MONMOUTH PARTNERS | INNOVATION INSIGHT IMPACT

INPUTTING INTO THE DALTON REVIEW: PATIENT WORKSHOP FINDINGS

September 2014

CONTENTS

Version: 1.0 (for issue)
Date: 22nd September 2014

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

This report has been prepared for the Department of Health (DH) by Monmouth Partners. It presents the outcomes and supporting evidence arising from two half-day facilitated patient workshops held on 26th August and 8th September 2014 in Leeds Town Hall. The aim of these workshops, and this report, is to incorporate a sample of patients' views into the Dalton Review.

In summary, this workshop report captures the discussions that a group of 17 patients and carers had regarding:

- Key attributes of highly performing providers
- Whether particular organisational forms being considered by the Dalton Review are more or less likely to foster these attributes.

Key findings

Apart from the attributes described on the next page, the workshops identified three fundamental findings:

1. Considerations of organisational form need to be framed in the context of what matters to patients and not (just) what matters to the system (i.e. clinicians, and managers).

2. Participants pointed out that, broadly speaking, organisational forms did not concern them too much.

   "The biggest issue is fragmentation – of non-joined up services. One arm does not know what the other is doing. The best model is the one that would join things up"

3. Based on the patients' views of the organisational models being considered by the Dalton Review against each of the key attributes that they identified:

   a) the Integrated Care Organisation, Multi-Service Chain and Service Level Chain models seemed more popular – i.e. the patients could see net benefits of creating opportunities for these forms

   b) the Operational Franchises and Management Contracts organisational model were less popular. However, this was in large part driven by discussion regarding the role of the private sector in operating franchises which tended to dominate the conversation rather than the practice of deploying interim management teams to improve failing Trusts' performance.

(These results must be tempered by the commentary provided for each attribute and the fundamental findings 1 and 2 above).

KEY ATTRIBUTES

Eight key, patient-generated attributes emerged from the events. None of these key attributes focused on process issues. Instead what arose was the need to ensure that care is joined-up, personal and of good quality.

It is recommended that these attributes are taken into account in the development and implementation of current and/ or new NHS provider organisational forms.

1. Improving national awareness amongst patients, the public and professionals of the **personal responsibility** that individuals have in healthcare (i.e. a broader focus than their rights)

2. Ensuring consistent **professional standards** throughout the patient journey

3. Facilitating **continuity of care** so the health professional and 'the system' knows the individual and supports a more holistic approach seeing the patient as a whole rather than just a body part

4. Reinforcing **co-production** by providing patients with the information and support they need to make truly informed decisions both about their individual care and more broadly about what is provided

5. Developing a system that delivers the correct **quantity of appropriate staff** in the appropriate setting(s)

6. Improving **communication** to enable two-way, more open dialogue between the health professional and patient

7. **Identifying and promoting good practice** (including feedback and insight) with patient and the system

8. Ensuring the system stays **stable** so that there is the opportunity for progression and innovation.

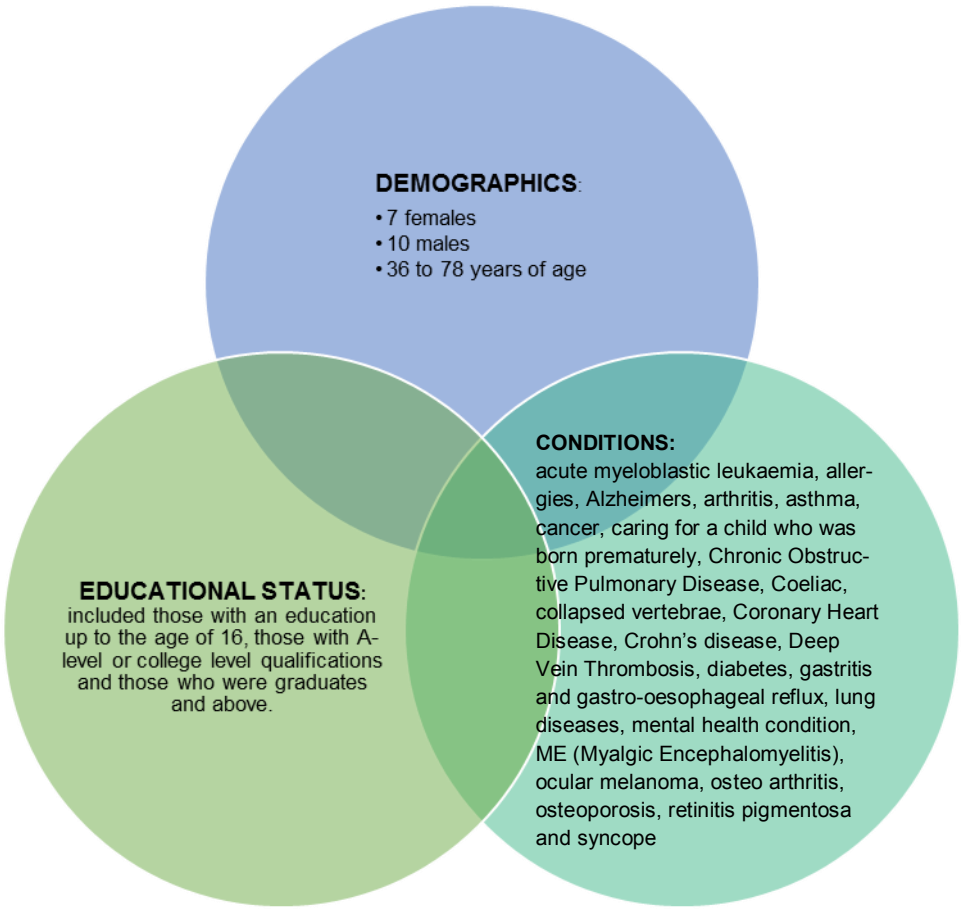
APPROACH

APPROACH

17 patients and carers were brought together by Monmouth on behalf of the DH to explore issues relating to the Dalton Review (www.srft.nhs.uk/dalton-review/) through two half-day facilitated workshops held on 26th August and 8th September 2014 in Leeds Town Hall.

Patients and carers represented a variety of views and were encouraged to illustrate their perspective, where appropriate, with their experiences, insights and ideas.

The group had the following attributes:



LIMITATIONS

Whilst measures were taken to try to provide a true reflection of patient views, readers should be aware that there are limitations with the findings:

- Although Monmouth endeavoured to involve patients with a variety of backgrounds and views, the group was not a complete representation of all of society.
- The patients that attended the workshop were already engaged in healthcare, experienced and vocal, as demonstrated by their interest and willingness to take part in this work.
- Despite invitations to younger people, there were no children or younger people present at the workshop to put forward the younger generation's perspective.

WORKSHOP AGENDAS

The agendas for both workshops were designed in such a way as to allow patients and carers to shape the discussion.

Workshop 1 focussed on learning from patients what they think are the key organisational attributes required of healthcare providers.

Workshop 2 sought to understand the extent to which the suggested models for organisational form supported these patient attributes.

Workshop 1: 26th August

- Introductions and why we're here today
- Dalton Review - a patient's guide
- The patient perspective - what does a well performing healthcare provider mean to you?
- Group Feedback
- Prioritising and exploring top attributes
- Group Feedback
- Summing up / next steps

Workshop 2: 8th September

- Objectives for today & recap of patient priorities (as identified in Workshop
- A quick refresher of the seven organisational models being considered
- Organisational Model #1: Multi-Site Trusts - Does this model tend to support or hinder patients' priorities?
- The six remaining organisational models - Do the models tend to support or hinder patients' priorities?
- Sub-group feedback & summing up

METHODOLOGY

In workshop 1, the 4-5 patients and carers at each of 3-4 tables were asked to explore in detail the key attributes that emerged from the initial whole group discussion. A scribe and reporter were nominated at each table and asked to respectively note down and then feedback the key attributes to the whole group.

In workshop 2, the group were reminded of the task at hand and the DH outlined the organisational models being used by the Dalton Review.

Some time was spent revisiting the key attributes of a good provider that the group identified in Workshop 1 and ensuring that these, given time for reflection, were still accurate and comprehensive.

The group was then asked, and agreed, to review the interplay of these attributes and the potential organisational models being considered by the review team.

FINDINGS

FINDINGS

What matters to patients — the key attributes

- The **personal responsibility** that individuals have in relation to healthcare
- Ensuring consistent **professional standards**
- Facilitating **continuity of care** so the patient is seen as a whole
- Reinforcing **co-production** so patients can make truly informed decisions
- A system with the correct **quantity of appropriate staff**
- Improving **communication** between the health professional and patient
- Identifying and **sharing good practice**
- **Stability** in the system

The key attributes that emerged derived from 17 patients in open grouped discussions. These were prioritised and agreed by the group as a whole.

The priority attributes identified and developed by the group were as follows:

1. PERSONAL RESPONSIBILITY

- Individuals have a responsibility as well as rights
- Education needed around roles and expectations of patients
- Patients should give back to the NHS rather than just take e.g. volunteering their time, feedback on experience (+ve and -ve)
- Patients have a responsibility to take care of their own health where they can
- Patients have a responsibility to not be wasteful in relation to NHS services e.g. not missing appointments – 85% of attendees said they would support a penalty fine for patients who continue to, and intentionally, missed appointments
- Conversations should be had around both patient rights **and** responsibilities. Greater awareness is needed of the 'contract' between the NHS and the public– only 20% of attendees had heard of the NHS Constitution.

2. PROFESSIONAL STANDARDS

- A need for confidence in consistent professional standards from start to finish. High quality professional standards include:
- Commitment to job from all health professionals i.e. focusing more on their work as a 'warm' vocation not just a 'cold' profession
- Honesty
- Accountability
- Partnership between the health professional and patient
- Supporting patient choice around their treatment and care.

- Professional accountability (at a national and local level) and transparency
- Staff have confidence to identify, bring to awareness and correct poor standards i.e. whistleblowing
- Training for staff.

3. CONTINUITY OF CARE — THE PERSON / SYSTEM KNOWS YOU (INCLUDES INTEGRATION / NAVIGATION)

- A holistic approach so the patient is seen as a whole rather than a body part - taking into consideration their background and personal circumstances
- Different parts of the system are 'talking' to each other i.e. seamless
- Information is recorded and passed through the system securely, accurately and consistently
- Care is easily accessible so patients know where to go when they need treatment / care
- Support beyond boundaries of hospital wards.

4. CO-PRODUCTION INCLUDING PATIENT EDUCATION

- Patients are given the information and support they need in order to make truly informed decisions
- Patients are more involved in their care and asked what they want.

5. QUANTITY OF APPROPRIATE STAFF (INCL. COMPASSION, EXPERIENCED)

- Ensuring the right number of appropriately trained staff are available to provide the right care at the right time in the right place.

6. COMMUNICATION (LINKED TO ATTRIBUTE 2)

- A culture that enables more openness between the health professional and patient – two-way dialogue
- Awareness raising in community – immediate and wider community
- Communicate all options available to patients
- Cultural sensitivity and respect needed from staff.

7. SHARING GOOD PRACTICE WITH PATIENT AND THE SYSTEM (INCL. FEEDBACK)

- Recognising excellence and enabling it to spread
- Learn from mistakes so good practice increases
- Encourage more feedback from patients – positive and negative.

8. STABILITY

- "Evolution not revolution"
- The need to allow constant development and innovation
- Less political intervention – avoiding huge shake-ups that delay progress / take things backwards
- Concerns over privatisation.

How the attributes map across to the organisational models

- Focus on outcomes of care not processes
- Struggled to grasp models without direct experience
- Most familiar with Trust model; most liked the sound of Integrated Care Organisations.

Patients were most familiar with the current Trust model and thus felt most able to comment on this model. However, their experience was mixed and participants preferred to evaluate other models in comparison to the status quo rather than comment on the multi-site Trust model.

Despite best intentions, participants struggled to completely identify with other models as they had limited direct experience of any/ many of them.

We have summarised the discussion in terms of positive or negative views of particular organisational form against each of the key attributes. Where there was no specific view arising from the group discussion or a consensus was difficult to assess then no value is given (ref: Table 2). Where the form was felt to positively encourage providers to adopt the behaviour a score of +1 is applied, if negative then a score of -1 is applied. The 'net scores' are summarised in Table 1.

The maximum and minimum score is therefore +8 to -8.

TABLE 1: SCORED ORGANISATIONAL FORMS

Attribute		S/M site	Fed	ICO	JV	MSC	OF & MC	SLC
Positives		0	1	3	0	4	0	4
Negatives		0	0	1	0	0	2	1
Total		**0**	**1**	**2**	**0**	**4**	**-2**	**3**

Key:

Models[1]

S/M site	'Traditional' NHS provider - Single or multi-site
Fed	Federations
ICO	Integrated care organisation
JV	Joint ventures
MSC	Multi-service chains
OF & MC	Operational franchises and management contracts
SLC	Service-level chains

[1] See Dalton Review papers / Appendices for fuller descriptions.

TABLE 2: VIEWS BY MODEL / ATTRIBUTE

Attribute	Overall view	S/M site	Fed	ICO	JV	MSC	OF & MC	SLC
1. Personal responsibility	Organisational form does not have a significant impact— +ve or –ve							
2. Professional standards	Chains potentially mitigate inconsistency between services. ICO might reduce / limit access to specialist skills.			-ve		+ve		+ve
3. Continuity of care—the person / system knows you (includes integration / navigation)	ICOs could enable integration. Specialist single service chains may cherry pick certain, discreet services & damage continuity of care.			+ve				-ve
4. Co-production including patient education	SLCs more responsive to customer views. Franchises are less likely to have time to develop enduring relationships.						-ve	+ve
5. Quantity of appropriate staff (incl. compassion, experienced)	Chains more likely to understand comparative measures of the 'right number of right staff'					+ve		+ve
6. Communication (linked to attribute 2)	ICOs have a better understanding of local culture but it only works up to a certain scale as with all models, it's more about the way people behave in the system.			+ve				
7. Sharing good practice with patient and the system (incl. feedback)	Chains effective at sharing / enforcing good practice within their boundaries.		+ve			+ve		+ve
8. Stability	Models favoured which enable strong NHS orgs to develop & spread their knowledge across the system.			+ve		+ve	-ve	

Within the constraints of this rudimentary scoring approach, the MSC, SSC and ICO models were viewed favourably and the franchise model negatively – primarily on the basis of some suspicion regarding the role of the private sector in operating NHS facilities. Other models were viewed neutrally. We recognise that this is a simplistic approach to summarising the discussion, however, and urge caution in reading too much beyond the commentary in Table 2.

Participants pointed out that, broadly speaking, organisational forms did not concern them much.

- *"Why bother without a guarantee that things will change; why not keep as is?"*
- *"Why not just take the best (outcomes) from each model and share?"*
- *"The biggest issue is fragmentation – of non-joined up services. One arm does not know what the other is doing. The best model is the one that would join things up"*

What participants were most interested in was the actual performance of individual organisations against the attributes outlined in Workshop 1.

In some ways this is the fundamental finding of this work. Namely that organisational form needs to be framed in the context of what matters to patients and not (just) what matters to the system (i.e. clinicians, and managers). The fact that the Dalton Review panel has no lay members on it, nor originally had a plan for patient engagement in the consultation process is an initial oversight that should be rectified in future work.

DETAILED COMMENTARY BY ATTRIBUTE

1. PERSONAL RESPONSIBILITY

- Organisational form was not felt to have a significant impact - positive or negative.
- There was much discussion regarding the debate within society regarding interplay of citizen rights and responsibilities.
- Question raised regarding the balance of personal responsibility vs accountability in an ICO model? There's an interesting dichotomy between the system 'navigating the patient', in contrast to current position in which (some, informed) patients navigate the system (i.e. provide integration).
- Part of a wider debate regarding role of NHS. Not seen as relevant to organisational form except insofar as there was a debate regarding the role of the private sector.

2. PROFESSIONAL STANDARDS

- Patients felt that there is currently huge variation in standards between and within organisations.
- Very dependent on the individual not the system. This lack of consistency was seen by some as a sign that there had been a decline in the 'ethos' of caring and healthcare as being a vocation/calling. Instead now seen as purely a job.
- Chains were seen by some as potentially a vehicle for mitigating inconsistency between services - as standards could be enforced and patrolled across sites rather than be dependent on local performance. Single service chains were seen as a particularly effective way of sharing specialist, niche skills across the NHS. Very positive view of specialist NHS skills being shared (e.g. Moorfields) but a balance of views regarding role of private sector chains, either specialist or multi-service.
- Some concern than focus on holistic treatment might reduce / limit access to specialist skills where these need to be provided at scale. Patients were conscious of the potential tension between services being local enough to enable integration with community and social based services but retain the scale to operate specialist services. Some concerns around added complexity in handover between services that this might introduce.

3. CONTINUITY OF CARE — THE PERSON / SYSTEM KNOWS YOU (INCLUDES INTEGRATION / NAVIGATION)

- ICOs were seen as positive for integration.
- Concern that specialist single service chains would cherry pick certain, discreet services and that this model could not be scaled across all services. In which case there would be real damage to continuity of care across multiple, linked service lines.

4. CO-PRODUCTION INCLUDING PATIENT EDUCATION

- Sense of trust in specialist services provided by single-service chains. They were seen as more responsive to customer views - and more willing (able?) to develop tailored patient-centred materials.
- Franchises felt like 'parachuting teams in' - and less likely to have time to develop enduring relationships with local communities.

5. QUANTITY OF APPROPRIATE STAFF (INCL. COMPASSION, EXPERIENCED)

- Linked to professional standards (attribute 2) - and many of the above points re variation apply.
- Chains seen as being more likely to understand comparative measures of the 'right number of right staff' across different parts of their operations. Single service chains seen as more likely to be able to parachute staff trained in other locations in, whereas multi-service chains might be more dependent on existing staff capability.

6. COMMUNICATION (LINKED TO ATTRIBUTE 2)

- ICOs seen as potentially having better understanding of, and sensitivity to, local culture and more direct interest in changing health behaviours - full range of options under one roof. But there was concern that ICOs only work up to a certain scale - there was some sense that beyond a certain ceiling behaviours / organisations became impersonal.
- But this was also a general concern regarding all models - it's more about the way in which people behave in the system, however it's structured.

7. SHARING GOOD PRACTICE WITH PATIENT AND THE SYSTEM (INCL. FEEDBACK)

- Chains seen as particularly effective at sharing/enforcing good practice within their boundaries.
- This was the only place where federations were mentioned (and even then only in passing).

8. STABILITY

- The attribute pervaded the whole discussion, with a general sense of unease that organisational form might be a Trojan horse for privatisation.
- Participants favoured models which enabled strong NHS organisations to develop and spread their knowledge across the system - hence the caveat around single -service chains - NHS = good; Independent = mixed (not necessarily bad).

LIMITATIONS / BIAS

LIMITATIONS / BIAS

Patient representation – the majority of patients are actively involved in their care and some have had previous discussions on this topic.

Attribute identification – the open nature of the event meant that patients and carers identified the attributes most pertinent to them. This resulted in these attributes gaining momentum throughout the day as the groups focused on them, to the potential exclusion of other attributes which might have been discussed had a topic guide or other 'external' influence been used.

One off event – this participation workshop was held as a one off event with little chance to 'test' any future options with participants. Future work of this sort should look to either spend more time immersing participants in activities to better understand the options (e.g. Citizen's Jury) and/ or look at different ways to frame the discussions to further engage patients and the public.

Subject matter – the difficulty of the topic was noted at the workshops and questions arose such as:

- What's a Foundation Trust?
- Why was Dalton chosen to lead the review?
- What is service-level?
- We can't represent all patients - we have varied experiences of care in and around Leeds
- What's the point of this – structure does not matter - it's outputs?
- How do we judge quality?
- We can't recommend models unless we've experienced or have been educated about them

NEXT STEPS

NEXT STEPS

The DH may wish to consider:

1. Ensuring that future reviews take patient perspectives into consideration from the start by including patient engagement activities as part of the work programme and including a minimum of 2 lay members on any panel(s)

2. Conducting a wider survey to determine any patient benefits/ concerns around the potential organisational forms

3. Triangulation of these workshop outputs with other patient input and amendment of attributes accordingly

4. Feeding back to workshop participants on outcome of their contributions including a patient version/ letter of the Dalton Review findings.

EVALUATION

EVALUATION

Attendees completed an evaluation form asking for views on:

- What they liked about the day
- What they didn't like about the day and improvements that they would suggest
- Whether they would like to be informed of any ongoing work in this area.

Out of the 17 patients and carers that attended the event, all of the attendees completed the evaluation form. The results were as follows:

26th August 2014

What they liked about the day

A strong message from the evaluation forms is that the patients and carers really enjoyed, and appreciated, the opportunity to share their ideas on matters relating to the Dalton Review. The attendees expressed that they felt the group sizes were right, allowing in-depth discussions which produced helpful insights. Another key point of praise was focused around the facilitation which the patients and carers described as "expertly" done and allowed "open discussions".

What they didn't like about the day and improvements that they would suggest

The main criticism of the day was that delegates felt that one individual concentrated on their own detailed experience too much rather than thinking about the big picture and caused disruptions to the discussions.

The key improvement that was suggested was therefore for additional emphasis of 'house rules' at the beginning of the workshop.

Whether they would like to be informed of any ongoing work in this area

11 of the 17 patients / carers indicated they would like to be informed of any ongoing work in this area.

8th September 2014

What they liked about the day

Several members of the group reiterated that they were pleased to be given the opportunity to give an honest opinion and have their views about a difficult subject listened to. The attendees stated that they liked the flexible approach for this difficult topic. They also noted that suggested improvements from the previous workshop were taken on board as shown by the initial announcement regarding personal stories which kept the discussions more relevant.

What they didn't like about the day and improvements that they would suggest

The key criticism that arose was that patients / carers felt there was scope for so much discussion and would like more time to understand the organisational forms. Additionally, it was suggested there could be more clinician involvement in group.

APPENDICES

A: DH PRESENTATION: ORGANISATIONAL MODELS

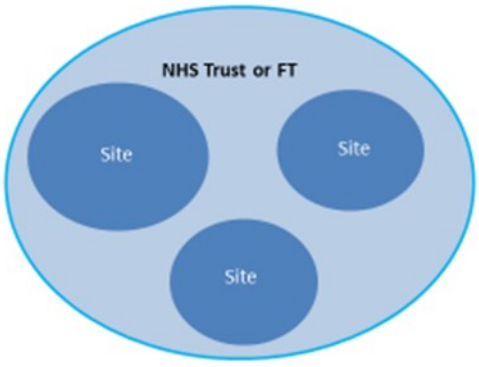
Patient and Public Engagement

The Dalton Review

New Options for Providers

Typology of models

Single or multi-site trusts



Governance
Operations

Most prolific model in English NHS, with standalone acute trust operating over one or more sites

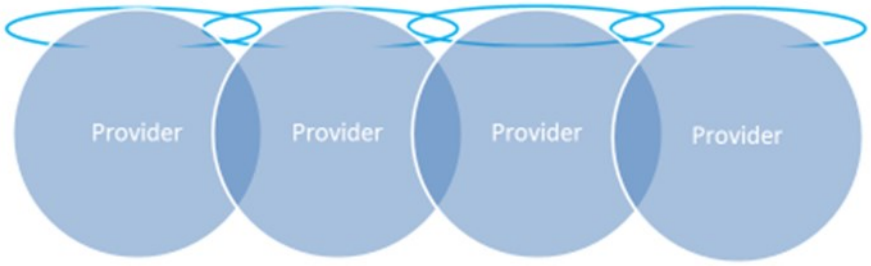
Organisational sovereignty	Assets	Intangibles	Range of services	Scale
Single organisation.	Some sharing across sites.	Single system.	Usually full range.	Single geography – local scale.

10 Dalton Review #DaltonReview2014

Typology of models

Federations

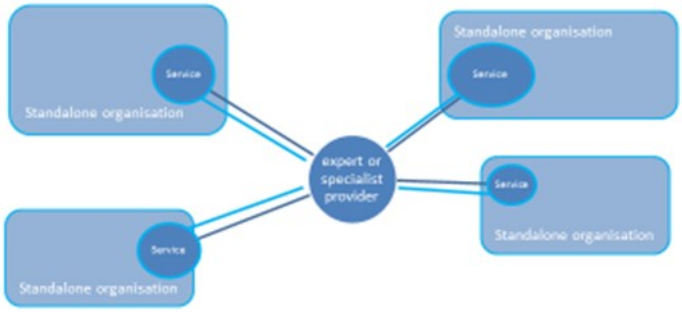
Organisations come together under overarching entity, with some shared operations and governance.



Organisational sovereignty	Assets	Intangibles	Range of services	Scale
Individual organisations maintain sovereignty, with some delegated to group organisation.	Ownership remains with individual organisations - some sharing of assets.	Standardisation of clinical pathways and some sharing of back office.	Dependent on model.	Usually local or regional level.

Typology of models

Service level chains

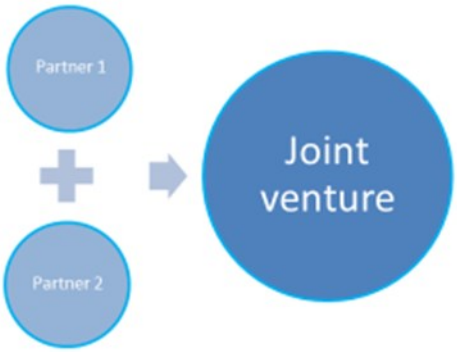


Individual services within an organisation delegated to an external organisation.

Organisational sovereignty	Assets	Intangibles	Range of services	Scale
Host and provider organisations maintain sovereignty.	Service operates within host asset structure.	Service maintains specialist provider methodologies, but sits within host management.	Single service as per specialty.	Up to national scale.

Typology of models

Joint ventures



Two or more organisations form new structure with shared equity and governance to provide services.

Organisational sovereignty	Assets	Intangibles	Range of services	Scale
New entity created, governance shared.	Depends on model – up to full sharing.	Single system – may adopt practices from both partner bodies.	Dependent on model. Usually single service.	Usually local or regional level.

13 Dalton Review #DaltonReview2014

Typology of models

Operational franchises and management contracts

Operational franchise

Management contract

Responsibility for running part of or whole organisation delegated to another organisation. Governance arrangements depend on model.

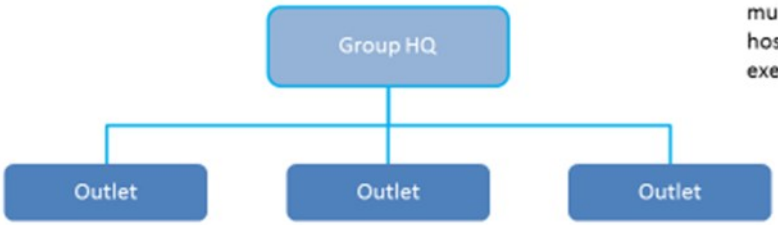
Organisational sovereignty	Assets	Intangibles	Range of services	Scale
Lead organisation gives up some or all of sovereignty.	Management of assets by contractor.	According to contractor.	Up to full range.	Single organisation.

14 Dalton Review #DaltonReview2014

Typology of models

Multi-service chains

Single entity owning and operating multiple standalone hospitals with single executive team



Organisational sovereignty	Assets	Intangibles	Range of services	Scale
Single executive organisation – varying degrees of delegation to outlets.	Single asset holder.	Standard pathways and procedures across chain.	Up to full range – few examples of full multi-service providers in English NHS.	Up to international.

Typology of models

Integrated care organisation

Formal or virtual vertically integrated organisation from primary to acute service levels, often serving a defined population.

Organisational sovereignty	Assets	Intangibles	Range of services	Scale
Depends on model – may form new organisation or combine through contracting.	Some sharing of assets.	Different methodologies across organisational tiers due to different service offer, but consistent approach overall.	Full range, including primary and community.	Local – defined population.