Beyond barriers:

How older people move between health and social care in England

Annex: Relational audit – summary of findings

July 2018

Contents

Background

A relational audit is a way of measuring the health and quality of relationships between people working within a particular system. A bespoke relational audit feedback tool, a 'scorecard', was designed to measure the health of relationships between people working within health and social care in the 20 local authority areas (systems) where the Care Quality Commission (CQC) carried out a local system review. This scorecard was designed by special advisors at the Whole Systems Partnership and Relationships Foundation in conjunction with the local system reviews team at CQC.[a]

The relational audit scorecard was emailed to system leaders from each of the 20 systems with a request to share this with staff working at all levels of their organisations.

Responses to the scorecard were analysed, summarised and presented to CQC's review teams ahead of carrying out fieldwork in each review system, in order to inform their lines of enquiry during the review. Further detail on the methodology, associated caveats and scorecard contents can be found in the appendices to this document.

More than 2,500 people responded to the scorecard across the 20 systems. These responses have been analysed to inform the main report of the reviews programme, *Beyond barriers: How older people move between health and social care in England*. This annex has been produced to explore some of the key themes in the data in more detail. The responses cannot be said to be nationally representative for the following reasons: they are based on just 20 systems, 19 of which were viewed as challenged systems based on a range of performance metrics; no sampling methodology was used; and themes from responses are skewed towards systems, organisations and role types with larger response volumes. Nevertheless, there are common themes in the data that we believe to be important for wider consideration by leaders at a national and local level.

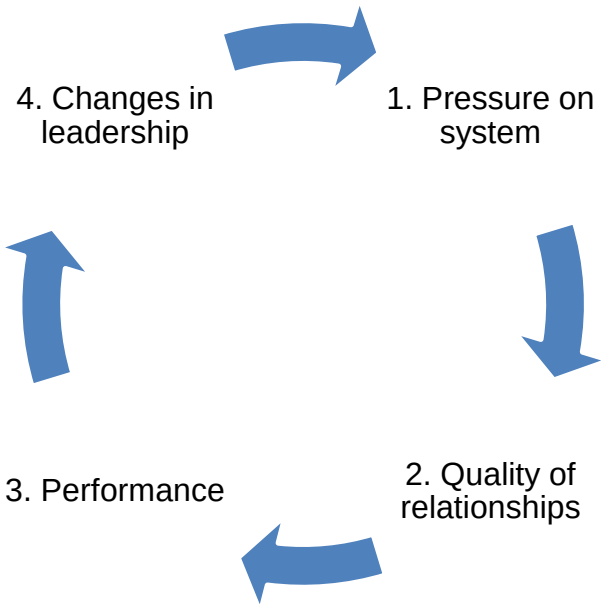
Executive summary and implications for policy and practice

- Healthy relationships between stakeholders are a vital component of delivering integrated services. However, the findings highlighted in this report suggest **possible disconnections within and across health and social care organisations.**
- **Organisational and staff changes slowing progress was a key concern** of people working in health and social care systems. A lack of stability in senior leadership was seen to hinder system improvement and long-term vision, and could also impact negatively on staff morale.

[a] CQC used this 'scorecard' under licence by agreement with Whole Systems Partnership and Relationships Foundation.

- **Financial and resource pressure were key concerns** reported by respondents from all sectors. These pressures were negatively impacting relationships, developing a shared vision and joint working across systems. A joint, system-wide approach to these pressures could improve what could be achieved in a system and encourage more positive relationships.
- **The existence of a blame culture was another key issue reported by staff at operational management and frontline levels.** This was seen as being influenced by system pressures and could impede joint working and affect the services people received. Linked to this, responses suggested people were often unwilling to taking organisational risks that might benefit the system owing to a fear of failure or criticism, which could further delay integration and progress.
- Compared with other sectors, respondents from **the voluntary, community and social enterprise (VCSE) sector rated the health of relationships in their systems worst**. They described a lack of recognition of their sector's value, a lack of engagement and consultation, and under-use of what they had to offer. However, some also described the VCSE sector's role as "filling gaps" in health and social care provision. Consideration needs to be given to how VCSE partners are recognised for their contributions and best used in health and care systems.
- **Frontline staff and administrative staff scored statements related to communication less positively compared with people working in more senior roles**. Ensuring good communication and involving all staff could improve relationships, facilitate stability and better inform decision-making.
- When moving toward integration and improved care pathways for older people, interpersonal aspects should be considered alongside structural changes. Enablers of open and honest relationships discussed by respondents included, **open communication, non-judgemental support, and trusting and respectful personal relationships**. However, organisational divides, defensive behaviours and a lack of honesty and transparency could act as barriers, and could be negatively influenced by system pressures.
- **The impact of system pressures on relationships and performance can result in a downward spiral** as summarised in figure 1 below. Responding to this requires targeted interventions that can be counter-intuitive. When working under pressure, it may seem difficult to justify spending time and resources encouraging good quality relationships, however doing this can break the negative cycle and lead to better performance.

Figure 1: Impact of system pressures on relationships and performance



1. When pressure on the system increases, the quality of relationships often suffers.
2. When the quality of relationships declines, this can result in poorer performance and outcomes.
3. When performance declines, leadership changes tend to happen more often.
4. When leadership changes regularly, the pressure on the system can increase.

Key concepts: relational value and relational proximity

The relational audit scorecard is based on two conceptual frameworks for assessing the health of relationships: relational value[b] and relational proximity. They describe the attributes of effective relationships.

Relational value is described by the Whole Systems Partnership and Relationships Foundation as:

- 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, in other words a relationship is 'for something' and can therefore be described as 'doing work' toward a specific goal or set of goals. Relational value is something that sets direction.

Relational value is understood to have five attributes:

- **Integrity**: the extent to which there is consistency and cohesiveness between parties.
- **Respect**: the extent to which people treat each other with respect.

[b] Relational value is a registered trademark of Whole Systems Partnership.

- **Fairness**: the extent to which people have equitable shares in the relationship.
- **Empathy**: the extent to which the parties in the relationship have compassion for each other and demonstrate an understanding of each other's needs.
- **Trust**: the extent to which people feel they can rely on others in the relationship.

These attributes of relational value are applied using a socio-technical framework with six dimensions:

- **Culture**: including norms and rules; relations between agencies (including shared history); mindsets and world views.
- **Vision**: including ideas about what the future could look like, and expressed goals.
- **People**: including individual staff skills, development and involvement.
- **Process**: including routines, standards, briefings, handovers, and working patterns.
- **Infrastructure**: including the physical space, such as transport and buildings.
- **Technology**: including the virtual space, such as IT, access to relevant information sources and technological communication.

Relational proximity is a different but related concept that is more focused on the 'closeness' of relationships and aspects that can cause barriers to that. It has five domains:

- **Directness**: how well people communicate in the relationship.
- **Continuity**: the extent to which relationships are consistent over time.
- **Multiplexity**: how well people in the relationship understand each other.
- **Commonality**: the extent to which there are shared aims or goals between parties in a relationship.
- **Parity**: the extent to which there are equitable power relations between people in a relationship.

The scorecard for the relational audit included 30 relational value statements, one for each of the five relational value attributes across each of the six socio-technical dimensions; plus five additional relational proximity statements (appendix 2). These statements were created specifically for CQC's local system reviews programme by the Whole Systems Partnership and Relationships Foundation special advisors together with the CQC local system reviews team. Applying the newer concept of relational value alongside the more established concept of relational proximity allowed us to gain a more in-depth perspective than we might have done from using either alone.

Detailed findings

Overall responses to statements

Details of respondents can be found in appendix 4. Respondents were asked to rate 35 statements on a six-point scale from “consistently not true” to “consistently true”. These ratings were attributed scores from 0 to 5 (see figure 2). Four of the 35 statements expressed a negative sentiment (for example, “Organisational and personnel changes slow progress”) as opposed to a positive sentiment (for example, “We treat each other fairly”). For the four negative statements, the scores were reversed to enable them to be compared alongside the positive statements.

Figure 2: statement response options and scores

Scale	Score for positive statement	Score for negative statement
Consistently not true	0	5
Rarely true	1	4
Sometimes true	2	3
Often true	3	2
Mostly true	4	1
Consistently true	5	0

Average scores across the relational value attributes and relational proximity domains were very similar and converged toward the middle, with relational value attribute scores averaging between 2.7 and 2.9 and relational proximity averaging a score of 2.5. These overall averages are not particularly meaningful, however, as they obscure the variation between individual statements and groups of respondents.

More is revealed by considering scores by individual statement. Figure 3 shows the overall scores for each of the relational value attributes and socio-technical dimensions, highlighting the three highest (best) and lowest (worst) scoring statements, which figure 4 describes in full.

Figure 3: Scores by relational value attributes and socio technical dimensions across all participants

	Socio-technical dimensions					
Relational value attribute	**Culture**	**Vision**	**People**	**Process**	**Infrastructure**	**Technology**
Integrity	2.98	3.14	2.93	2.67	2.68	2.53
Respect	2.75	2.83	3.11	2.91	2.91	2.35
Fairness	3.32	3.08	2.90	2.77	2.91	2.58
Empathy	2.81	3.03	2.53	2.55	2.82	2.57
Trust	3.14	2.71	2.15	3.08	3.08	2.73

Figure 4: Best and worst scoring relational value statements across all participants

Best scoring	We treat each other fairly.	Fairness/Culture
	We can be open and honest in our dealings with each other.	Trust/Culture
	We experience a common purpose across the organisations in meeting the needs of our clients.	Integrity/Vision
	Getting in touch with people is easy and reliable and doesn't slow communication.	Integrity/Technology
	Decisions about how we use technology takes into account the needs of all parties.	Respect/Technology
Worst scoring	People take organisational risks where this has the potential to serve wider system goals without fear of criticism or failure.	Trust/People

Figure 5: Scores by relational proximity domains across all participants

Relational proximity domains				
Directness	**Continuity**	**Multiplexity**	**Parity**	**Commonality**
2.31	2.14	2.50	2.93	2.66

Figure 5 shows the best and worst scoring relational proximity statements. The best scoring statement was: "People are not consulted and have little influence on decisions that affect them"[c] and the worst was: "Organisational and personnel changes slow progress".[d]

There was some consistency among the 20 systems on the best and worst scoring statements overall. The statement about being treated fairly[e] was consistently in the top five and the statement about risk aversion[f] was consistently in the bottom five for each system. All but five systems also scored worst on the statement about organisational and personnel continuity in the relational proximity statements.

The best scoring statements present a cohesive picture of what healthy relationships might look like: having a common purpose that all parties in the relationship are committed to, where all parties are meaningfully involved, and people treat each other fairly and can be honest and open with each other.

By contrast, the worst scoring statements highlight key barriers, for example where a lack of continuity might contribute to poor communication between organisations, potentially leading to problems such as decisions around technology, and leaving people not confident to take risks that might positively benefit the system.

Due to analytical capacity only free text comments relating to the best and worst scoring statements across both frameworks combined were selected for further analysis, which is presented below.

[c] Proximity/parity
[d] Proximity/continuity
[e] "We treat each other fairly."
[f] "People take organisational risks where this has the potential to serve wider system goals without fear of criticism or failure."

Analysis of free text comments: best scoring statements

"We can be open and honest in our dealings with each other"
(Trust/Culture)

"We treat each other fairly" was the best scoring statement, but as we received relatively few free text responses related to it we analysed comments form the next best scoring statement, "We can be open and honest in our dealings with each other". This statement comes from the 'trust' relational value attribute and 'culture' socio-technical dimension.

Enablers

There were positive comments about openness and honesty in relationships across sectors and respondents working in most role types in the systems we reviewed. In these comments, factors influencing positive relationships included having **open communication** between different organisations and **non-judgemental support**. Relationships characterised by openness could facilitate positive relationships and joint working. As one respondent working in an operational management role at a health commissioning organisation described, "*relationships are open and honest on the whole, and this really benefits the way we work together.*"

Historic relationship quality between organisations could impact on the openness of current relationships. While one social care senior executive described how "*over the years our relationship [with the continuing healthcare team] has developed based on mutual trust and respect*". In another system, a respondent working in a health provider felt that *"historical animosity and distrust"* had not been addressed. However, **trusting and respectful personal relationships** between individuals could be contrasted with poorer organisation-level relationships, "*Individuals build relationship based on respect and trust but this does not work on an institutional level" (role not identified, social care commissioning organisation).*

Barriers

A lack of collaboration, trust and openness affected system working for stakeholders at all levels, and across sectors. Stakeholders from all role types reported **organisational divides** and **defensive behaviours** when people appeared to prioritise their own goals over whole system working:

"In my view [the local authority] do not see health issues as a priority and focus more on budgetary concerns and the cost of social services than the quality of the service being provided to their residents. When challenged they become very defensive."

Senior executive, health provider

A **lack of openness, honesty and transparency** was a theme at senior executive and operational management levels. For example, another senior executive in a health provider

said that they were *“rarely honest about the overall strengths and weaknesses of different partners and organisations”.*

Leadership behaviours could discourage openness and transparency across levels. For example an operational manager in social care commissioning said that being honest and transparent could be “*met with criticism”*. A respondent selecting multiple roles and working in social care commissioning and provision said that, “*where we have been open and honest with any challenges this has resulted in support at a local level but complete alienation at senior management level”.*

The pressures associated with **delayed transfers of care** could contribute to divisions between partners at all levels. One health commissioner cited the requirement of regulators for them to *“report delays and admissions by social care or health responsibility”* as being a barrier to a collaborative, transparent and supportive environment in health and social care. At the front line, one respondent working in a health provider said the pressure to reduce delays drove dishonest transactions between colleagues for *“a bed at any cost”.* This breakdown in trust negatively affected working relationships.

“We experience a common purpose across the organisations in meeting the needs of our clients” *(Integrity/Vision)*

The statement above is from the 'integrity' relational value attribute and 'vision' socio-technical dimension. This statement was rated joint second best overall.

Enablers

Senior executives from most sectors commenting on the existence of a shared vision in their systems for the people they serve were often positive, for example describing their work toward this aim. There was recognition of **working together in spite of challenges**, the need for **vision to align with action**, and the facilitative role of **stable leadership**.

“In the last two years we have made huge steps forward as a system to work together towards a shared goal which is patient-centred and organisationally agnostic. We know we are not perfect but there is a real will to work collectively to overcome what are often complex challenges.”

Senior executive, health provider

Senior executives from social care providers were a notable exception to this, however. Although only two respondents addressed these issues, they highlighted concerns about the focus being on finances rather than people, and a lack of shared vision between local authorities and social care providers which negatively impacted their working relationships. Operational management staff across sectors also often described having a shared vision and purpose positively, for example telling of collaborative working that was benefiting the people they serve and ensuring the person is at the centre of decisions. Operational

management and frontline staff from health providers in particular tended to comment positively about how they worked together at a local level in the best interests of the people they served. This could be facilitated by training and peer support for staff and working towards a no-blame culture:

"There have been significant improvements over the past few years in the way the different organisations communicate and work together for the benefit of the patients… Working relationships between the different organisations have also dramatically improved with more training and peer support which has been a benefit to all and must also be a benefit for patients."

Operational manager, health provider

A few staff at various levels across sectors described the need for commissioning to facilitate a shared vision for improved care. However, a shared vision and outcomes could be developed despite the lack of integrated commissioning.

Barriers

A few senior executives across sectors felt that **organisational needs could take priority over having a common purpose to meet the needs of the people they served**. This could be linked to pressures of workload, financial pressures (discussed in more depth later in this report) or a lack of coordination; compromising relationships and a system focus on people.

"The system simply doesn't operate as a system. The needs of individual organisations take priority over the needs of the elderly people we are supposed to be here to serve, the role of prevention is consistently ignored and truly collaborative working is poor or non-existent."

Senior executive, multiple organisation types selected

Operational managers described how **poor relationships between partners could be a barrier to a shared vision and purpose**. Poor relationships between commissioners and providers were highlighted by operational managers across sectors:

"Too often the commissioning authorities do not listen to providers. There seems to be differing values and aims between the two. Every organisation should be working to achieve the same goals to ensure quality of care for the people we care for – this sometimes feels lost."

Operational management, health provider

Comments from frontline staff often echoed these perspectives, for example, describing how **funding and resource pressures** could take precedence over meeting the needs of people:

"There is still too much time spent on organisations trying to gate keep and protect their own budgets rather than trying to work together in the best interests of the person."

Frontline staff member, social care commissioning

Additionally, frontline staff across sectors noted that the **lack of a shared vision** or approach in a system, for example in relation to risk, or a **lack of flexibility** in a system, could prevent them from delivering the best care:

"Frontline staff are trying to build strong working relationships for the benefit of service users however the rigidity of some health systems makes this task challenging on a daily basis."

Frontline staff member, social care provider

Staff in other roles (or those who had selected multiple or none in their responses) across sectors also described organisational and relational barriers to working to a common purpose of good outcomes for people. These included conflicting organisational priorities and external pressures, a blame culture, a lack of joint working, and practical constraints. However, others also described working collaboratively to meet the needs of people or described improvements in developing a shared commitment, and collaborative working towards improved outcomes for people.

"I have worked for the NHS for over 15 years and it's only really now that I can see changes in the way things work for patients that means that needs are being met across providers and the wider community networks in a truly holistic way."

Multiple role and organisation types selected

Analysis of free text comments: worst scoring statements

"Organisational and personnel changes slow progress" *(Proximity/Continuity)*

The statement above is from the relational proximity domains. This was the worst scoring statement overall.

In some systems, **changes at the senior leadership level were described as having negative impacts** by people across roles and sectors. The implications included changes not being followed through or a loss of knowledge about the system, and could lead to a lack of direction or long-term vision.

"Some good work was done in 2017 at the senior executive level but changes in senior permanent appointments in the local authority have meant that the wider buy in has been affected as many appointments have been filled by interims and consultants. [This means] agendas have become more restricted and short term."

Senior executive, health commissioning

Staff not in senior executive roles also identified that organisational changes could negatively impact staff retention and morale. Operational managers from social care providers additionally described the **implications of personnel changes on their workforce capacity**. The loss of experienced staff as well as difficulties recruiting or cuts to staff numbers increased pressure on those remaining.

"People take organisational risks where this has the potential to serve wider system goals without fear of criticism or failure." *(Trust/People)*

The statement above is from the 'trust' relational value attribute and 'people' socio-technical dimension. Free text comments associated with this statement described issues such as a blame culture and dealing with risk. The majority of free text responses came from those in operational management and frontline roles.

Respondents described how **system pressures could lead to a blame culture** between partners, mirroring the themes from other statements described above: "*We talk about DTOCs [delayed transfers of care] and not patients, it is a blame culture"* (operational manager, health provider).

Defensiveness and a focus on apportioning blame rather than acknowledging underlying issues and identifying solutions were evident. This was mentioned at all levels and across sectors, but was particularly prevalent among responses from operational management and frontline roles. They identified a **blame culture as hindering joint working**, with time spent on allocation of blame for, rather than attempts to resolve, issues:

"Rather than acting in a defensive way, using our expertise to achieve the best outcome for adults would appear to be better use of time."

Frontline staff member, 'other' organisation type selected

Only a few senior executives addressed these topics in their comments, but there was some difference between their comments and perceptions of frontline staff. Although some of those at the most senior level tried to model good working relationships, for example a willingness to take risks, they felt this wasn't always effective at facilitating positive change throughout all levels of organisations. On the other hand, from the perspective of those on the front line, the role of managers and leadership could be viewed as promoting negative cultures of blame:

"People are often afraid to do anything that might bring them notice. Investigations often look for deviations from policy rather than actual root cause. There is a culture of blame and pervasive fear on the part of employees."

Frontline staff member, health provider

Some operational managers and frontline staff from social care and those who selected multiple or no organisations identified a lack of trust and fear of blame with regard to their interactions with staff in acute hospitals. For example, some described feeling that health organisations blamed social care providers for delays in discharge from hospital.

"There are many times when health professionals aim blame at the [adult social care] team, especially in regard to discharges from hospitals when the reasons behind the delays are not necessarily for [adult social care] to resolve."

Frontline staff member, social care commissioning

This contrasted with how operational managers and frontline staff from health providers discussed blame. They didn't mention social care explicitly (referencing "different parts of the system") when discussing issues of blame, and a few also mentioned problems with a blame culture within their sector. This may indicate more sensitivity to issues around blame culture among staff from health providers, or that the issues within their own sector take greater prominence than those beyond it.

Staff at all levels noted that **risk aversion could slow progress and create barriers to joint working**: "*The system as a whole has become risk averse and avoids opportunities to innovate due to a fear of not getting everything right*" *(senior executive, social care provider)*. A few respondents from social care felt that health services were too risk averse.

Pressured funding environments could mean that risk taking was not always supported:

"*The system relies on individuals being heroic and brave, but when pilots end and no more money is available to continue good work, it is disheartening."*

Senior executive, health provider

A lack of trust and risk aversion was also linked to silo working. However, where respondents felt there was a commitment to working towards reducing blame across the system, they reported positive benefits for relationships and joint working:

"I believe there has been a significant improvement across the organisation and those of our partners and stakeholders… We have a [team] that meets and works together daily in a non-blame manner to get the best result for patients… The benefits and risks are shared. There are now integrated roles and focus and it is so much better for patients and staff."

Operational manager, health commissioner

Both blame culture and risk aversion seemed to be highlighted alongside situations where integration was not working, for example where there was fragmented or silo working or no shared understanding or goals. Financial and other top-down pressures also impacted negatively.

Financial and resource issues

"Day-to-day decisions about resources and priorities reflect our shared long-term goals" *(Proximity/Commonality)*

We chose to explore the free text comments related to this statement from the relational proximity domains, as financial and resources issues were key themes raised in the comments by respondents from all sectors. Although a few respondents did feel that financial challenges could be overcome and that their systems worked well despite challenges faced, comments around finances were almost universally negative.

Respondents from across the health and social care sectors (providers as well as commissioners) described how **financial pressures were negatively impacting joint working,** causing barriers to integrated working, constraining investment and driving changes based on cost-saving: "*Extreme lack of capacity, man power and funding seriously limits what can be done and stops innovation" (multiple roles selected, health provider)*.

Financial pressures could lead to tensions between organisations, for example regarding who is expected to fund a particular service or need. At all levels, there was a concern that people making decisions often **put finances before people or quality**. Respondents from health and social care providers described how **financial pressures negatively impacted the quality of care** they could provide, including around discharge planning. This could affect people's access to services or force them to pay more for their care. In one system, people's experiences were negatively affected by delays in the continuing healthcare process.

"With all the cut-backs, lack of staff and increasing paperwork it has become increasingly difficult to provide a safe and consistent service for the residents. We feel that we are no longer able to provide a good quality of life for them as we were in the past. There is only time for basic care, and little or no time for social interaction."

Frontline staff member, social care provider

The way that services are commissioned and funded could negatively impact on joint working. This could create inefficiencies within a system and drive competition between partners rather than collaboration. As an operational manager from the VCSE sector described, *"the competitive nature of commissioning acts as a deterrent to genuine partnership and creates an atmosphere of mistrust."*

A few respondents from health and social care providers recognised the need for more joined up budgets between health and social care, as one frontline staff member from a social care provider commented: *"working more equitably with our health colleagues and an equal share in resources available would help the system work much more effectively."*

These themes came from staff at all levels, but there were some differences when considering responses by role and sector. Senior executives from health providers tended to describe how **financial and resource pressures were hindering their ability to make progress on system-level goals and plans**.

"Although the system response is improving, the staffing pressures experienced across organisations is limiting the pace of progress. There is a real willingness to work together and reduce the historical interface issues that limit our ability to work seamlessly but the resources (staff and non-staff) are not always available in a timely fashion."

Senior executive, health provider

However, senior executives from social care providers talked more about the **financial sustainability** of their organisations and how commissioning decisions were impacting on this and putting people put at risk.

"[The local authority] and [clinical commissioning group] have generally had very good working relationships with providers but these have been compromised by an aggressive stance on funding, which is cost-reduction led, and rarely needs led. As a result, the system puts people at risk."

Senior executive, social care provider

Frontline staff across sectors described similar issues such as a lack of resources and a need for greater funding, as well as joint working around funding and budgets. As among senior executives, those in other roles in social care organisations also recognised **the impact of commissioning, fees and the different funding models between health and social care**. Health providers meanwhile discussed **capacity issues in community services** (including health and social care services) impacting on their ability to discharge people to the community.

Comments from respondents working in the VCSE sector that mentioned financial pressures were also almost universally negative. Like those from the health and social care sectors, they noted that financial pressures were impacting on access to services and quality of care. They also described the challenges inherent in the way the sector is commissioned, and how this impacts on relationships:

"There is a vast, untapped resource in the community that is not only under-recognised, but actively undermined by current commissioning and partnership arrangements. The competitive nature of commissioning acts as a deterrent to genuine partnership and creates an atmosphere of mistrust."

Operational manager, VCSE sector

A few VCSE respondents additionally described how **the VCSE sector was providing services to "fill gaps" in public sector provision**: "*The voluntary sector is under*

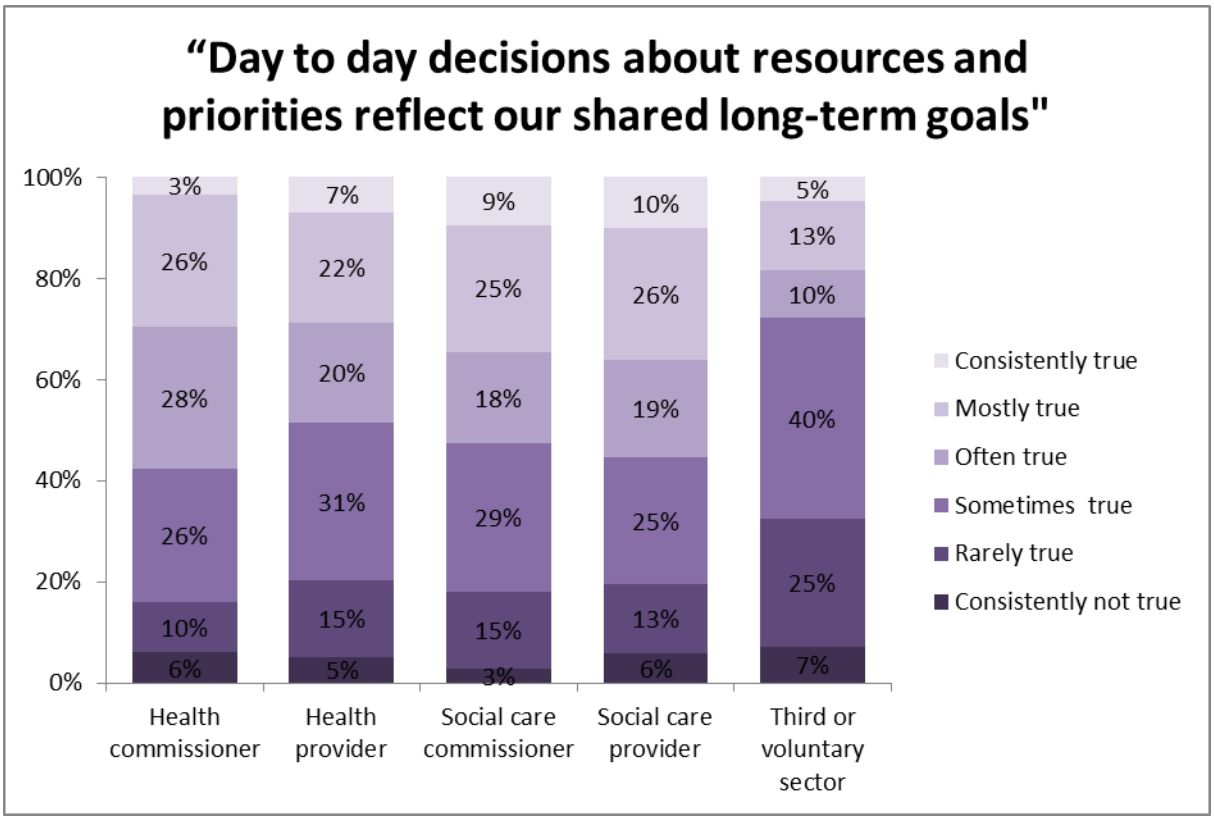
resourced and props up the system, as do family carers" *(senior executive, VCSE sector)*. They felt that the contribution of their sector was not properly recognised, the impacts of funding cuts not acknowledged and (perhaps unsurprisingly) that there was a need for greater investment in their services.

"There is a lot of talk about prevention and delivering services at community or locality level, however not the matching investment. There is an assumption that voluntary sector organisations and volunteers will deliver more for no investment."

Senior executive, VCSE sector

The negative sentiment of VCSE respondents on this issue was also captured in the statement scores, where there was a large distinction between the VCSE responses and those of other organisation types (figure 6). Less than a third of VCSE respondents felt this statement was often, mostly or consistently true compared to half or more of other organisation types.

Figure 6: Proximity/commonality results by organisation type



Findings by respondent type

Length of time in the system

In terms of length of time working in the system, scores were slightly worse the longer a respondent had spent in the system (see figures 7 and 8).

Figure 7: Average relational value scores by length of time working in system

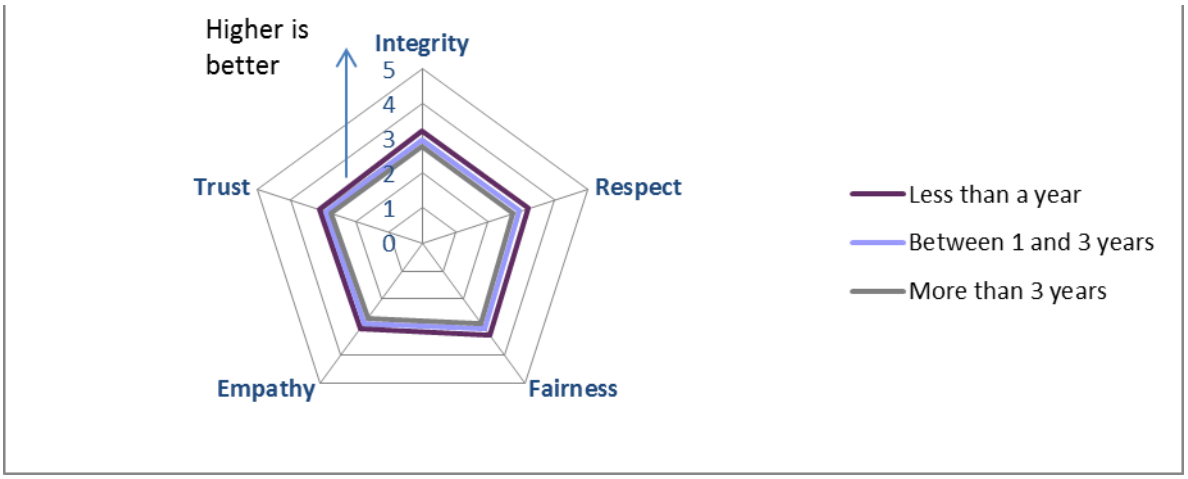
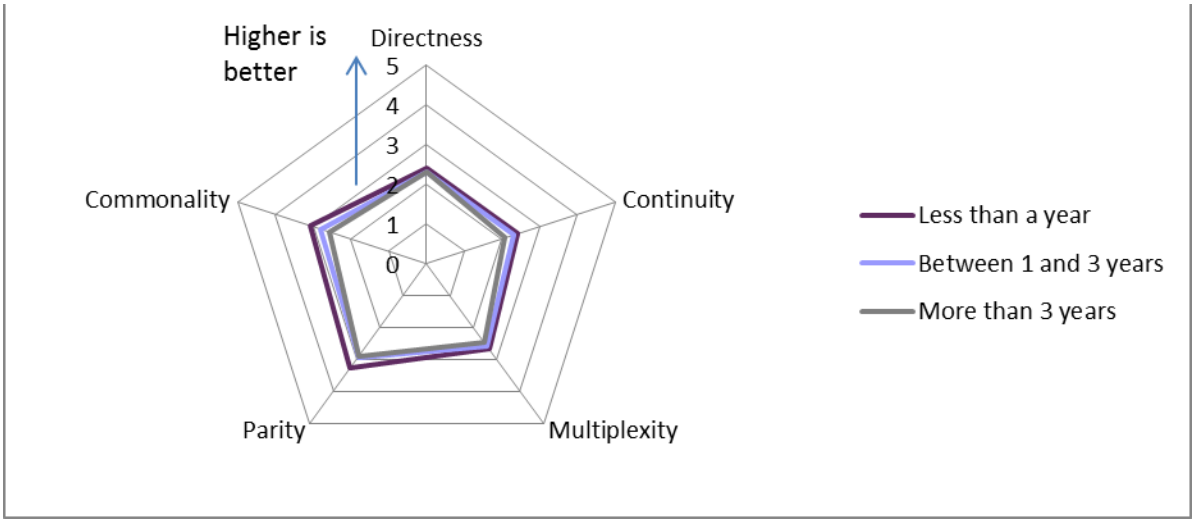


Figure 8: Average relational proximity scores by length of time working in system



Organisation type

Overall there did not appear to be large differences between average responses from those in different roles or from different organisation types. However these averages tend to obscure differences between groups on individual statements. Some of these differences are explored in more detail in this section.

Figures 9 and 10 show that, overall, **VCSE sector respondents had worse average relational value and relational proximity scores than respondents from other organisation types**. As seen above, on some statements such as the one about resources

(figure 6), these differences could be quite large. It should be noted, however, that respondents from the VCSE sector represented only 7% of total respondents and in some systems there were only a handful of respondents from this sector.

Figure 9: Average relational value scores by organisation type

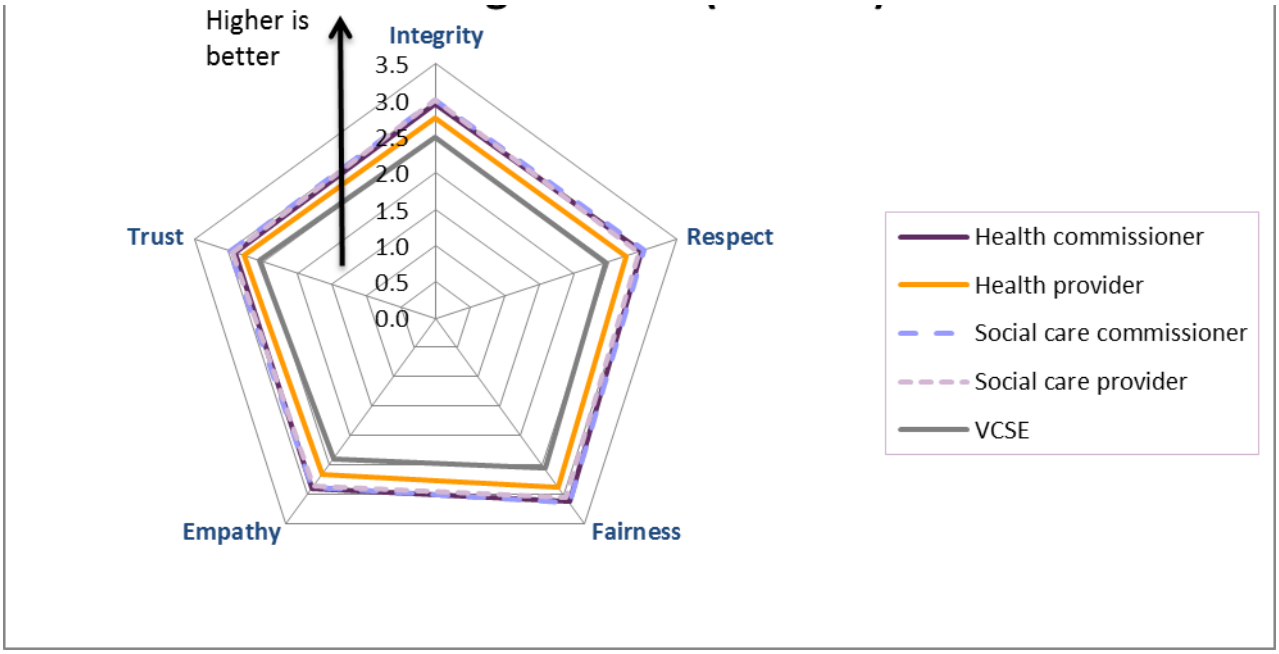
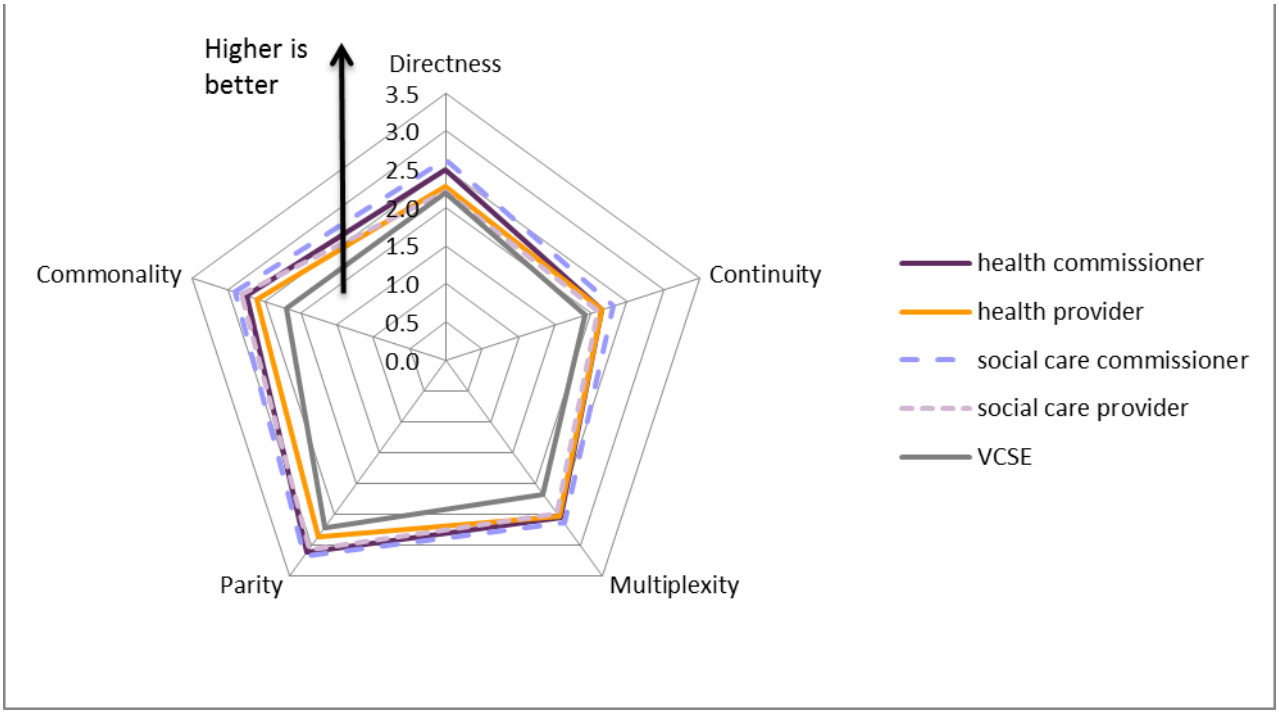


Figure 10: Average relational proximity scores by organisation type



We analysed the free text comments submitted by VCSE respondents to explore the issues they were commenting on in greater depth. The number of VCSE respondents leaving free text comments was low (59 free text responses in total across the 20 local systems) and

most of these were from people in operational management or senior executive roles. However, by organisation type they left the largest percentage of free text comments.

Financial concerns were a key theme among VCSE respondents, as described above. Another key issue raised by VCSE respondents was **the lack of recognition** of the role their organisations could play in supporting older people. Although not the case for all respondents, more commonly there was a perception that relationships were unequal: "*The [voluntary and community sector] is often seen as the 'poor relation' – not 'professional' and not understood" (senior executive, VCSE sector)*.

Lack of engagement or insufficient consultation was another key concern, particularly among senior executives. Again, this was not universal, and meaningful consultation could enable VCSE organisations to feel valued:

"At every stage of this journey there has been extensive consultation to ensure that everyone's view has at least been considered. As a [large] preventative service, my organisation is fully engaged with statutory and voluntary sector partners and we feel included, valued and 'listened to'."

Senior executive, VCSE sector

That this comment came from a larger organisation, however, is relevant when contrasted with concerns that smaller organisations were marginalised compared to larger players. This suggests a need for systems to consider all relevant VCSE partners when they are consulting and commissioning services.

The lack of recognition and engagement could mean insufficient sharing of resources (skills and talents) between sectors but also **under-use of what the VCSE sector can offer.**

However, a few respondents did present an improving picture with partnership work planned or happening. A few senior executives (as well as other staff) were generally positive about the progress made with regard to joint working in their systems, but this could vary depending on the organisation the respondent was from in a system.

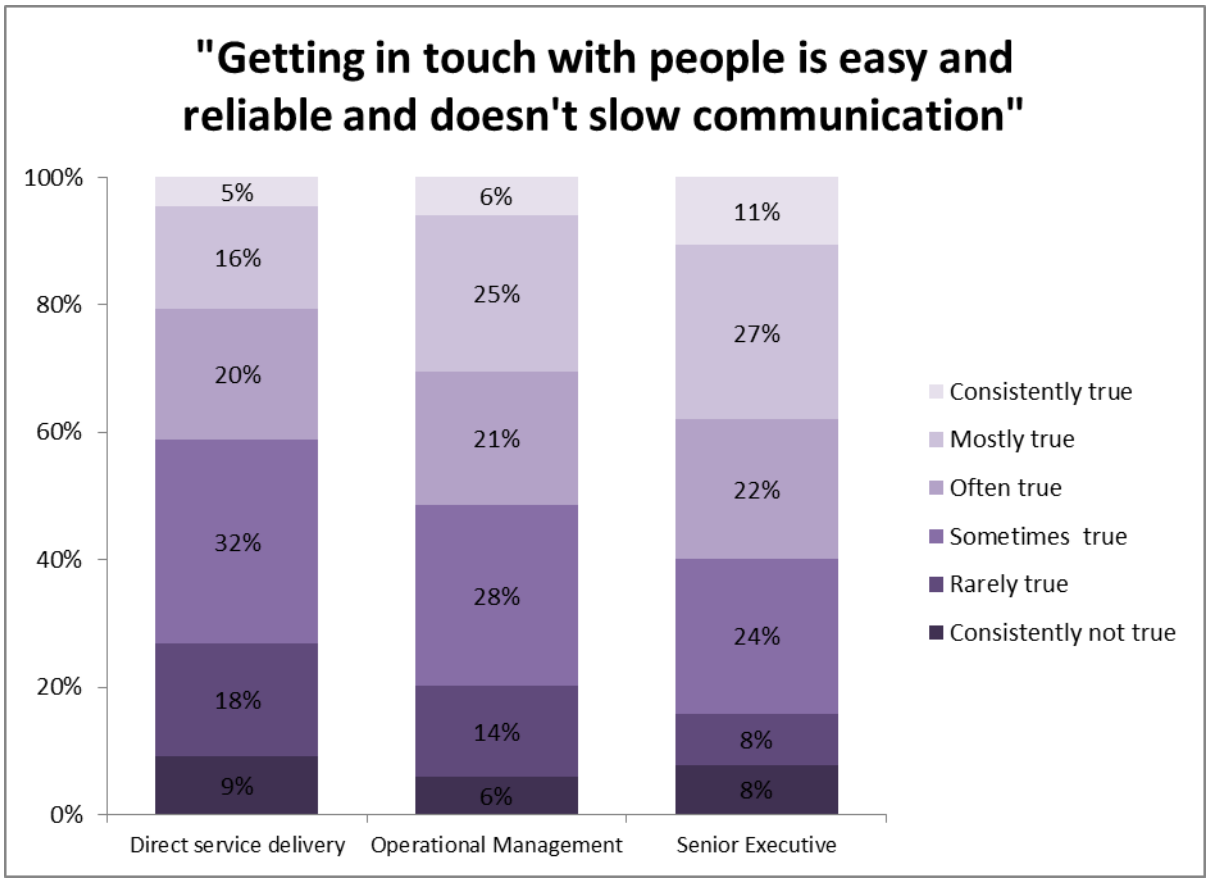
Role type

In terms of primary role, administrative staff tended to rate relationships most positively across the relational value attributes, although this was largely reversed on the relational proximity statements. However, it should be noted that respondents from this role type represented only 11% of total respondents and in free text comments a few administrative staff explicitly noted that they were rating relationships as they saw them but that they felt this was not representative of the whole system.

Generally, senior executives and operational management rated the health of their relationships slightly more positively than frontline staff. In particular, within the relational

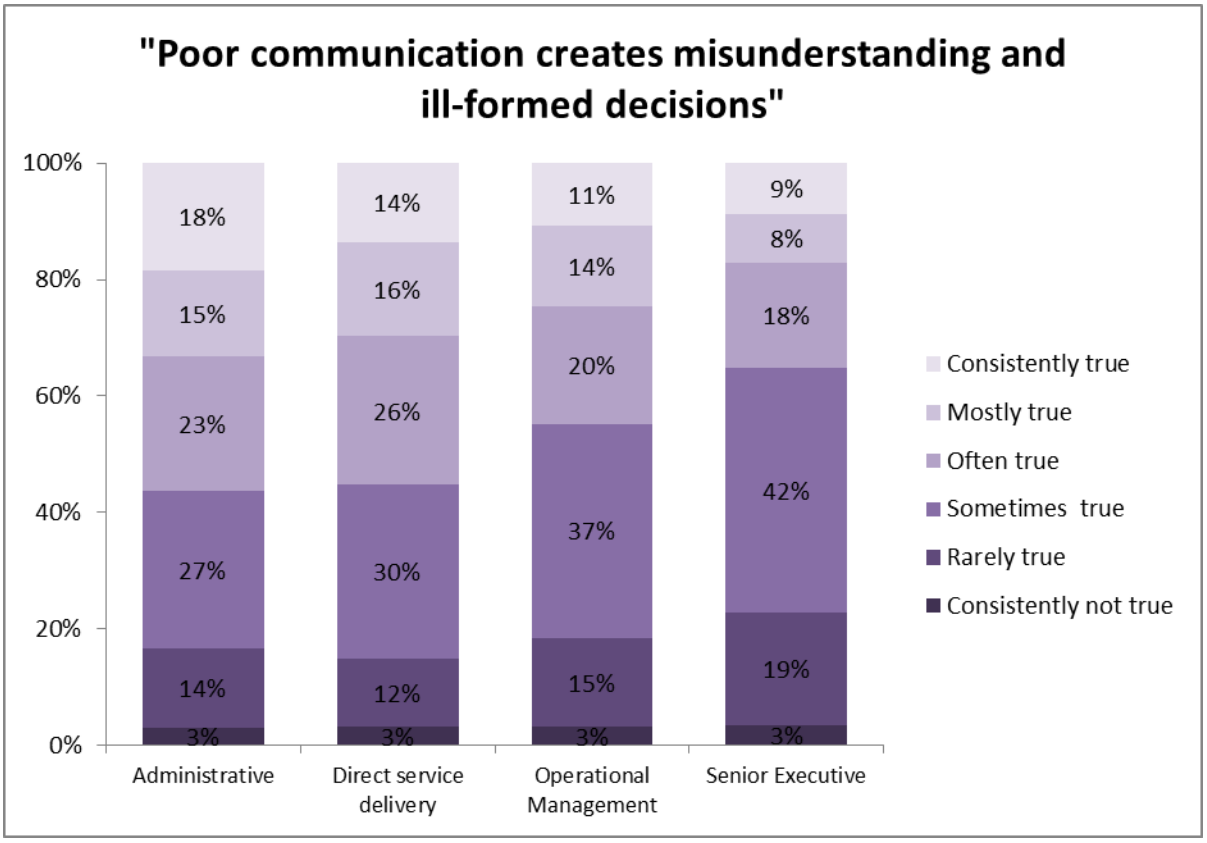
value framework, staff in direct service delivery roles rated statements associated with staff involvement and individual respectful relationships, how systems and processes work, and feeling able to take organisational risks without fear of criticism or failure, worse than other role types. However, the starkest contrasts in scores between role types were in relation to the statements about communication[g] in both frameworks (see figures 11 and 12), with frontline staff giving the worst scores and senior executives the best. This indicates that issues with communication are a more common challenge for frontline staff and may reflect the different nature and needs surrounding communication at different levels and a possible disconnect between frontline and more senior staff.

Figure 11: Integrity/Technology: responses by role type



[g] Integrity/Technology: “Getting in touch with people is easy and reliable and doesn't slow communication” and Proximity/Directness: “Poor communication creates misunderstanding and ill-formed decisions”.

Figure 12: Proximity/Directness: responses by role type



Alongside frontline staff, administrative staff gave the worst scores compared to other role types on relational proximity statements relating most closely to everyday experiences of communication (figure 12) and being informed and involved in decisions.[h] They also gave the worst scores on statements relating to limited knowledge causing problems and missed opportunities, and organisational and personnel change, which could both be a result or a cause of poor communication and involvement.

[h] "Poor communication creates misunderstanding and ill-formed decisions" and "People are not consulted and have little influence on decisions that affect them".

Appendix 1: Methodology

A link to the online relational feedback tool (scorecard) was sent out by CQC in the second week of the local system review process for each system we visited, using the system key stakeholder contacts list returned from each system's system oversight information request (SOIR). The scorecard was open for approximately two weeks.[i] System contacts were asked to cascade the feedback tool in their organisations in an attempt to reach the widest possible range of people working in the local health and social care system. At the deadline date, results were analysed and presented to the CQC review team for each individual system so the findings could inform the site visits. Responses received after the deadline have been incorporated into this document.

Respondents were asked to rate 35 statements (appendix 2) on a six-point scale from "consistently not true" to "consistently true". They were also asked to give an indication of the type of organisation they work in, their role type, and length of service, and there was a short free text comment box at the end of the survey if they wished to add any comments relating to their responses (appendix 3).

Analysis consisted of converting statement ratings into scores from zero to five and then calculating the averages across the relational value attributes and socio-technical dimensions, the relational proximity domains, and across individual statements. As four of the 35 statements expressed a negative sentiment (for example, "Organisational and personnel changes slow progress") as opposed to a positive sentiment (for example, "We treat each other fairly"), the scores for these statements were reversed to enable comparison alongside the positive statements, so high scores are good while low are bad for all statements.

Scores were considered by role type, organisation and length of service. The free text comments submitted were coded in MaxQDA against the relational value and relational proximity framework concepts. Due to analytical capacity, only free text comments relating to the highest and lowest scoring statements; to VCSE sector responses; and to those relating to financial and resource issues were thematically analysed to explore the issues in greater depth and add insight.

Alterations to method

As there was no opportunity to pilot the tool, some small changes were made following initial roll out, including randomising the order of the statements and adjusting the wording and instructions on the email invitation and online form to encourage participation and further sharing of the feedback tool. Additionally, the wording of the five statements relating

[i] . The first area, Halton, had less time to respond than other areas. Owing to holidays and requests for extensions some areas were given longer to respond

to ‘Infrastructure’ was altered to clarify what these statements represented. An option was also added to state the role type if ‘other’ was selected.

Risks and limitations

The lack of a pilot meant alterations to the method were made mid-programme (as described above) and so the questionnaire was not consistent across all systems.

Additionally, because the method relied on local stakeholders disseminating the tool, we had no control over who it was sent to or how it was advertised beyond our initial contact with the named individuals on the system contacts list. Generally the number of responses received from different stakeholders increased as the review programme progressed and the profile of the reviews increased. However, the fact the tool was only open for a short window of time may have limited the number of respondents. Technical issues meant that organisations in some areas had email policies blocking the hyperlink that took them to the online tool. While some people contacted us about this and we were then able to advise them (and subsequent participants) how to access the feedback tool, it is not possible to know how many potential respondents were affected by this issue.

Because of these reasons, it was not possible to calculate a response rate and the responses therefore cannot be considered to be representative of perspectives across the 20 systems reviewed. Moreover, because this tool only gathered views across 20 systems, 19 of which were considered to be challenged based on performance against a range of performance metrics, these findings cannot be considered to be representative nationally.

The relational audit was designed to capture a snapshot at a particular point in time. It should be noted that some systems were going through significant periods of change at the time the audit was conducted, meaning the snapshot captured might differ if undertaken again.

Finally, the pace at which the analysis was conducted meant strategic decisions were taken on which issues to focus, particularly in relation to the analysis of the free text comments. This is therefore not a comprehensive analysis and was guided by the scores for the statements.

Appendix 2: Relational audit statement matrix (September 2017)

	Culture	Vision	People	Process	Infrastructure	Technology
Integrity	We work together effectively irrespective of differences in organisational culture.	We experience a common purpose across the organisations in meeting the needs of our clients.	The right people with the right competencies are involved to achieve the intended outcomes.	We have appropriate systems in place to communicate and coordinate our differing activities.	Our buildings enable us to provide seamless care.	Getting in touch with people is easy and reliable and doesn't slow communication.
Respect	Each organisation's values and beliefs are reflected and accepted in the overall system of care.	We understand that different organisations need to achieve their own goals, but this doesn't get in the way of shared objectives.	We value each other's contribution to our shared purpose.	Concerns or needs arising in one of our organisations can be expressed and are acted on appropriately.	Where or how we meet takes account of everyone's needs.	Decisions about how we use technology takes into account the needs of all parties.
Fairness	We treat each other fairly.	We acknowledge and appreciate that each organisation has investment in the shared purpose.	We all have equal opportunity to access key people as appropriate.	The different contributors to the system of care operate in a transparent way.	We all have easy access to the places we meet.	The technology we use does not disadvantage anybody in the system of care.
Empathy	People act in ways that show an understanding	We use our best endeavours to support each other	We make efforts to enquire about the opportunities,	We plan and implement change together,	The buildings we use are suited to encourage face-	Any limitations in the ability to use particular

	of the needs of other organisations.	to achieve each organisation's goals.	pressures and constraints on our different organisations.	leading to understanding of the wider impact on other parts of the local system.	to-face contact.	technology in parts of the care system are understood and accommodated.
Trust	We can be open and honest in our dealings with each other.	We express aims in terms of joint goals rather than those for our respective organisations.	People take organisational risks where this has the potential to serve wider system goals without fear of criticism or failure.	In the complexity of what we are seeking to achieve we acknowledge and learn from our failings.	The buildings we use provide a safe place to engage with others in as open a way as possible.	We can rely on support functions and information provided by others.
	Directness	**Continuity**	**Multiplexity**	**Parity**	**Commonality**	
Proximity	Poor communication creates misunderstanding and ill-formed decisions.	Organisational and personnel changes slow progress.	Opportunities are missed and problems caused as a result of limited knowledge about other organisations.	People are not consulted and have little influence on decisions that affect them.	Day-to-day decisions about resources and priorities reflect our shared long-term goals.	

Appendix 3: Relational audit feedback tool – questionnaire wording

[Area]: Welcome to CQC's local system review relationship feedback tool.

Dear colleague,

As part of CQC's planned local system review, this is an invitation to provide your views about the quality of relationships in your local system.

Our review is looking at the way different parts of the health and care system work together in your area for older people. As part of our work, it is important that we understand how relationships are working in the local system so we know where things are working well and where there are opportunities for improvement. What we mean by 'system' is the people and organisations that you have regular contact with in providing health and social care services for older people.

Instructions

Below you will find some statements and a choice of rating against each statement. Please consider the statements and reflect on the extent to which they have been true in your recent experience of the local system of health and care for older people. We recognise that there may be a variety of different relationships within a system – if so, please choose the rating that best fits your overall experience, and use the free text box at the end to give us more detail.

This will take about 10 minutes to complete. Your responses will remain anonymous and you will not be identifiable in our findings.

Thank you for your participation.

Care Quality Commission.

Please rate the statements below against the choice that is closest to your view.

1.

*Our buildings enable us to provide seamless care

Consistently not true	Rarely true	Sometimes true	Often true	Mostly true	Consistently true

[For statements 2 to 35, see appendix 2]

36.
Please add any comments that you would like to make about the way different parts of the system work together to deliver health and care provision for older people in your area. Please limit response to approximately 150 words.

37.
This response is confidential, however we ask below for some general information so that we can understand any differences in aggregate scores, for example different perceptions between broad staff groups.

Please tick as many as apply to you.

	Does apply
Type of organisation you work for	
Health commissioner	☐
Health provider	☐
Social care commissioner	☐
Social care provider	☐
Third or voluntary sector	☐
Other	☐
Your primary role in the system	
Senior executive	☐
Direct service delivery (health or social care practitioner)	☐
Operational management	☐
Administrative	☐
Other	☐
Length of time working in this local system	
Less than a year	☐
Between one and three years	☐
More than three years	☐

Appendix 4: Summary of response numbers and respondent type

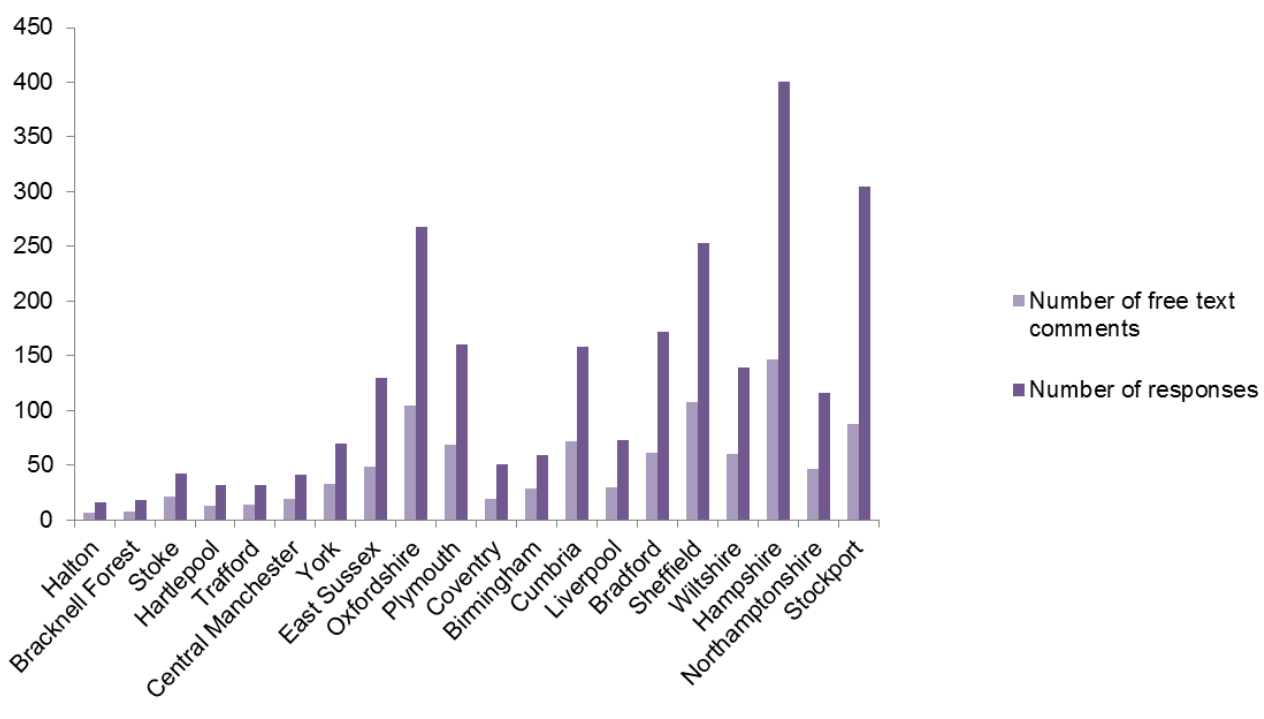
Figure 1 shows the numbers of responses to the relational audit feedback tool (received as of 5 April 2018). It was not possible to calculate a response rate as we were not able to monitor the extent to which system contacts were able to cascade the feedback tool across their organisations. However, as is clear from figures 1 and 2 below, response numbers varied significantly between areas. Both figures are arranged by review date to show how response numbers changed over time.

Figure 1: Breakdown of response to the relational audit feedback tool for the 20 areas in the local system reviews programme

Area	Sent to	Response (total)	Free text comments
Halton	25	16	7
Bracknell Forest	43	18	8
Stoke on Trent	22	43	22
Hartlepool	36	32	13
Trafford	67	32	14
Manchester	153*	42	19
York	36	70	33
Changes made to tool and method (detailed in Appendix 1)			
East Sussex	56	130	49
Oxfordshire	82	268	105
Plymouth	78	161	69
Birmingham	43	59	29
Coventry	68	51	19
Bradford	43	172	61
Cumbria	178	158	72
Liverpool	96	73	30
Sheffield	34	253	108
Wiltshire	61	139	60
Hampshire	58	400	147
Stockport	46	305	88
Northamptonshire	72	116	47
	Total responses:	2,538**	1,000

* This high number was due to the system contacts list containing all social care providers rather than just key stakeholders.
** Two of the responses received did not have an allocated local authority and therefore have not been included in these findings. This was likely due to those individuals copying and pasting the online tool web address and deleting the area when they did this.

Figure 2: Responses by local system review area



Across the 20 systems, the largest number of responses came from those working in health provider organisations (see figure 3). In terms of time served in the system, the vast majority of responses came from those who had worked in their local systems for longer than three years (see figure 4). The most common role type selected was 'direct service delivery' (see figure 5). It should be noted that respondents were able to select multiple answers (or not respond) for the questions relating to role and organisation type, and length of time in the system, and therefore the categories ‘multiple’ and ‘did not answer’ have been included in the charts.

Figure 3: Responses by organisation type

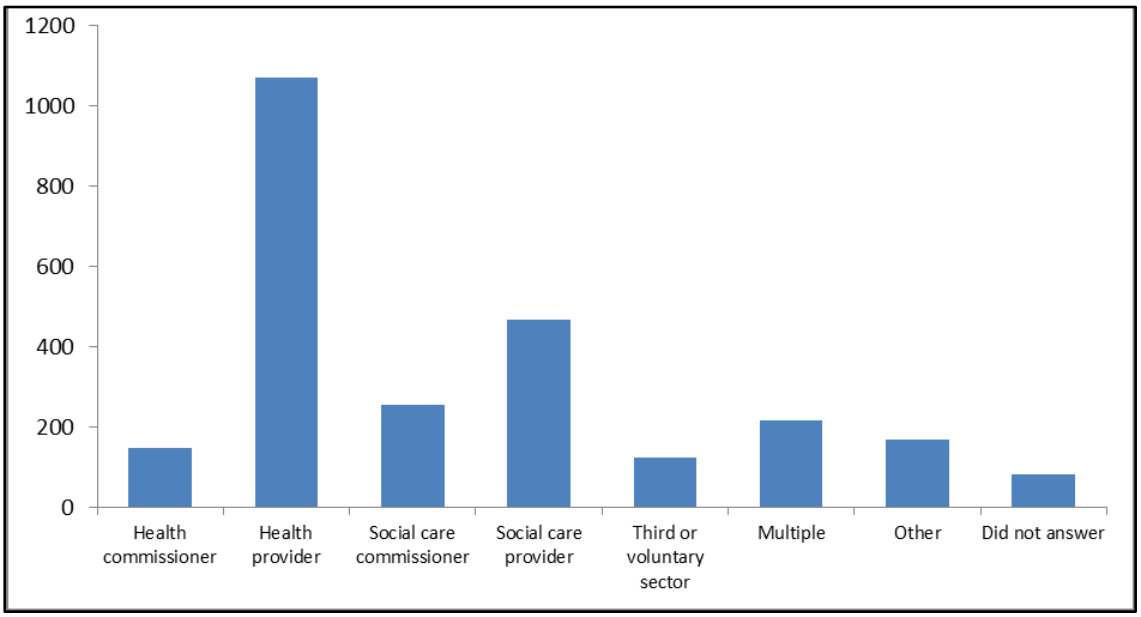
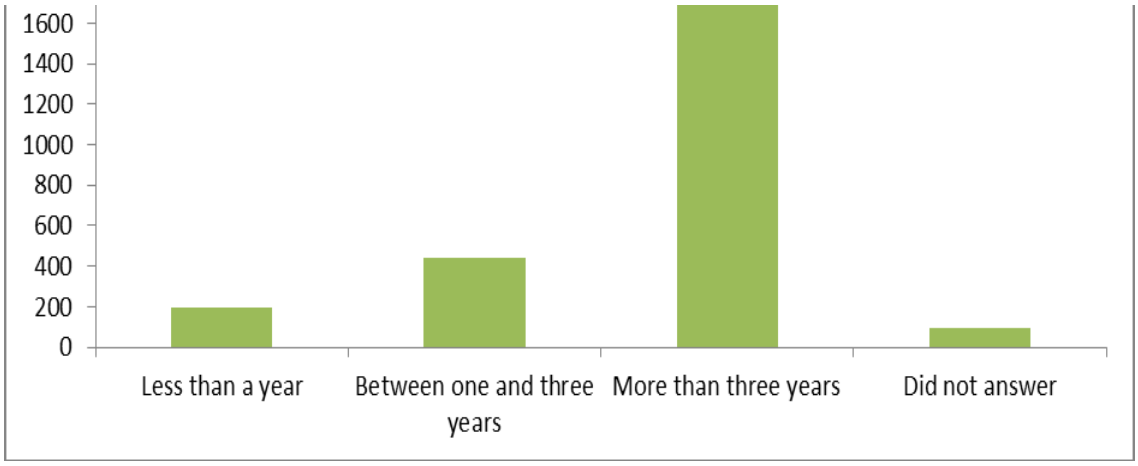


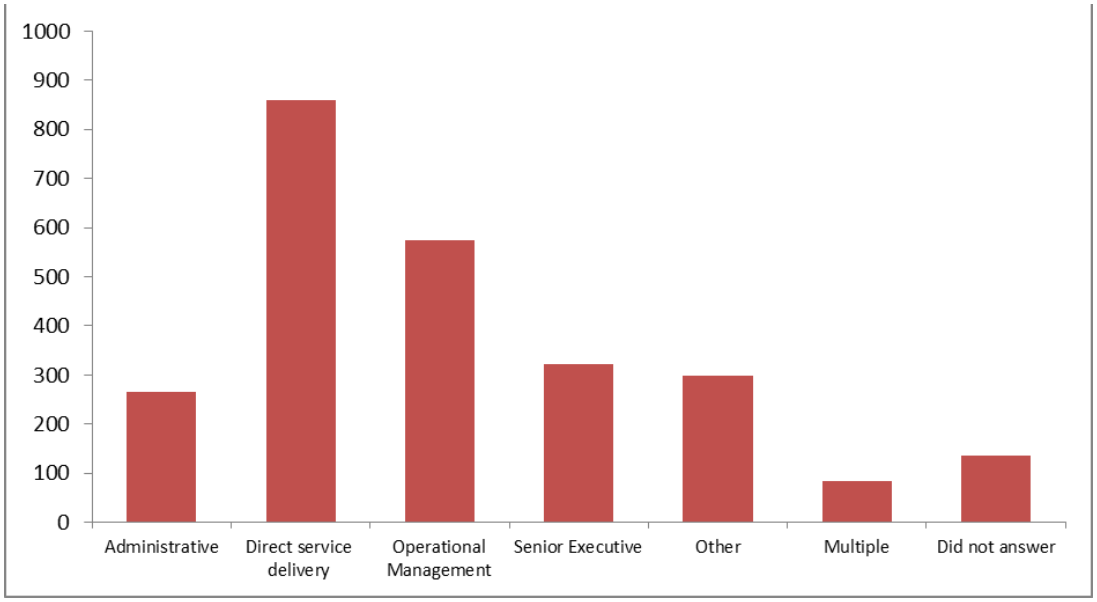
Figure 4: Number of respondents by length of time served in their local system*



*Four respondents were removed from this chart as they ticked multiple options.

As noted above, after the first six areas a free text box was added next to the 'other' role type to try to understand what roles were being missed from the pre-chosen categories. While this box was not always completed, it highlighted some misunderstanding of the categories. For example, respondents supplied roles we would have categorised under the pre-existing ones (such as occupational therapist, social worker, allied health professional) as well as roles that our categories did not capture well (such as various types of council officers, volunteers, finance roles, and councillors). This is worth bearing in mind for any future work with this tool.

Figure 5: Number of respondents by role type



Like the responses to the 35 statements, the number of free text responses also varied by role and organisation type. Respondents selecting senior executive roles left the most free text comments, with 52% doing so. VCSE respondents were the sector that left most free text comments, with 47% doing so.