Supporting transformational change – the relational dimension

An introduction to relational value (R^v)

Whole Systems Partnership

WSP works to support health and social care partners to improve the way they work as they seek to achieve the best possible outcomes for patients or clients.

September 2016

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Acknowledgements

I am indebted to members of the WSP team for their contributions to this document. In particular Dr Paul Grimshaw, our KTP Associate, and Dr Brennan Jacoby, a 'freelance philosopher'. Both are pursuing their own publishing opportunities but have generously contributed to this work. Others have commented, particulary in order to make a challenging topic as accessible as possible. Thank you.

Peter Lacey, Director, WSP

Addendum

Since producing this document two related academic papers have been published:

Paul Grimshaw Linda McGowan Elaine McNichol , (2016),"Building a system-wide approach to community relationships with the findings of a scoping review in health and social care", Journal of Health Organization and Management, Vol. 30 Iss 7 pp. 1047 – 1062

Paul Grimshaw Linda McGowan Elaine McNichol , (2016), "An Extra Care community's perceived priorities for 'whole system' relationships: A Q-methodological study". Health and Social Care in the Community, Issn 1365-2524. Jan 2017.

January 2017

Read this first…….

Our purpose in preparing this booklet is to describe what we mean by relational value (R^v). Our long experience of supporting health and social care organisations has consistently pointed toward the need for effective collaboration and joint working at all levels and in each part of the systems we are part of, something that is impossible if relationships are poor. And at a time when these relationships are increasingly under pressure, from financial pressures and the complex nature of our work, rediscovering the critical role that healthy relationships can play has never been more important.

What do we mean when we talk about relationships? How can we recognise when they are suffering, and what can we do about it? Our answer is to see relationships in the context of a whole system perspective[1], which "*recognises how actions in one part of the system can impact on other parts, producing patterns of behaviour over time*". This brings life to what otherwise appears to be either a mass of disconnected entities or a fixed and intransigent arrangement that is resistent to our attempts to influence it.

But a system is more than the sum of its parts. The systems we are part of do not run on strict rules that force us to follow procedure to the letter, and thereby enable us to 'predict' the outcomes. They are made up, in large part, by people who make choices, express preferences, are more or less reliable and more or less interested in the same goals as you or I. How we relate is therefore so much more than simply a set of impersonal connections. A set of relationships in a particular context has a life of its own.

Relationships are hard to measure, although our research, and common sense, suggests that they play a vital role in achieving effective and resilient outcomes. What we are describing as R^v is a resource that is dependant on, but also distinct from the individuals who contribute to building or reducing it within a system. We are seeking to demonstrate that it is our behaviours, and the choices we make in acting these out, that provide the channels through which R^v is developed. And we make the case that building relational value has intrinsic worth because of who we are as human beings, as well as being instrumental in helping to ensure that our health and social care systems are effective in delivering improved health outcomes.

About us:

WSP has a long track record of supporting health and social care partners in developing and delivering on strategic change. We have used both quantitative tools and a strong engagement ethos in all our work, and have long recognised the importance of the relationships that underpin partnership working in achieving effective and sustainable change. We have pioneered the use of relational health audit tools in the health sector, owing a tremendous debt to a family of charities in Cambridge, and increasingly beyond, that now come under the umbrella of the Relational Thinking Network. We remain a committed member of that network.

In addition, over the past two years, our research partnership with Leeds University School of Healthcare Studies has enabled us to offer a distinct and specially tailored approach to relational thinking that is rooted in the culture and expectations of caring. Much of what is reflected in this booklet has emerged through this research and the subsequent application of our development of the concept of relational value (R^v). As we develop our understanding of R^v we are working to embed its principles in how we support health and social care, ensuring effective and benefical relationships with our customers and partners.

Please feel free to contact us with feedback or for further information either directly to peter.lacey@thewholesystem.co.uk or by registering on our website.

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[1] This is covered in more detail in our 'sister' Good Practice Guide which is an introduction to System Dynamics Modelling.

1 Introduction

1.1 The state we're in

Our health and social care sector spends a large chunk of our national income; and they spend it on us, and on behalf of us in order to protect, heal and restore. This is a precious and vital part of our culture and society and we've signed up to giving the responsibility for ensuring that this continues to government, national and local, holding them accountable, both directly and through those who they fund to deliver care and support.

We should therefore be concerned, despite the good intentions of all those in the sector, whether professionals, managers, policy makers or volunteers, when we hear about mistakes, 'scandals' or poor quality, or simply experience ourselves sytems that seem to get in the way of the quality and outcomes that we aspire to. When such events occur, often described as being endemic to a whole organisation, and we scratch the surface, we find examples where trust in the system is waning, where compassion is leaking, or where disadvantage and inequality fail to be addressed – and this despite often exceptional care at an individual level. When we witness these deficits in the system we look to explain, and often to blame, but our remedies rarely do more than remove the symptoms. They are sticking plasters rather than deep seated healing.

We believe that insights and remedies to these challenges can be generated by a greater recognition of the role that relationships play in our health and social care system; relationships between individuals, but also between teams, organisations, professions and along the 'chain of command' that make up the system. What we lack is a language and a toolkit to unlock this dimension of health and social care.

This booklet describes one way, rooted in research and beginning to be tested 'in the field', that we believe has significant potential. It describes a new approach to thinking about relationships. It suggests we will need to move away from some of the long held but arguably shallow understanding of relationships that sees them as being simply a series of connections and transactions; and move toward an understanding about how our actions, and the systems and processes that steer them, contribute to either a positive build up, or a draining away of what we have described as 'relational value' (R^v).

1.2 The benefits of thinking about relationships

Our research, conducted as part of a Knowledge Transfer Partnership with the University of Leeds School of Healthcare Studies, has helped us to develop an understanding of the importance of R^v. We have identified five key attributes for this often overlooked resource, namely integrity, respect, fairness, empathy (or compassion) and trust – all of which we can see and feel within a system of care as much as we do in individuals. We are building an evidence base for these attributes, and the benefits they can bring. For example, there is research that demonstrates a positive link between managers' *integrity* and profitability; there is also evidence that a focus on *fairness* increases the emotional attachment and investment that people make to their organisation; that *trust* strengthens strategic partnerships; and that *empathy* is an essential component of the leadership required to deliver change and manage crisis[2].

If we can evidence the benefit of relational value then surely we have a responsibility to ensure we pay it full attention, alongside other resources we need to manage within the health and social care system. Just saying 'wouldn't it be nice', and passing it over as 'too difficult' is not sufficient. Being proactive about the recognition and development of

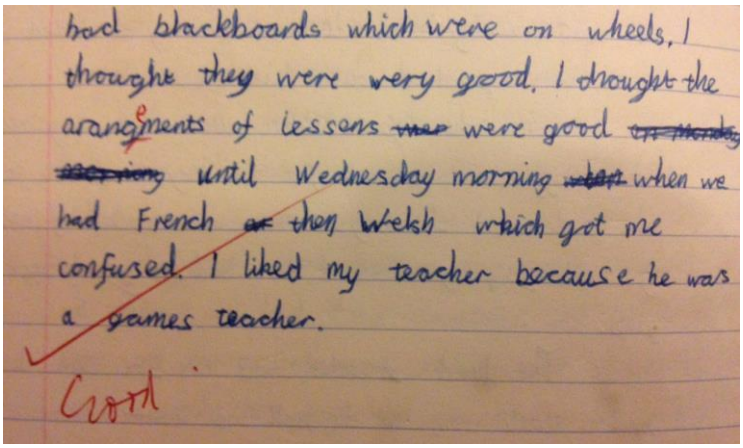
[2] This evidence will be published separately as the outcome from the research work being undertaken by Dr Paul Grimshaw.

relational value therefore needs to become part of every policy maker, executive, manager's or leader's brief. What follows sets out more detail about the attributes of relational value, how you might assess or measure them and how you might start to influence the behaviours that can be helpful or harmful to the development of R[v]. Our early work in this area is used to illustrate this.

But before that we will dig a bit deeper to demonstrate that the way we think and talk about relationships can be deeply rooted in the worldviews that surround us, and that this can affect how we act and what outcomes might be expected from the systems we inhabit.

1.3 The significance of the language we use

Below is an extract from my class exercise book after a week in secondary school. My 'Wednesday morning experience' is a reflection on how we can get confused with language – it happens to us all, and not just between French and Welsh lessons! We often joke about pronunciation, but perhaps more important is the sometimes slippery meaning of the words we use. This is compounded by the fact that the meaning of particular words or phrases, change over time. We were recently challenged about why we didn't use the word 'love' in our thinking about relationships. Our answer was not to deny that the concept of love is important, but that it carries such a broad range of meanings that would make its use potentially misleading[3].



Any one word can have several different meanings in different contexts, but we also use different words to reflect a similar underlying idea. For example, compassion and empathy have a similar underlying meaning (an understanding and orientation toward addressing another person's situation) but you are unlikely to use the word compassion in the Board room when expressing an attitude. In that context empathy might be more appropriate. We need to understand the subtleties, and the power of language. And language can be a powerful tool when we use words in a way that either endows them with new meaning, or which rediscovers meaning that has been lost. That is our goal when we talk about relationships, i.e. to provide a powerful and incisive way of talking about a subject that has perhaps got lost in our modern culture.

1.4 The wider view

In the world of systems thinking there is a premise that solving problems simply by pushing harder on the system that has created them is often a recipe for disaster. And we're in company here with Albert Einstein, who once claimed that "*we can't solve problems by using the same kind of thinking we used when we created them*".

Think about these examples:

- At a network meeting for a group of clinicians and other professionals, a 'looming crisis' was shared where significant shortages in staff at a particular skill level was leaving the service vulnerable and potentially unsafe. The 'normal' route to resolving staff shortages would be to use locum or agency staff, but it was recognised that after a point this can lead to further pressure on existing staff and also affect the

[3] Feel free to contact the author for a theological reflection on love as a key driver for relational value.

ability of the unit to attract more permanent staff. The 'fix' would only make the situation worse.

- Or take another situation in which the drive toward efficiency in a hospital gets close to unsafe levels of staffing so that the only route to financial viability is to attract more income through more hospital admissions, which is exactly the opposite of the overall intent of reducing costs.
- Or consider the A&E department that is becoming overcrowded resulting in more patients being moved to trollies in the corridor to avoid 4hr breaches, when the solution lies in swifter discharge and freeing up of capacity.

In each case current thinking about solving a problem only makes it worse. The solutions lie outside the short term fire-fighting crisis, but we're often poorly equipped to think beyond the immediate and familiar responses. If we apply this to the observation we have already made about the reducing levels of trust in our health systems or the leakage of compassion, even when professionals fully intend to exhibit these values, then we see how current ways of thinking, dominated by legislation and inspection, can become ineffective. The way we think and talk about relationships – competition instead of collaboration or transaction rather than conversation – is where we start to identify what it is that is driving relational value to the fringe, or beyond. We therefore need to be aware of how and why we think about relationships in the way we do, and challenge ourselves to think differently, lest we simply repeat our errors – or worse.

To dig deeper it is necessary to enter the world of philosophy and it's close relative, ethics[4], which is about how we act in given situations, the choices we make, and the underlying way we think about the way things are, which informs these actions. The work by Dr Jacoby (part of which is summarised in Appendix 1) challenges us about the way that we think about relationships. It suggests that our 'modern' worldview has the potential to undermine our ability to build relational value, despite many of the undisputed benefits it can bring. If we can identify these worldviews, and then explore different ways of thinking about relationships in health, these alternatives must (if we follow Einstein's advice) form part of how we address the problems we have identified – the answer does not lie in simply more of the same ways of thinking!

When our worldview has the potential to undermine something as precious and as essential to our society as our health and social care system then it is time to redress the balance…….

What we should look for in addressing many of the challenges we face in health and social care, and beyond, is the use of reason in such a way as to respect the social dimension of how we as human beings 'work things out'; the holism that balances physical and mental explanations of how we know and who we are; a scientific method that does not stop short when we run out of numbers to count things with; a respect for freedom within the bounds of our responsibilities to others; and a celebration of our individual uniqueness without atomising and isolating us from that which helps to define who we are. ***To achieve this, we need the language of relationships****.*

1.5 What do we mean by the word 'relationship'?

What, then, do we wish to convey when we use the word relationship? The word can be used in different contexts and carry different meanings. For example, we can express locations on a map as being in a spatial relationship, or we can say that a league table denotes an ordinal relationship between the top and bottom performers. But these are both examples that lack a human dimension. If we talk about relationships between people in

[4] See also Appendix 1, which is based on a paper entitled 'A view to care: Worldviews and 'relational value' in contemporary healthcare' by Dr Brennan Jacoby. A copy of this paper is available on request.

the same way as we talk about spatial or ordinal relationship then we clearly lose a significant amount of richness.

Relationships in the human domain are more than just 'connectedness', or even a set of behavioural rules or triggers that in some way 'determine' how we behave. Our 'modern' way of thinking can incline us toward reducing how we think about relationships as if they consisted only of physical connections, a spatial pattern or network of actions and reactions. When thinking about relationships in this way we lose the opportunity to think about relationships as a resource.

Thinking about a relationship as a resource that is distinct from the relating parties and yet is dependent on them for the character, resilience and impact of that relationship is a core premise underpinning what we mean by 'relational value'. So, when we say for instance that we have 'trust' in a relationship we are somehow saying something more than that the parties to the relationship are trustworthy, although it is likely that they are. As a way of describing relational value you might think of it as:

the lifeblood of a system, organisation, partnership or team of people. It is the medium through which our interactions pass that either enhances or distorts our ability to achieve our common goals.

We are therefore using the idea of relational value (R^v) as something that:

- Exists **between** individuals, groups or organisations that can be given a value that is distinct from, though dependent on, the parties to the relationship. For example, the level of trust in a relationship can be measured and is distinct from, though dependent on, the level of trustworthiness of the parties to the relationship.
- Has a **purpose**, or an expected outcome, in a particular context, i.e. a relationship is 'for something' and can therefore be described as 'doing work' toward a specific goal or set of goals. R^v is something that sets direction.
- Will result in the emergence of a set of 'system' **attributes**, the primary ones that we have identified are integrity, respect, fairness, empathy and trust, the composite of which is R^v.

The attributes of relational value are enhanced, or reduced, through the actions we take and the **behaviours** we develop. Whilst measuring R^v directly may be difficult it is possible to observe the behaviours associated with these attributes. Based on this evidence it is possible to assess the levels, or take the temperature, of relational value in a given system.

1.6 When will R^v be useful?

The symptoms of poor relational value are wide and varied, but they may include:

- Working to the role;
- Continued failure of operations to fulfil strategic aims;
- Absenteeism;
- High staff turnover;
- Staff burnout;
- Signs of withdrawal or silence between important teams or individuals;
- Slow or non-sharing of information between important groups;
- Lots of 'pretty talk' but failure to address the elephant in the room;
- Placing personal need over system goals.

A diagnosis that traces such symptoms back to a deficit of R^v can, however, be more difficult. Open hostility and hence real visible evidence of poor relationships in most organisational environments might not be obvious. Perhaps the team or organisation has

existed without major visible issues for a while. So when might we be at most risk of low or changing relational value? Here are some suggestions:

- When new systems or technology are introduced;
- When new teams are formed;
- When new groups have to work together;
- After major change or organisational or system disruption;
- Where relationships are vital to delivery but time is short;
- When existing teams stop performing;
- When undertaking inter-disciplinary working;
- When the focus of a team changes;
- When performance measures shift radically;
- When new team members enter an existing team.

These are times when using R^v can help.

2 A framework for relational value (R^v)

2.1 The relational sphere

Instead of thinking of ourselves as isolated individuals undertaking discrete tasks in a chain of events, as encouraged by our modern view of the world, we need to refocus on the social nature of our work, i.e. the fact that our interactions with people create responses and feedback that are often left unnoticed. The use of relational language is a major step in this direction. We have already introduced the concept of relational value and the proposition that it can be developed as individuals face 'the other' in relationship. This moves us away from thinking about ourselves solely as islands in a purely biophysical ocean, toward seeing value in the things that join us together.

The Dutch philosopher Dooyeweerd described this through the idea of 'spheres of sovereignty'. For example, if we have an economic problem to solve then financial language and measures are entirely appropriate, but if we use economic ideas and language as the key drivers in addressing matters of a personal nature, for example in a family setting, then we short-change these situations and devalue what's actually happening. Similar tendancies may be apparent in the way we think and are encouraged to act in our health and social care systems.

2.2 The attributes of relational value

We have adopted five 'spheres of influence' in developing the idea of relational value. They each relate explicitly to a different 'level' of interaction and require a human dimension to fully understand what is happening. We are broadly following the spheres described by Dooyeweerd and have identified the following for use in the composite idea of relational value[5]:

- **Integrity** is a foundational concept that underpins the potential for developing relational value. This idea is akin to that of 'order' or consistency and reliability, without which it is difficult, and sometimes even impossible, to develop meaningful human relationships.
- **Respect** refers to the 'social' sphere requiring consideration and appropriate social intercourse in order to build relational value.

[5] In addition to the work of Dooyeweerd we are also referencing here work by J Ive in 'Relationships – The Philosophical Foundations', an unpublished contribution to the 2015 Relational Academics Forum.

- **Fairness** reflects the 'judicial' sphere in which just deserts are assured and disadvantage avoided or compensated for.
- **Empathy, compassion or benevolence** combine to reflect the 'ethical' sphere in which decisions are made with full consideration of the other with whom we are in relationship.
- **Trust** exists in the sphere of 'belief or faith' in others.

Taken together they constitute relational value, as illustrated in Figure 1 below (Table 1 provides a fuller definition and examples of what these attributes look like 'in the flesh').

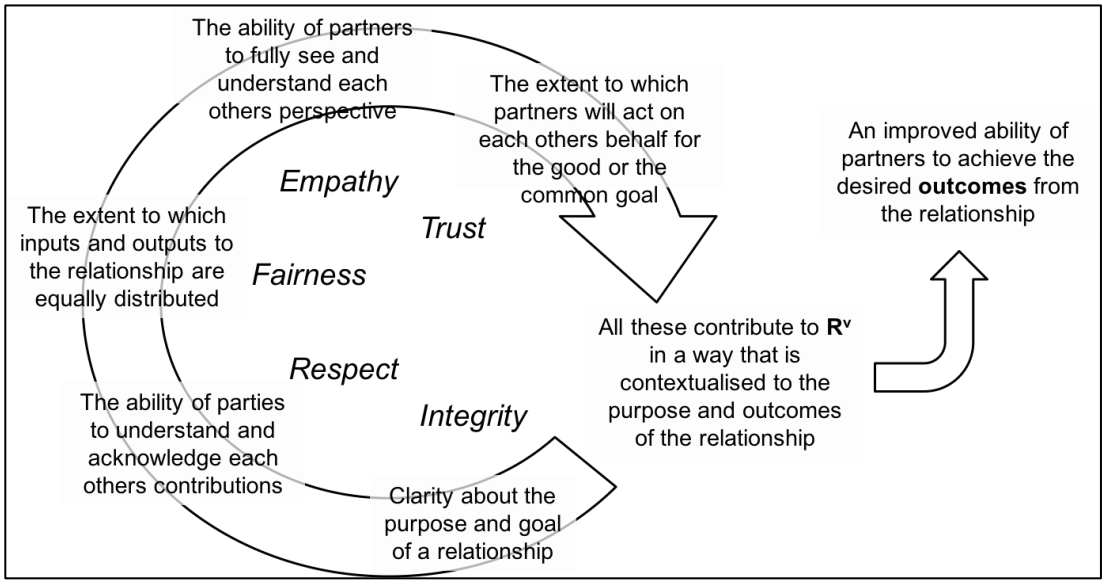


Figure 1 The attributes of relational value

When we apply this framework in a real life context the purpose of a relationship will be critical in determining the appropriate level and balance of these attributes. There is no prior assumption that it is necessary to 'max out' on each attribute. A certain level of an attribute may be 'sufficient' for the purpose, for example if a relationship is relatively short term and focused, then investing a lot in certain areas of the relationship may not be necessary.

In addition, a higher level of a particular attribute than is necessary may be counter-productive. For example there may be cases where too much respect can be counter-productive and lead to an inability to express an appropriate alternative viewpoint. This may, for example, make whistle blowing more difficult because calling people to account in this way requires a healthy dis-respect for the assurances of others if indeed they are acting unethically. Or consider empathy where offering some degree of concern for the unreasonable tasks another person has to undertake might be useful to the individual and the local context, yet this empathetic focus needs to be weighed against the expense and the functioning of the wider system. We see this every day where people are apt to focus on the plight of an individual in crisis rather than think how we might effectively change a system which could alleviate the suffering of millions.

We will return to the practical application of the framework later, but it is important to see this framework as flexible and adaptive to specific situations and contexts.

The following table provides more detail about how we are describing the attributes of relational value:

	Definition	For example…..	What it would look like……
Integrity	***How things interconnect and function:*** Reflects the consistency with which interactions between parties to a relationship can be relied upon and leads to the development of a sense of unity, wholeness, coherence, cohesion, undividedness, togetherness, solidarity or coalition.	When decisions or actions from a joint health and social care planning group are carried out as agreed, with no single party pursuing alternative routes for its own ends.	The purpose or function of the system is understood and owned by all with clear boundaries, within which everybody pulls together – genuine common purpose.
Respect	***How we treat others:*** Ensures due regard for the feelings, wishes, or rights of others. Comprises: consideration, thoughtfulness, attentiveness, politeness, courtesy, civility, taking into account, making allowances for, taking cognisance of, observing, paying heed/attention to, bearing in mind, being mindful of.	Being careful not to undermine the actions or position of another party through the way you speak about them.	That each party, individual, group or organisation, has a recognised contribution to make, without which the purpose or function of that system cannot be achieved to its full potential.
Fairness	***How equity is achieved:*** Occurs where parties to a relationship are treated equally, for example with respect to executing procedures, and where the explanations provided to people are open and accessible to all, having the effect that any prior disadvantage is removed to the greatest extent possible.	Making sure that the criteria and weighting that contribute to decision making are clear to all those seeking to benefit from that decision, and that it is evident that such criteria are adhered to.	That no one individual, group or organisation is seen to take advantage of a weakness in another; which may arise through privileged information, political influence.
Empathy	***How much we understand each other:*** Is expressed through relationships based on compassion. In an organisational context this means that we make efforts to understand the pressures experienced by other parties and work together to address these over time and across settings.	When considering change or restructuring, ensure that the impact at each level of the organisation is understood and taken account of in design and roll out of future services.	That each individual, group or organisation is able to 'live in someone else's shoes' and by doing so be sensitised to the risks arising from a lack of integrity, respect or fairness.
Trust	***How much we put ourselves in other peoples hands:*** Is the optimistic acceptance of a vulnerable situation in which the truster believes the trustee will care for their interest. This leads to the emergence of reciprocity, obligations and common identity and the emergence of a range of behaviours such as: cooperation, risk taking, obligations arising and being adhered to, belief in the future value of cooperating and the ability of systems to deal with complexity.	Sharing the responsibility for staff recruitment across a health and social care community, not at individual organizational level.	That others will act in your interests, and visa versa, as a means to achieve the overall purpose and function of the system within which you are operating and are committed to.

Table 1 The attributes of relational value

2.3 The socio-technical frame and whole systems thinking

If relational value (R^v) represents a core concept we need a way to apply it within an organisational or systems context. We have therefore adapted the idea of the socio-technical framework (STF) from a body of work, attributed largely to the Tavistock Centre[6]. This framework has developed as a number of researchers noted the changing, more open nature of knowledge based inter-dependent organisations, coupled with the large impact that introducing new technology in the workplace has on human systems.

The STF as an evaluation tool has emerged as a way of building improved understanding and design of organisational environments to reflect the 'whole system'. It considers organisational impact beyond traditional boundaries as well as the influence of the social or relational context. The STF is designed to be flexible to the context and can be represented in a number of ways. WSP have adapted the STF headings outlined by Challenger & Clegg[7] and have grouped a set of inter-connected elements that cover the full extent of relationally important health and social care behaviours and practices.

This framework identifies the contributions that are made to the effective and smooth running of an organisation or system and we are currently developing the STF to cover a number of overlapping areas:

- ***Culture*** or '***the way we do things around here***' which will be reflected in symbols, stories, norms and rules; relations between agencies (including shared history); mind-sets & worldviews; how lessons are learnt; reward structures; the way that structures evolve and general employment practices.
- ***Vision,*** or ideas about ***what the future will look like***, such that it reveals organisational focus; for example 'security dominated' versus 'freedom supporting' behaviour; or the expressed goals of each team & prioritization of organisational aims; or specific targets and actions that are built in to realise the vision.
- ***People, i.e. the human space***, examines empowerment, local leadership, client/user involvement, multidisciplinary working, tenure, continuity, timely communicating behaviour, training, opportunities for learning, eliciting and respecting ideas, use of expertise (contributions), innovating behaviour and individual skills.
- ***Process, i.e. our routines***, which includes activities of communication, coordination and cooperation. Rigidity or flexibility in deployment, level of organisational focus, addressing unintended consequences. Processes are visible in standards, briefings, handovers, working patterns and visual prompts.
- ***Infrastructure*** or ***the physical space***, including the basic physical and built environment including transport, buildings, the peopled environment providing opportunities to flex, change and improve.

[6] Davis, M.C., Challenger, R., Jayewardene, D.N.W. & Clegg, C.W. (2014). Advancing socio-technical systems thinking: A call for bravery. Applied Ergonomics. 45, pp171-180

[7] Rose Challenger & Chris W. Clegg (2011) Crowd disasters: a sociotechnical systems perspective, Contemporary Social Science, 6:3, 343-360,

- ***Technology*** or ***the virtual space***, including software, IT, safety, failures, the use of appropriate tools, system simulation, access to relevant information sources and technological communication e.g. telemedicine.

We believe that each of these contributions to the effective working of an organisation or system can be endowed with relational value (or not), although once again the extent to which this is possible or necessary will be context specific. Together, the attributes of relational value, seen through the socio-technical framing of an organisation, provides a powerful new way of conceptualising, understanding and addressing some of the seemingly intractable challenges that emerge from our complex organisations and systems. The approach provides the basis for innovative and, we believe, sustainable solutions – which we will begin to unwrap in the next section.

2.4 The evidence base

The ideas that have contributed to the emergence of R^v have been developed in our research project through a thorough literature search and an applied piece of the research in an Extra Care Housing unit being opened by one of WSPs clients. Material from this work is shortly to be published in a peer-reviewed journal.

We have already noted how this research has begun to build the case for a greater focus on relational values in general. The applied research is designed to understand the nature and value of relationships in a particular context and inform the development of tools to help assess the values, underpinning behaviours and the impact of these on relationships. The broad sweep of the research programme to date has involved:

- A literature search focused on an initial list of values that include a relational component from the published literature on health and social care services for frail older people;
- The construction of statements consistent with these findings that can be tested in a care setting;
- Conducting semi-structured interviews with residents and others involved in the opening of a new extra care housing unit where the statements created above can be tested and 'sorted';
- The use of 'Q' methodology, which is a research approach used in the social sciences to study people's subjectivity or viewpoints, with a view to establishing a sound evidence base for the use of a range of statements in this particular context;
- An assessment in the care setting using the outputs from the above research and making recommendations to enhance relational value.

Our ongoing research programme will be considering the transferability of both the emerging set of statements and the framework itself, as well as developing evidence of improved outcomes. We have also adopted an iterative, action learning approach to applying this research in the consultancy environment. Figure 2 illustrates this with an image of Tower Bridge – when the road is down there is an open flow of knowledge, experience and ideas between the research literature and practice environments, each informing and adding value to the other. At times, it is necessary to raise the road so that the research can focus on the data collection and analysis from the field study. The insights and knowledge gained from that process can then be shared and explored to assess their transferability to a different practice setting. This then leads to a further research cycle of practice informing research which in turn informs practice.

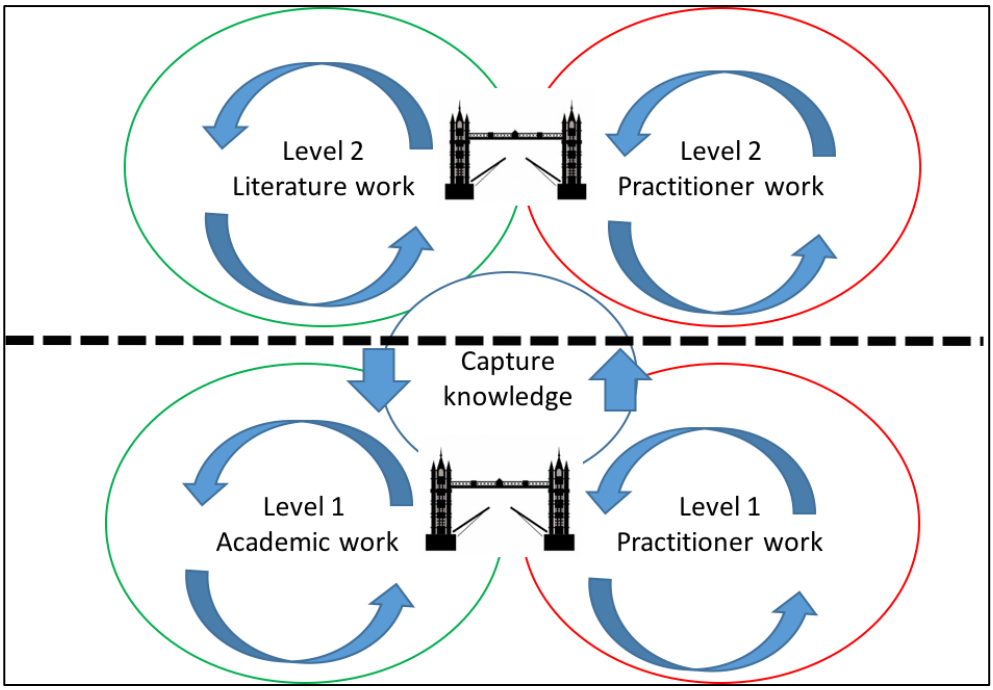


Figure 2 Our action learning approach to applying the research into R[v]

2.5 The systems thinking perspective

Figure 3 reflects how we are thinking about the process for developing the attributes of relational value. This type of process will be taking place for each attribute of relational value, and will not be operating in isolation. We have used the example of trust, but this immediately suggests that part of the ***prior conditions*** for a trusting relationship consists of the presence of other attributes of relational value. It is difficult, for example, to imagine trust in a situation where people do not respect each other.

As well as the need for certain prior conditions we need to take the individuals' team or organisation into account, and particularly their ***propensity*** to display a particular relational attribute. If, for example, someone brings a history of broken trust to a given situation their individual propensity to commit to a new trusting relationship may be limited. However, given the right circumstances the interplay between ***capability*** and ***opportunity***, which are provided by individual propensity and the prior conditions, creates either a virtuous, or vicious cycle of development.

If the opportunity for displaying trust is taken, involving a conscious decision by one party to a relationship, and if that opportunity is reciprocated by the other party, then it has the potential to increase the capability to trust. Increased capability can then feed back into recognising and acting on further opportunities to trust. Of course, the opposite could occur, hence the creation of enhanced prior conditions and individual development to improve propensity to trust are important starting points, as well as places in the system that can be acted upon once identified as contributing, or not contributing as the case may be, to the development of relational value.

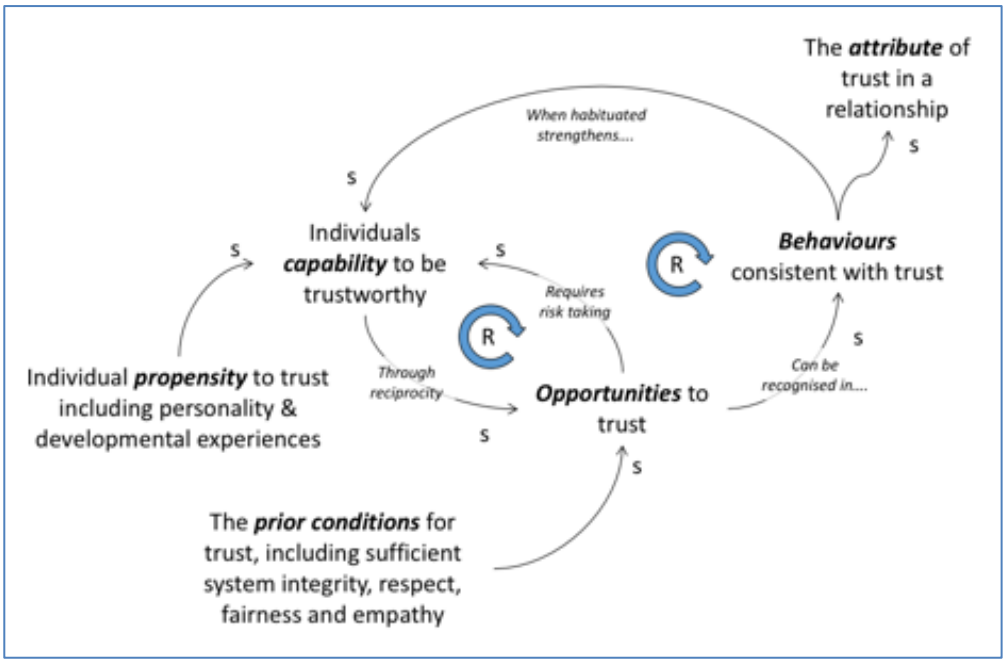


Figure 3 The dynamic nature of building attributes of relational value

It then follows that if more opportunities to act in a trusting way are taken then ***behaviours*** consistent with trust will be increasingly habituated and become 'safe' in the context of a particular relationship. This further improves individual capability to respond to opportunities where trust is displayed. Finally, it is the behaviours that lead to the development of the ***attribute***, in this case, of trust.

It is, however, difficult, if not impossible, to directly measure what we have described as an attribute of relational value, in this case trust. However, it is possible to measure, or at least assess the frequency with which behaviours consistent with trust are displayed. That is why in the tools we are developing we have created an evidenced based set of statements that reflect behaviours or practices because they provide indirect, but strong, evidence of the presence of the attribute.

2.6 The world of relational thinking

There is a growing recognition of the contribution of relationships in the way we run our businesses, or organise our public services. The relatively recent move toward 'triple-bottom-line' reporting for large corporations is witness to this fact – Board members and investors now expect to see the reporting of financial, environmental and social factors and their impact – and social factors in some instances include the quality of relationships. This is coupled with the rising interest in resilience, particularly in environmental impact, that feeds into greater expectations of sustainable value development, again an area where relationships play an important part.

Coupled with this growing interest it is not surprising that different tools and approaches are also emerging. Appendix 2 provides a fuller explanation of the similarities and differences between R^v and three other tools, namley Relational

Proximity (RP)[8][9], Relational Capability (RCp)[10] and Relational Co-ordination (RC)[11].

Relational Proximity concerns itself with 'distance' by exploring five dimensions of RP, i.e. directness, continuity, context, commonality and parity. Together these give an appreciation of the preconditions for good relationships, and the extent to which they are present or not, thus providing a valuable context for conversation and change. Relational Co-ordination is closer to network theory and emphasises roles within a system, thus providing the opportunity to explore organisational change linking into wider organisational performance measures. Relational capability is more focused on the individauls who are party to a relationship. All these approaches have examples of applications in health care, with RC rooted primarily in the US Health Care system.

3 Putting relational value (R^v) 'on the road'

3.1 Simply opening people's eyes to R^v

Those people striving to improve and sustain high quality health and social care, from individual clinicians to senior management teams to auditors and policy makers, are facing an increasing complex and financially challenged system. They are all striving to make the most of the resources that are at their disposal. In the main they will think of those resources as money, time and all importantly the people who work in the service. However they may not have considered or have time to consider the importance of the networks and relationships that individually or as an organisation have been nurtured and developed.

We are therefore aiming to open people's eyes to this tangible resource in the shape of R^v. The aim is help people to use this understanding to find the right balance of attributes needed to drive forward strategic change or service improvement in a particular context. They would also be able to trace a path from where they are to where they want to be.

3.2 An outline of the process

Using the R^v framework effectively is best achieved by use the following simple steps:

1. A period during which the nature and boundaries of the system (which can be a service, a team, an organisation or some other joint working arrangement) are explored and agreed on. Key at this stage will be to determine the purpose for which the system exists.
2. To explore what shape of R^v is desirable and appropriate for the purpose of the system (i.e. to agree what 'good' might look like).
3. To undertake an assessment using the R^v framework either through a simple survey instrument or through semi-structured interviews with as many contributors to the system under investigation as possible.
4. To use the assessment to explore the behaviours that might be lacking compared to that which is required to achieve the goals of the system.

[8] http://relationalthinking.net/relational-analytics-2/
[9] WSP has previous experience in applying the Relational Proximity Framework under license.
[10] See http://www.relationalcapability.com/
[11] http://rcrc.brandeis.edu/

5. To make a plan to address these short-comings using the outcomes from the assessment and an understanding of the dynamics of building relational value.
6. To set a reasonable period after which a re-assessment of R^v can be undertaken, or to put in place an R^v tracker as part of 'normal business'.

As in any effective change process this is an iterative, learning approach. It complements similar approaches by having the relational domain as the central focus.

3.3 Examples where we are already using R^v

WSP are already testing and refining this approach in a way that ensures our research and theory is brought to life. At the time of writing there are four applications being tested[12]:

- We have completed an assessment of R^v for a strategic health and social care partnership tasked with working together to achieve improved outcomes for the people they serve, and are about to undertake the same assessment in a second geographical location.
- We are using the R^v framework as one dimension of an evaluation of new ways of integrated working, alongside economic and patient outcome indicators. We are looking to identify the extent to which R^v has contributed to success in different localities where Integrated Neighbourhood Teams have been developed.
- We are using the R^v framework as part of a National evaluation of Electronic Palliative Care Coordination Systems (EPaCCS) to understand the extent and nature of benefits to patients, carers and professionals experience of care following the introduction of this technology.

All of these examples are feeding into improvements that will be the subject of future evaluation and refinement of the framework and tools themselves through our research partnership. Appendix 3 provides two case studies that have been developed to help you think through how the R^v framework might work in practice. We invite you to put yourself in the shoes of the people described and to begin the journey of developing a richer understanding of the relational dimension to the systems we work in every day.

3.4 WSP's own R^v

WSP are also using the framework to assess our own R^v as a consulting group – the results of which will be shared on our website in the near future. This will also influence how we work in collaboration with others. In order to 'practice what we preach' WSP commits to acting:

- To build integrity, i.e. a consistency and reliability that wherever possible dovetails with our clients or partners needs, whilst retaining an appropriate level of independence to ensure our input and advice is consistent with being a 'critical friend';
- To build respect, i.e. recognising the experience and knowledge that those we work with and for have acquired, and acknowledging these sources wherever they occur;

[12] These, and other examples, will be published on our website at regular intervals, which can be found at; http://www.thewholesystem.co.uk/relational-thinking/

- To build fairness, i.e. ensuring that all those we work with as clients or partners can benefit from our expertise wherever they start from;
- To build empathy, i.e. recognising any constraints or pressures that clients or partners work under and seeking to work in a way that can ameliorate these.
- To build trust, i.e. anticipating and fulfilling the expectations of clients and partners in ways that go beyond what has been specified but which are necessary to achieve the joint goals we have set.

We welcome observations and comment whenever these behaviours are not fully demonstrated and will seek to address them.

3.5 The way ahead

WSP's development path for R^v has a number of goals:

- To raise the profile of the role that relationships play in achieving effective and efficient services that achieve improved outcomes for patients and clients across the health and social care sector. Using this understanding amongst senior managers and executives to show how it impacts on both policy and monitoring.
- To encourage the adoption of the broad R^v framework and associated language by publishing our work under a creative commons licence.
- To further the research into the contribution that relationships play in health and social care through our partnership with Leeds University and our involvement in the Relational Thinking Networks Academic Forum.
- To develop tools, and enable them to be hosted online, that gather consistent sets of data that can be used for both benchmarking and further research.
- To reflect R^v, using our growing evidence base, in our simulation modelling such that the human factors are fully recognised as a contributor to effective and sustainable strategic change.
- To undertake consultancy work across the health and social care sector using the R^v framework, and to work with others who may wish to do the same using appropriate commercial arrangements.

We hope that you will consider joining us on this journey.

Appendix 1: More about worldviews

Worldviews are built on assumptions and beliefs about who we are as human beings and how we relate to the rest of the world around us. They are built on a broad set of assumptions that provide patterns of expectations in what we observe, how we make sense of what we observe, and therefore how we act. Exposing the patterns of expectations is, according to Mary Midgley, a prominent British Philospher, the business of philosophy.

These world views are 'ways of thinking', but also ways of telling stories about where we have come from, what has led to our success or failures, and where we are heading – as individuals, groups, organisations or even as a society. The 'meta-narrative' we use to tell these stories reveals our underlying beliefs – just think for a moment about how you tell the story of the NHS……..

- Are you continuing in the footsteps of the NHS's founding fathers to slay one of the giants of social malaise;
- Are you in pursuit of an ever greater ability to conquer disease and rid the world of debilitating illnesses;
- Are you part of a story in which the health service is increasingly burdened by bureaucratisation or creeping privatisation?

Each one of these will reflect the patterns and beliefs we bring to our work. They can co-exist, each may have an element of truth, few will tell 'the whole story', but how we tell the story is important. However, the worldviews that give rise to these stories are not just theoretical constructs. They affect behaviours, which impact directly on how we relate to each other. If you believe you're in a competition or in a market this will affect what you do when confronted with a challenge or an opportunity.

So we are right to ask the question, what thinking informs how we 'do' health and social care today and why might it impact on relational value? We can outline these as the five 'isms' of the modern worldview.

Rationalism: that we are rational creatures is as old as the hills, but enlightenment thinking elevates rationalism to lofty heights and makes the individual the final arbiter of what 'makes sense'. Fundamentally rationalism therefore has no need to recognise that we are social creatures. Our language betrays our reliance on this element of the modern worldview: we 'work it out for ourselves'; we need to be personally convinced before acting. Being rational is, of course, important. It has underpinned many scientific advances, and the sometimes belligerent stand by individuals against the current received wisdom has led to major and positive steps forward. The opposite or antidote of rationalism is therefore not to be irrational or anti-rational. However, the inward orientation at the root of philosophical rationalism can lead us to disregard, or at best reduce the insight that reason can and should also have a social dimension.

Dualism: is the belief that mind and body are separate things. When Descartes declared '*I think, therefore I am*', he was expressing his belief, arrived at through a rational process, that it is easier to doubt the reality of physical things than it is to doubt the reality of what we think, i.e. the mental side of life. We can doubt everything, Descartes declared that he could doubt averything except that he was thinking! Fundamental to this way of thinking is that '*how we come to know*' becomes more important than '*who we are*' – that epistemology trumps ontology. But once again 'how we know' leans heavily on the individual looking inward rather than on the process of knowing and understanding that arises when we retain that part of our understanding that declares that we are social or relational creatures.

Scientism: science and the scientific method have, once again, contributed immensely to the advancement of healthcare and improvement in health and wellbeing. However, scientism is something different – it is the elevation of the physical over the mental, and potentially the invasion of the physical explanation into the mental or emotional challenges

we face. *Scientism* therefore relies on its historic predecessors of rationalism and dualism and makes that which is testable by the scientific method more important than the mental, spiritual or relational components of life.

Liberalism: democracy, freedom, fairness and respect for all citizens are the foundation stones of a modern liberal democracy that we do well to value and protect. These ideas have pre-modern roots, but have once again taken a turn in the modern era such that we now believe that our goal should be '*freedom from*' rather than '*freedom within*'. Its goal is unfettered, individualised freedom. However, building relationships can be described as the process by which we give up 'freedoms from' in choosing to commit, to respect and to love another, i.e. 'freedom within' a set of responsibilities. If we allow liberalism to drive our healthcare systems, it is no wonder we leak these relational qualities.

Individualism: it is perhaps not surprising that the four isms outlined above lead to the belief that we are, at the most fundamental level, autonomous beings. Were we to think about our individual identity, gifts and qualities as contributions to building relationship then our uniqueness will have value and reflect our social being, but as long as we think about such characteristics as being autonomous, atomised entities we reduce our potential for relationship to the connectedness witnessed between the balls on a billiard table.

In the work from which this section is drawn, Jacoby says "*the Modern worldview is not just one which values reason, science, freedom and individuality……..* (it) *presents a view of humanity that does not acknowledge the social value of community, interdependence or vulnerability".* This 'down-side' of the modern worldview, i.e. the loss of a relational perspective, points to a valuable perspective that society has lost.

A consequence of the modern worldview in healthcare can, for example, be seen in the bio-medical model of health, which Jacoby details and demonstrates as being reliant on the five isms outlined above. The way we think about health and illness, underpinned by the themes of the modern worldview, limit our ability to think about people in their social context or to adopt a 'holistic' view of people, having both physical and mental capacity, capability and needs.

So, for example, patient autonomy, rooted in liberal individualism, has been described as leaving little room for the principle of beneficence in the expectations of professional role, as pledged to in the Hippocratic oath. This leads to an increase in patient consent procedures, which in turn reduces trust and respect between the professional and patient. And so, says Jacoby, "*the assumptions at work in healthcare today limit the ability of healthcare institutions to respond well to relational challenges involving trust, compassion and equality*".

It could equally be argued that the way we have developed the organisational structures and systems of healthcare delivery reflect the down-side of the isms of the Modern worldview. If, for example, the interactions between patients and their professional carers are thought of as being a series of transactions, or tasks, even if the individual professionals wish for different, we create a context that drives them toward atomising those they care for from their relational context and toward treating the condition rather than the person. And if that's how we reward those organisations responsible for service delivery then there is the risk of gradually eroding the relational value that may be present [see the WSP Blog Compassion – not just for nurses].

Our call for a response to some of the shortcomings of the Modern worldview is not unique, as Jacoby outlines in his paper. Both feminist and virtue ethic approaches have much to commend themselves in this field. There are, however, good reasons why a relational approach has particular benefits.

Appendix 2: Relational frameworks and tools

Here we describe and compare three other tools that are available to explore and measure relationships. Along with R^v they have all been applied in health care settings.

Relational Co-ordination (RC) is based on a theory that improved coordination of tasks is central to improved organisational performance. This is achieved by a reduction in information failures. The aim of RC is improving the coordination of tasks through harnessing relational dynamics by better management of inter-dependent reciprocal tasks. The relational quality is expressed through communication, knowledge, goals, respect and the ability to solve problems.

RC's focus on roles is a way to keep the analysis in the realms of organisational relationships, recognising the potential darker side of what can be viewed from one perspective of very strong, close relational ties that can actually detract from organisational performance or be inappropriate or more difficult to explore. RC is highly validated in the academic sphere and particularly strong in healthcare.

This rigorous evaluation inevitably also introduces a level of reductionism in relation to analysing the content of a relationship e.g. respect is elicited through a single question in relation to another role. RC is less useful in a system where the relationships with non-role based individual's needs to be examined or included within the analysis. For example, residents in a care home. RC may also be problematic whereby there is sensitivity around the groups themselves being divided up by role or when roles and inter-dependencies are not clear or deliberately ambiguous.

Relational Proximity (RP) has grown from many years thinking and writing on the importance of relationships in organisations with particular emphasis on relational closeness rather than connectivity. RP breaks relationships down into 5 main dimensions (Power, Story, Information, Purpose & Communication) that provide a framework for the pre-conditions for the emergence of closer relations. The RP tool aims to identify gaps that prevent closer relations. RP is closely aligned to much of the work associated with Social Capital and the potential benefits of harnessing the power of relationships.

RP is well placed to be deployed as a multi-purpose tool for revealing important relational components affecting a particular relation on a particular task(s). This can be used for organisational groups or individuals, for example when 2 teams have been brought together and relational problems persist in undermining some aspect of desired performance.

For both RC & RP a higher score suggests better relationships between roles or professional groups and therefore improved organisational performance. R^V differs from RC & RP here in that what is established by the framework is a balance of scores based on the context. For example, high empathy scores on some dimensions may not be useful or even appropriate.

R^V is most powerful where the focal point is the impact of relationships in a wider social system. R^V is being designed to connect with wider system level data from a variety of different performance measures, ultimately leading to a benchmarking tool that can be used to set parameters in the context of strategic change, such as when using systems modelling in situations where currently the proxy for the impact of human relationships is either omitted or a 'best guess'.

Relational Capability focusses on the individuals' capacity develop and maintain healthy relationships. It is closely linked with improving wellbeing.

All tools create visual displays and provide data that can be re-tested with the same groups over-time.

Tool	Theory	Focus	Context	Validation	Implementation	Conceptual measures
R^V	Broadly based on philosophical, sociological and psychological theories plus the 'grey' health and management literature, and contextual practitioner experience of health and social care.	Can be used to 'take the relational temperature' of a system without the need, in complex and multiple sets of relationships, to map every related pair seperately.	Targeted towards strategic evaluation of relationships across the 'whole system' of multiple health and social care contexts. Highlighting the independent value of relationships within a system that are dependent upon but distinct from the individual actors	Validated through working with healthcare practitioners through an ongoing action learning framework. Has the potential, and is being applied in connection with other systems thinking approaches to organisations.	Context specific application with a core set of statements delivered in different models of application and simulation. Requires skills or 'light' consultancy to frame the correct targeting of the tool. Can be delivered through a matrix framework and workshop 'case simulation' methods Builds language for action and intervention planning Establishes a language for long term development of healthy relationships	The framework comprises a matrix of 5 attributes of relational value as well as 6 domains of a systems approach to an organisations socio-technical make-up. The attributes of relational value are identified as: • **Integrity:** How things connect and 'run' • **Respect:** How we treat others • **Fairness:** When people are not disadvantaged • **Empathy:** Going the extra mile. • **Trust** Knowing that there's always someone looking out for you
RP	Theoretical background is grounded in a growing broad based evidence of value of relationships, expressed widely in theories of Social Capital.	Focus on distance between parties, applicable across organisational relational contexts Most powerful in revealing disparities in relations between groups.	Used to reveal the key indicators of relational quality between a number of known groups.	Grounded in many years thinking & writing on relational issues in many contexts (often policy level) and practical application of the RP tool. Validation in on-line reports and self-authored material.	Requires skilled consultancy to identify relational focus and to bring together targeted groups. Ties in with formal change processes Builds language for action and intervention planning Creates visuals and useable and comparable data	The tool uses 5 domains, with a number of subdrivers in each case: • **Directness:** ways of meeting or connecting • **Continuity:** relationship over time • **Context:** the breadth of understanding of each party to a relationship • **Commonality:** alignes goals and common purpose • **Parity:** the recognition and appropriate use of power
RC	Theoretical background links to social psychology/ management	Strong in healthcare with a focus on team and organisational performance	Targeted towards organisational change Provides structural data explicitly for visualisation	Highly focussed definition and applicability Validated by use and third party testing	Fewer dimensions to administer than other tools Requires skilled consultancy to deliver the outputs to the organisation	Grounded on the impact of coordination to deliver better organisational performance through a relational component that connects different roles to perform particular tasks.

	studies & network theory	Focus on roles retains link to organisational relational emphasis Grounded in US healthcare context	Readily linked to other organisational performance measures	Wide literature support in management journals for the constructs underlying the theory and approach Evidence claims for positive impact on range of measures	Structural data can reveal strength of connectivity between roles and groups Benchmarking data is available to RC users	• **Communication** group/frequency/timely/accuracy • **Problems** team based problem solving • **Knowledge** of each others roles • **Respect** is group based • **Goals** are shared
RCp	Individual capacity to develop and maintain healthy relationships – linked to improved well-being. Developmental/ Citizenship/ Humanist tradition	Relationship quality is a capital asset and Relationship Quality and Work Engagement are correlated.	Couple/Family relationships/Education/Early years/public health. Connects work and social family life through actions. Contexualised for SMEs.	Research conducted with one plus one and Working Families (data not available). Cases included on website show suggest early scope of implementation.	Training programme to develop relational capability in individuals. Tools are a series of work packages delivered within consultancy framework using meetings and formal research techniques such as focus groups. Main components of toolkit enable; • Building a relational business case • Providing relational statements for embedding in practice documents • Mindful working tool (Initiation, trialling and reflection) • Diagnostic tool for managers (where are they on the relational journey) • Series of relationally focussed actions SME toolkit (including legal aspects)	Measure the environment in its abilty to establish and nurture relationships. Action learning approach using a number of diagnostic tools to capture key areas connecting relational capability and work performance. Key areas emerging from study which have been considered include; • Work-family conflict • Presenteeism and overwork • Flexible working • Gender

Appendix 3: Some vignettes to help you explore R^{v}

The following vignettes have been developed to help you think about some of the relational challenges present in typical health and social care situations. They would provide a platform from which the use of the full R^{v} framework could be facilitated.

Case study 1: A group of senior managers from across the local health and social care system meeting together over a period of at least a year to jointly ensure improvement in care delivery by the use of earmarked funds.

Who is present: The senior managers could include Directors of Adult Social Care, Finance Directors, Senior Clinicians – nurses or doctors, Chief Operating Officers, Chief Executives, Directors of Communities, Partnership Directors They would be either part of the Senior Management team of the local Clinical Commissioning Group or of the Local Authority.

The aim: The health and social care community has secured some funds to improve the delivery of care for your local population. This joint team will be held to account for the use of the money. The purpose of the group will be to decide the most effective areas for investment that will benefit the whole of your local population, outline the expected outcomes and ensuring that they are delivered. Some examples of your investment might be new joint assessment and care planning teams for the frail elderly, common quality improvement programmes in nursing and residential homes, joint programmes of brief advice and guidance on drugs and alcohol.

Things you might be considering: The range of things that you might be considering could include:

- Where to invest for the best outcomes for your local population?
- What can you do better jointly that you couldn't do as separate organisations?
- Have you got clear outcomes against each investment?
- Is there a methodology for monitoring those outcomes?
- Are the outcomes being delivered? If not why not?
- Are you on budget?
- Are your partners and the public aware of your plans?

Considering Rv :

- Decide what relationships within the team and between the two organisations might help you to achieve your aims on time
- Decide what behaviours might be seen if those relationships were in place? For example the ability to have the difficult conversation
- Self-assess your present position using a WSP R^{v} framework looking at the five attributes within the six dimensions of the Sociotechnical Framework
- Identify the gaps and why they might have occurred
- Working through this might in itself lead to understanding and improvement or a more structured development programme could be put in place

Case study 2: A group of clinicians alongside patient and carer representatives meeting together over a period of about six months with the aim of improving the care of people suffering with neurological conditions in your local community.

Who is present: The clinicians could include Physiotherapists, Consultants, GPs, Occupational Therapists, Specialist Nurses, Dietitians, Social Workers, Care Workers from a variety of organisations such as NHS Trusts, GP Practices, Local Authorities, Voluntary or Charitable. The patient and carer representatives could have knowledge and experience of one specific illness. The patient representatives may well have a level of disability.

The illnesses: The neurological conditions that you are considering range from Multiple Sclerosis, Motor Neurone disease, and Parkinson's to some much rarer illnesses that affect a very small number of people. All of them are progressive diseases with periods of remission but the trajectory varies greatly depending on the specific diagnosis. The level of disability and dependence increases over time. Those suffering from these chronic conditions are of course subject to the same likelihood of having another ailment e.g. heart attack, pneumonia as the rest of us but often their care in hospital is more complex as a result of their underlying conditions.

Things you might be considering: The range of things that you might be considering could include:

- Does diagnosis happen quickly enough?
- Is there enough specialist advice available?
- Is there equity access of all the different aspects of care?
- Are the patient's social and economic issues properly considered?
- Is there enough information out there?
- Are those staff who come in contact with these patients infrequently adequately prepared?
- Do carers have sufficient support?

Considering Rv

- Decide what relationships within the group might help you to achieve your aims on time.
- Decide what behaviours might be seen if those relationships were in place? For example the ability for the carer representatives to understand and contribute to the conversation
- Self-assess your present position using a WSP Rv framework looking at the five attributes within the five dimensions of the Sociotechnical Framework
- With the help of WSP identify the gaps and why they might have occurred
- Working through this might in itself lead to understanding and improvement or a more structured development programme could be put in place