THE POINT OF CARE FOUNDATION SUBMISSION TO THE CONSULTATION ON THE HOPE NETWORK

Introduction

This submission to the NHS England/NHS Improvement consultation on the HOPE network is from the team at The Point of Care Foundation (POCF) that supports the network, and plan and delivers network meetings. Our objective is to feed information into the consultation that will hopefully be helpful for answering the consultation question: *"Planning for the real – what would be the key characteristics of a really good network for you?"*

Professional networks such as the HOPE network are a common form of social organisation in healthcare systems where they differ widely in terms of purpose and how they work. There is a substantial body of published research on professional networks that helps us understand: what networks can and cannot achieve; what makes them effective and what good network leadership looks like. POCF recently commissioned a report on the research evidence about networks from an independent researcher. We run three national networks including HOPE and wanted to learn from best practice.

This submission draws on the research report: section one summarises the key findings from the evidence about social networks relevant to the HOPE network. Sections two and three provide summary data on the network and its members, and in the final section 4, we briefly reflect on the implications of the research for HOPE and the lessons we have learned from our involvement with the network and the members since 2015.

1. Network research: types of network, network characteristics and success factors

There are three types of professional network in healthcare. Networks for

1. Delivery and development
2. Learning and support
3. Agency and advocacy

Research shows that learning and support networks should offer these tangible benefits to members:

1. Learning and capacity building, helping members to see networked learning as part of their professional lives, not an add on
2. Access to and leveraging resources and knowledge
3. Advocacy

Networks need two things from the people who lead them:

1. Conscious facilitation and attention to building relationships
2. The ability to develop trust between members while working towards common purpose.

The NHS Leadership Academy has identified the key tasks of network leaders as to offer

- Clear transparent communications that reach members wherever they are

- Clarity about the aims, values and activities
- Clear direction to build a shared sense of purpose.

Successful networks have these features in common

- common purpose
- clear and compelling vision and goals
- identity shared by the members
- organised around big compelling issues that are important to members and attract significant interest from key stakeholders and sponsors
- meet members' needs whilst working towards collective goals
- adaptive leadership – collaborative, responsive, distributed
- strong relationships and ties, developing trust
- levels of engagement and involvement depend on needs of individual
- helpful outputs – tangible benefits
- trust and reciprocity are important

In professional networks, people who join networks opt for one of three positions: *lurker*s, *engaged* and *cor*e. The ratio of *lurkers: engaged: core* members in most professional networks is typically *90: 9: 1*. What this means, is that in most networks it is normal to find a small minority of very active and engaged core member; a larger minority of actively engaged members and a majority of alert but passive lurkers who keep in touch with the network and are aware of what it is doing but who have low levels of participation in network activities.

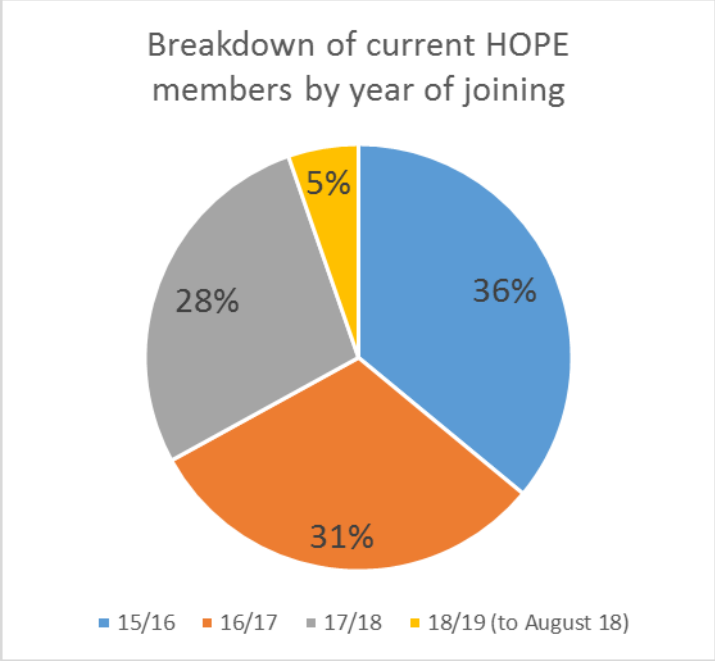
2. HOPE network facts

HOPE aims principally to be a learning and development network, but within the resources available, and from time to time it has focussed on agency and advocacy for members.

Our aim in growing and developing the network has been to create a psychologically safe space and relationships of trust with funders and members, along with a programme of work that is led by members' expressed needs and preferences. The feedback from members to date and the fact that the network has continued to grow by word of mouth confirms that members do trust the network and feel connected. In the original prospectus and funding application POCF argued that having an independent, third party facilitating the network would add value for both members and funders: for members it would help to build trust by offering a closed environment for open and honest conversations between members, and for the funders it would offer access to the members to test ideas and obtain feedback on national policies. We believe that the first objective of building trust with or the members has been achieved and that we are making good progress towards developing real conversations between the members and national decision-makers about important matters of policy.

Membership size and by type of organisation

There are currently 301 network members. The pie chart shows the breakdown of membership by the year of joining the network. A third of the membership have belonged since year 1.



HOPE membership breakdown by type of NHS organisation is shown in the table below.

Type of organisation	Percentage with at least one HOPE member
Acute trusts	69%
Community and mental health trusts	62%
CCGs	12%
Ambulance trusts	50%
Other: specialist trusts, hospices, AHSNs	48 members

Geographical spread

The network membership is concentrated more in the south of the UK and across midlands than in the north of the country. More striking is the low attendance figures at meetings from organisation in the North of England (31 percent), compared to 67 percent in London. This is part of the rationale behind the regional HOPE network meetings we have been running in 2018.

As of August 2018	Percent of members who have attended at least one meeting
East	61%
East Midlands	59%
London	67%
North East	33%

North West	31%
South East	65%
South West	60%
West Midlands	48%
Yorkshire	8%

Network activity levels

Using the categories from the network research to categorise the HOPE membership we have

- 29 *core* members (attended more than four meetings)
- 82 *engaged* members (who have attended between two and four network meetings)
- 190 *lurkers.* The *lurkers* engage mainly by reading the network newsletters, with an average of 54 members reading every newsletter; 49 lurkers have also attended one meeting.

	Core	**Engaged**	**Lurkers**
A normal network	1%	9%	90%
HOPE Network	10%	27%	63%

3. HOPE members

The network membership is very heterogeneous. The job titles and scope of responsibilities of the members vary widely: the most frequent titles are patient experience lead; patient experience manager; and head of patient experience. The variations and additions to titles include references to: engagement, engagement and involvement, volunteers, complaints, stakeholders, quality and quality improvement.

The common core tasks that define the majority of members' roles and take up most of their time are the collection, analysis and reporting of patient feedback to front line teams and into governance processes.

The job titles do not reveal a great deal about levels of seniority in the organisation, or where members sit in their organisations. Anecdotally, the membership divides roughly into two unequal sized groups. The smaller group is made up people who have been in patient experience posts for five or more years, who are experienced, confident and have relatively access to executives and other senior people in the organisation when they need it. The larger group is made up people in patient experience roles who are new in post or in more junior roles.

Most members are positioned within nursing directorates but some report into other directorates such as facilities, estates and hotels; customer services; communications and quality and safety. Some but not all of the members belong to patient experience teams that vary greatly in size from two to fifteen.

There is no formal recognised training or qualification for patient experiences roles in NHS trusts and HOPE members come into their roles from a variety of background experiences, training and qualifications.

The application form for asks people who want to join the network to tell us what they hope to gain. In line with evidence on other professional networks, members' goals fall into three categories:

1. Personal – increase knowledge, meet peers, gain insights and ideas
2. Practical – learn from best practice; share practice
3. Strategic – network with national leaders and share views

4. Reflections

The HOPE network is more active and its members engage more intensely once they are members than in other comparable professional networks in health and care systems.

In the first two years of the HOPE network's existence we explored with the members a number of ideas about how they might connect with one another. Some members wanted to establish buddying and mentoring schemes, and others wanted to do reciprocal visits to each other's organisations. The POCF team put a good deal of effort into trying to get these ideas into practice but met with very little success. There was, and still is, a gap between what members aspire to and what they are actually able to commit to day to day.

The enthusiasm for the network and the face to face meetings as evidenced in the word of mouth growth of the network and the feedback (reported to funders in quarterly reports) is generally positive. However, attendance at meetings is skewed toward members who can get recover travel and expenses from their organisations and who can take the time to travel to London or to one of the regional venues. There is however a small number of members who do travel long distances very regularly to attend the meetings.

There has been no demand from the members to date to offer webinars or to provide social media platforms for members to connect with each other. It is difficult to know whether this is because members have diverse needs or because they find it difficult to access digital platforms when at work. Beyond the HOPE network the POCF experience of using these technologies to connect with community networks is mixed. We find webinars work for teaching and information-giving, but are not effective (or at least not yet) as a medium for building trusting relationships in a large and relatively diverse community.

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