One respondent stated that she was unsure of the meaning of the question.

Method

For questions 2,3 and 4 the data was clustered under generic headings to enable the generation of higher-level information. The clusters are presented in the order of popularity. The full set of data for these questions is available, with each response numbered so that individual responses can be tracked.

Question 2: What are the systemic issues and challenges that you are faced with?

The following themes were identified and illustrative examples are provided for each.

1. 'Silo' working and interface issues (30 items)

- Complexity of geography, large number of organisations and people involved
- Incompatible targets, legal requirements and commissioning inflexibility
- Disconnected pathways and problems around boundaries e.g. between GP and hospital, hospital and social care
- Lack of national or local coordination

2. Funding issues and impact on quality (25 items)

- Competing priorities of quality and finance
- Delivering more (volume and quality) for less resource
- Enforced cost improvements
- Measuring impact of financial constraints within an organisation rather than across the system
- Non-aligned funding streams

3. Collaboration, relationships and team working (18 items)

- Lack of understanding of different perspectives and roles
- Communication issues, inability to respond quickly to changes, unwillingness to share information

- Lack of trust of other agencies, organisations and professions

4. Culture (15 items)

- Attitudinal differences, values-based dissonance
- Persistent historical understanding of roles
- Patient seen as a 'commodity' going through organisational processes
- Systems designed around the needs of staff, not the patient
- Protection of self-interest

5. Staff and skill shortages (14 items)

- Staff and skill shortages in key areas, organisations are focussed on their own recruitment needs as opposed to the system as a whole
- Consistent and safe staffing levels
- Turnover
- Poor morale leading to difficulty in recruitment

6. Information/information technology (11 items)

- Different IT systems, difficulties in accessing and sharing clinical information
- Timeliness of data
- Conflicting reporting
- Lack of supportive technology which can ensure more interaction with local population and dispersed staff

7. Demand and expectations of population and patients (8 items)

- Unrealistic expectations from the public of what the NHS provides
- Increasing demand and complexity of needs e.g. frail elderly
- A lack of collaboration and real understanding of changing demographics

8. Engagement (7 items)

- Espoused versus actual value placed in engaging patients
- Too many stakeholders to engage
- Patchy engagement in certain areas
- Lack of leadership

Question 3: If you were leading the system, as a system, what would this look or feel like?

The following themes were identified and illustrative examples of data are provided.

1. Partnership and team working (27 items)

- Health, social care and lifestyle service providers linking up to address the prevention agenda
- A seamless system with shared expertise and knowledge of who has which skills so that they are used to their best potential and shared across organisational boundaries
- Close working relationships through SLAs and data sharing agreements coupled with common and established aims and outcomes.
- Behaviours show that those involved want to work in this way and not to work on their own agendas

- Open dialogue, transparent decision making, fair, challenging, critical friends and pragmatism
- Great partnership working, collaborative learning, patient involvement in learning events
- Local hub of resources which could only be accessed if effective multi-agency (statutory and non-statutory) working was demonstrated, with co-location of key services for people with learning disabilities, especially NHS and council services

2. Clear accountabilities and shared values (20 items)

- Creation of a common aim with clear objectives and a shared vision
- A system of accountability and responsibility for staff to 'own' the system they work in
- Aligned priorities and common principles
- People feel valued for their contributions

3. Patient-centred care (19 items)

- The system would be unblocked, drained of complexity and routed back to common sense, centred on patient pathways rather than mapped around bricks and mortar
- Direct and automatic involvement and partnership of patients and citizens when designing services or making changes
- Freedom to design roles around the service user
- Working towards a system that is fair and takes into consideration the diverse population that we serve
- Patients leading their care and involved in change alongside staff

4. System integration (17 items)

- Much more integration between primary and acute care and between health and social care
- Provider services are integrated with shared generic workforce training for all CYP practitioners, accessing specialist advice/practice in the community setting
- Organisational barriers would no longer be barriers for patients and staff. It would be streamlined to minimise fragmentation and waste
- Borough based integrated delivery structure, single unified network structure for primary care, standardised terms and conditions across all providers.

5. Budgets, resources and commissioning (16 items)

- Joint monies and resources to call on
- Funding streams to follow pathways and not individual services.
- Finance for longer pump priming
- Population based, commissioning led, driven by evidence and outcomes – reducing variations in pathways and clinical practice

6. Leadership (8 items)

- Leaders working together to solve common problems; understanding that there will be some winners and losers but that ultimately everyone will win
- Aligned senior teams
- Conversational not confrontational leadership

7. Training and development (6 items)

- Registered and non-registered health and care professionals being educated together and co-learning
- Flexibility to educate employees across organisations and professions
- Responsive and high quality training to ensure consistent and auditable processes

8. Technology (6 items)

- Real time information
- IT systems that support new models of service delivery
- Use of technology to improve communication with GPs

Question 4: and, what would be different as a result?

The following themes were identified and illustrative examples of data are provided.

1. Improved outcomes and patient experience (28 items)

- Patient experience wouldn't be so variable, equality of care
- More sustainable high quality clinical outcomes
- Targets would support each organisation to achieve the best outcome for the patient
- Patient pathways and flow would be improved

2. Culture Change (26 items)

- A level of service that rebuilds pride in delivering the best we can for our patients
- People would want to come and work in our sector
- There would a narrative of what was happening that would engage people on an emotional level and draw them to the overall values and behaviours
- Seeing where everyone fits in the grand scheme of things would facilitate improved communication, improve inter-professional relationships and create a shared sense of purpose
- Happy customers, reducing demand, happy staff, stable service

3. System Integration (10 items)

- Traditional organisational boundaries and roles will be changed
- Staff working to a single governance system
- We would provide a single approach for the whole population whatever their health or care needs; generalist or specialist; physical or mental; adult or child
- Emergency care planning; workload and timing efficiently managed
- Improved communication, speed of referrals and access to local intelligence

4. Resourcing (10 items)

- Changes in tariff and contracting would incentivise different behaviours and encourage systems working
- Better flow, reduced overall cost
- Early identification of issues/trends to enable a proactive response
- A financially viable NHS

5. Leadership (6 items)

- Accessible transformational leaders with the courage to instigate and see through real change, reliant on genuine policy consultation
- A small number of strategic leaders who collaborate and lead change
- Valued leadership at all levels in the organisation

6. Partnership and team working (6 items)

- Multiagency professionals engaged in making every contact count
- Local health and care partners would collaborate to resolve the issues for our population

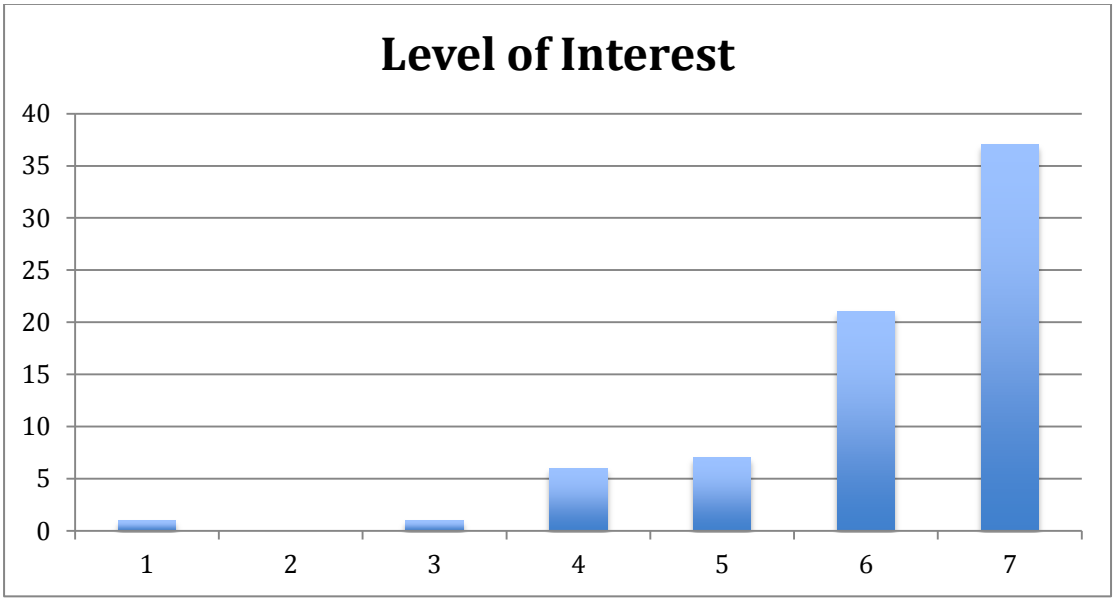
7. Learning and education (5 items)

- Issues, learning and improvements shared widely across the health sector
- Increased awareness of clinical research and its benefits; increased uptake of clinical research
- Improved quality of education, motivated staff proud to be educationalists

8. Information (4 items)

- Real time information that links all systems to allow accurate fast responsive decision-making
- Huge reduction in time wasted on IT glitches

Level of interest in working on the issues identified



Using a seven-point rating scale, where one is 'not very interested' and seven is 'extremely interested', 80% (58) of the respondents were either very (6) or extremely interested (7) in working on the systemic issues they identified. Conversely only 2 respondents were not interested.

Preliminary Conclusions

The basic structure of communities of practice identified by Etienne Wenger[1] comprises three basic elements: a *domain* of knowledge, which defines a set of issues; a *community* of people who care about this domain and the shared *practice* that they are developing to be effective in their domain.

There are arguably two main domains identified through the survey: one concerns 'silo working', culture, collaboration and engagement and the other concerns demand management, resourcing, workforce and IT. This provides an excellent starting point for engagement of the wider community through the planned events and activities to take this work forward.

The themes that emerged from the question about system leadership reinforce the sense of common ground. However, there is a sense that the generic nature of many responses indicates that the community doesn't fully understand the problems yet. So at a *practice* level there is more work to be done for effective system leadership to be understood and developed. It is also evident that more effort to help others understand what 'systems' and 'systems leadership' mean in this context would be worthwhile. This information is also valuable in guiding further activities and actions in this project.

It is clear that members of the community are facing similar problems in working systemically and that these domains or groupings are complex and longstanding 'wicked' issues that require sustained learning. This is exactly the type of problems that lend themselves to a supported community of practice approach.

The breadth of response reflects the strength of current networks and gives a useful guide regarding gaps in the level of engagement. For example, it is clear that more involvement from social care agencies and local government is important in forthcoming events.

The purpose of the survey was to obtain insiders' views to guide the learning of KSSLC and LLA and this survey has succeeded in this aim. It has clearly highlighted the key challenges of system working (the domains) together with a community of people who care about those issues and are prepared to work together to tackle them. There is also a compelling level of agreement on the benefits of addressing the issues. The survey has also provided rich data that will be drawn upon and used in future activities and events.

Lorna Wellsteed, Director Wellsteed Associates
2nd May 2016

[1] Cultivating Communities of Practice, Wenger, McDermott and Snyder. Harvard Business School Press, 2002