SOCIAL POLICY RESEARCH FOR CORNWALL

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A systems view of health and social care: structures, processes and teams

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On this web site I am posting (under POSTS) a collection of essays on case studies of planning and policy-making in the field of health and social care that I have written over the past five years. Many are specific to Cornwall, in the far south-west of the UK, where I have lived since 2005, but all of them to a greater or lesser extent have required me to look at the national context, so they have a much wider application and relevance.

I look at health and social care organizations with one question in mind: How does the system work? As someone who was brought up as a physicist, I have a keen interest in exploring and revealing the mechanisms and processes within systems made up of interconnected parts. I have been particularly struck by the difficulty I encountered in discovering the processes, other than recognised medical and surgical procedures, that take place within the National Health Service.

Take planning, for example. Having spent a number of years researching urban planning processes, I knew of course of the existence of the Royal Town Planning Institute in the UK, and I was aware that a number of British universities offer post-graduate degree courses in urban planning. So I have been intrigued to find there are no equivalents for health care planning. This has led me to ask how the NHS Long Term Plan was arrived at (a current project of mine) and to follow closely the processes of planning new models of care in Cornwall that are currently under way.

A lack of awareness of process crops up in surprising places. For example: NHS England's guidance for hospital trusts on counting 'delayed transfers of care' from hospitals sets out three decisions that have to be taken before a patient is ready to go home, but the guidance does not say whether they have to be taken in a particular order or how they fit in with various administrative steps that are also required. So no clear process is prescribed. This leaves hospital trusts free to make up their own rules as they see fit, and these differ widely from one trust to another, so not only can trusts not be compared but nothing is learned by adding the figures together: this does not produce a total from which anything can be inferred.

Processes take place within systems, and every system has a structure. The term 'structure' conjures up visions of an organizational hierarchy, such as NHS England / regional teams / hospital trusts, while within hospitals we find the paediatric team, emergency team, etc., headed by consultants in charge of junior clinicians and working alongside ward-based nursing teams.

(See, for example. *Who's Who in the Surgical Team*, published by the Royal College of Surgeons of England.) The traditional organization chart, with a hierarchy of boxes connected by various lines denoting accountability and communication channels, describes these structures perfectly well. Observe that the teams that we see are teams designated as such by senior managers.

But we can take a very different approach. Consider a patient who is taken into an acute hospital with a medical or surgical condition that requires treatment. We can trace their path, their 'trajectory', through the hospital, from emergency department, via assessment and testing, to treatment, recovery, subsequent care and eventual discharge.

Note two things here. First, many of the clinical and other practitioners involved along this trajectory will have no occasion to meet, but we can view all of those people as members of a team concerned with that patient. I call this the 'patient-centred team'. They are members of this team by virtue of the fact that they depend on one another - for post-operation care of the patient, for example, and for hour-by-hour records to be taken of the patient's condition - and have to communicate with one another, to pass information on. The patient-centred team can be seen as comprising not only the core group of professionals concerned with the patient but also a wider group, such as the patient's family and close friends who have a concern for the patient's welfare and may have useful insights into their condition and behaviour. On this view we can put the patient himself or herself at the centre of the team.

The second thing to note is that although many clinical and other practitioners may never meet face to face, except perhaps at shift handovers, we may still regard them as members of a single patient-centred team. The team is a 'team over time', we might say.

We now have the beginnings of a battery of concepts - process and structure, the patient trajectory, the patient-centred team - that we can use to analyse the way that the NHS works. We shall need others notably 'culture', which may be specific to a particular profession or department or group or a whole organization. This would embrace 'how we do things here', the values implicit in what is taken for granted about inter-professional relationships, and attitudes to how strictly 'the rulebook' should be followed.

For an illustration of what I have done with a slightly earlier version of this approach, see How a lack of teamwork at the Royal Cornwall Hospital contributed to the death of a child with autism.