The King's Fund Ideas that change health care

Appendix 11

Approaches to better value in the NHS

Improving quality and cost

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Key messages

- Like many health care systems, the NHS is increasingly focusing on how it can improve the value of the services it delivers, that is, how it can deliver the highest-quality health outcomes at the lowest possible cost. This requires a change to previous approaches to improvement, which have often reviewed the quality of care and the cost of care separately.
- Although many organisations have a shared understanding that value is a result of the balance between quality and cost, there are substantial differences in how they develop strategies to pursue better-value health services. For example, some have large-scale plans that encourage uniformity, standardisation and compliance, while others have plans that are focused on encouraging frontline innovation. This demonstrates there are multiple 'routes in' to the 'value improvement agenda' for hospitals wishing to improve their services.
- However, our research highlights there are some common factors across hospitals that have developed value improvement strategies. Delivering better-value services requires a sustained focus and an understanding that these initiatives will not necessarily deliver quick in-year benefits. It requires considerable levels of staff engagement and a commitment to invest in building the capacity and capability of staff to deliver change.
- Effective stakeholder management with other provider and commissioner organisations in the local health and care system is also necessary to ensure that the planned changes are well understood and aligned with wider attempts to improve care for local populations.
- We have also found that more work is needed to develop quantitative and qualitative measures and leading indicators that demonstrate that value improvement strategies are on track and effective.
- While pursuing better-value services is not easy and is not a short-term fix, the organisations that have made some early progress with their value improvement strategies have reported benefits to patient care, increased financial performance and a greater sense of agency and strategic focus in their work.

1 Introduction

The NHS in England is under pressure due to rising demand for services, an unprecedented period of funding constraints and growing staffing shortages. In June 2018, the government put forward a new five-year funding offer for the NHS in England (Department of Health and Social Care 2018). But even the increases proposed under this package are less than what is needed to sustain, improve and transform NHS services. The enduring challenge facing the NHS is how to use its resources most effectively to improve the health and wellbeing of the population.

The purpose of this report

The current financial pressures and funding constraints that the NHS is experiencing have understandably led to a renewed focus on how NHS organisations can improve the value of the services they offer to patients.

This report explores how three different organisations are attempting to improve in this area. We specifically look at how they have developed **organisation-wide** strategies to improve value, building on our previous reports on how individual clinical services or teams have pursued value improvement (Ross and Naylor 2017; Alderwick *et al* 2015).

None of these organisations are at the end of their journey in terms of value improvement – indeed, they would argue that they are in the foothills. Also, all three organisations have taken very different approaches to the pursuit of value. But there is still much to learn and much to share from the variety of these early approaches to value improvement.

We have brought these organisations' stories together in this report to highlight the opportunities and challenges that they have encountered as they attempt to coherently bring together measures to improve the quality and efficiency of services, and to share this learning for other organisations wishing to develop their own strategy for value improvement.

Our approach

We carried out a literature review to assess current approaches to improving value in the delivery of high-quality health care in the United Kingdom and other comparable health care systems. We then had a roundtable discussion where nine representatives of NHS hospitals and national bodies shared their experiences of value improvement.

The majority of this report is based on telephone interviews with staff from three NHS acute hospital trusts – the Royal Free London NHS Foundation Trust, Bolton NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust – and site visits to these hospitals. We carried out the interviews between December 2017 and April 2018 with 18 board members and senior clinical and managerial leaders across the three hospitals. We transcribed and analysed the interviews and roundtable discussion to understand the key characteristics of each organisation's approach to value, and the barriers and enablers for developing and implementing an organisation-wide value improvement strategy.

We chose the hospitals based on a review of their hospital performance against quality and financial performance measures – such as their quality ratings from the Care Quality Commission – and personal knowledge of the hospitals' value improvement work. We selected them to represent different parts of the country and different types of hospital – including district general hospitals and a large multi-site tertiary teaching hospital.

Our previous reports on quality improvement noted that improvement work is a goal of all types of provider organisation (Ross and Naylor 2017; Alderwick *et al* 2015). While we focus on hospitals in this report, we hope in our future reports to focus on how non-acute organisations pursue value improvement and how it is sought more widely across local health and care systems.

What is 'value' in health care?

One of the most commonly used definitions of value in health care is achieving the best outcomes at the lowest cost (Porter 2010). Although there are many different articulations of value in health care, the same underlying concept of a balance between health outcomes and the cost of services often lies at the heart of these different definitions.

The Institute for Healthcare Improvement (IHI) in the United States has developed a 'Triple Aim' framework – a framework to optimise health system performance that focuses on improving the health of the population and patients' experience of health care, while reducing the cost of health care per head (Institute for Healthcare Improvement 2018). The definition of value in health care is at the centre of this framework.

The work of Sir Muir Gray has translated the Triple Aim into a UK context and identified the different ways in which value can be conceived (Gray 2015). These include the following.

- Allocative value – allocating value to different groups equitably in a way that maximises value for the whole population, eg, has the optimal level of funding been allocated to asthma programmes, and has this funding been further allocated optimally across the diagnosis, prevention and treatment of asthma?
- Technical value – ensuring that resources are used efficiently and effectively, minimising waste and avoidable harm when delivering care.
- Personalised value – ensuring that decisions are based on the things that matter to the individual patient.

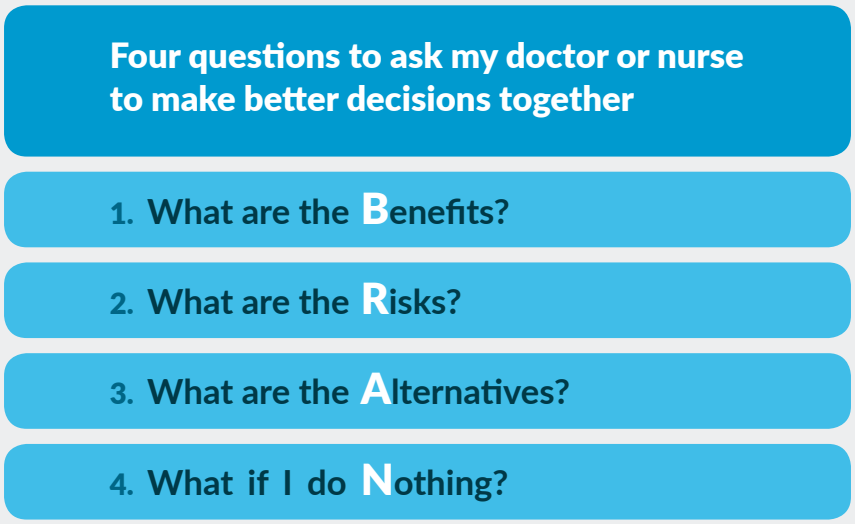
All of these different aspects of value are important to consider – a knee operation can be successful technically if it is delivered in a safe and effective manner, but if it was not the optimal intervention to meet that individual's clinical or emotional needs then the surgery was nevertheless of suboptimal value.

It is also important to clarify what distinguishes 'value' from related initiatives to improve the quality of clinical care or efficiency in the NHS.

First, as the simple knee surgery example demonstrates, value is not synonymous with productivity or efficiency. 'Productivity' focuses on how the 'inputs' of a health care system (eg, staff, clinical supplies and equipment) are used to provide a certain volume of outputs (eg, accident and emergency (A&E) attendances, outpatient appointments and general practitioner (GP) appointments). 'Efficiency' in delivering health care services takes the cost of delivering these outputs into account. Value as a concept is distinct from these measures because it focuses on outcomes, rather than outputs.

Second, the term 'health outcomes' encompasses more than the quality of care that is delivered. Unnecessary care, medications, investigations or treatments can be delivered to patients effectively and compassionately, but if they are not needed in the first place, this is not using the resources of a health care system to deliver best value for patients or populations. For example, value improvement initiatives such as Choosing Wisely encourage patients to ask a series of questions to make better and more collaborative decisions (Figure 1). In crude terms, in addition to looking at whether a health system is 'doing things right', the value agenda also looks at whether a health system is 'doing the right things'.

Figure 1 Examples of questions developed by the Choosing Wisely programme

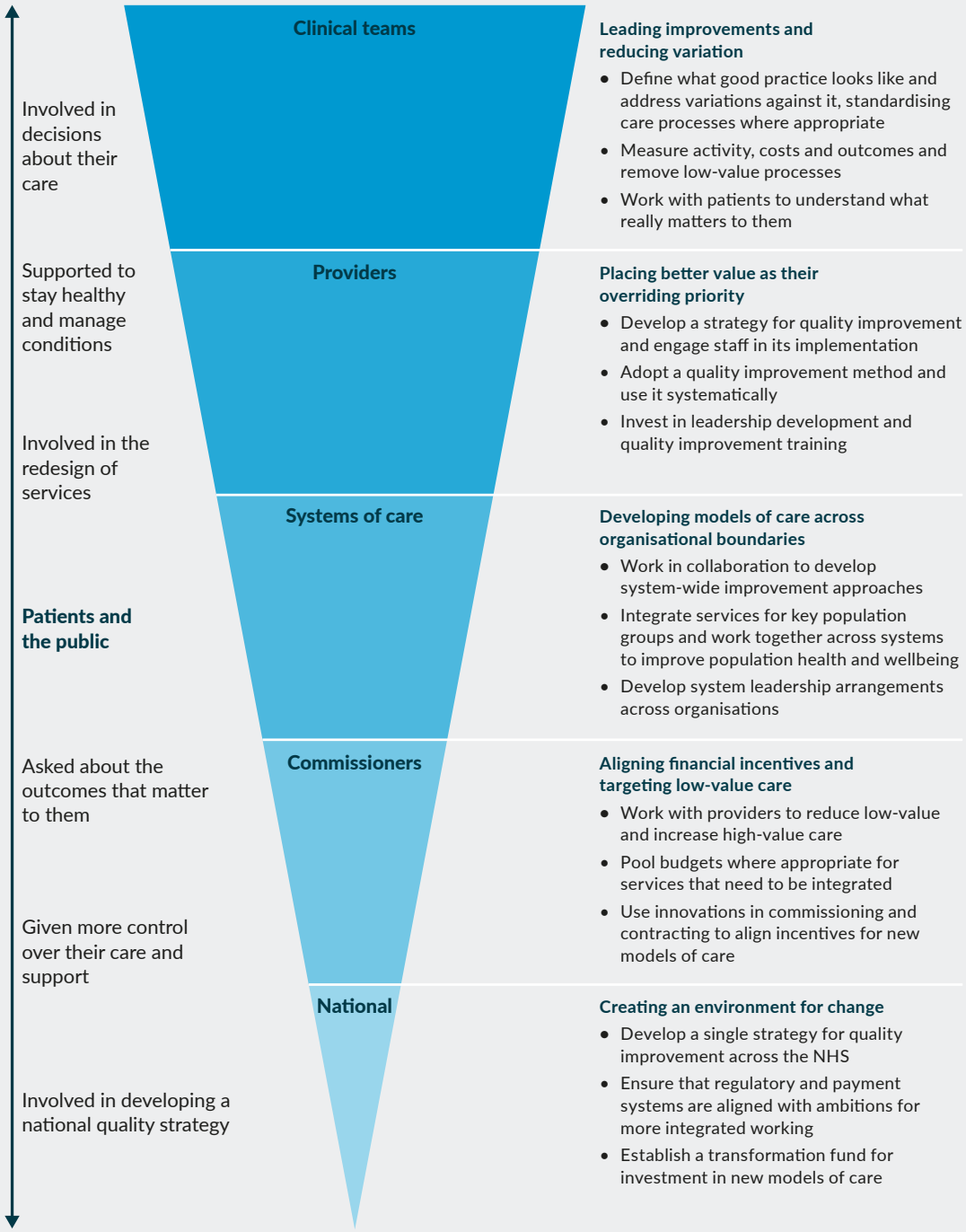


Source: Choosing Wisely UK (2018)

Third, value can operate at multiple levels. We have already noted that value can be thought of at the level of individual patients, groups of patients or populations. But different agents also play a role in delivering value, from the individual patient and clinicians involved in an episode of care or developing a treatment plan, to clinical teams developing plans for their services, to organisations and the commissioners who plan and purchase care for those organisations and the patients who can guide clinical professionals in determining what actions will deliver greatest value (Figure 2). Having focused in previous reports on the value delivered at system and clinical team levels (Ross and Naylor 2017; Alderwick *et al* 2015), this report focuses on value at the organisational level.

Finally, if value is the quotient of 'outcomes over cost', then action can be taken to improve value by addressing the numerator (improving outcomes) or denominator (reducing costs) of this equation jointly or separately. Better-value care might be cheaper (if the quality of the service is maintained or even enhanced) or the cost might be static (if the quality of care rises); value might even be improved by spending more, as long as quality improvements are rising even more steeply. As Alderwick *et al* (2017) note: 'Improving quality and reducing costs are sometimes seen as conflicting aims when they are in fact often two sides of the same coin.'

Figure 2 An agenda for action



Source: Alderwick *et al* (2015, p 115)

Why is value important?

Delivering better-value health care means better care for patients at a lower cost to taxpayers. This is reason enough to pursue the value agenda. But there are at least two further reasons that make the value agenda particularly important at this point in time.

The first reason is the sheer scale of the financial challenges facing health care services and the considerable opportunities to reduce costly waste. The NHS hospital sector overspent by £1.7 billion in 2017/18, and 65 per cent of NHS organisations providing acute hospital services were in deficit. This was despite the NHS provider sector as a whole delivering £3.2 billion (3.7 per cent of total expenditure) in cost savings in 2017/18 (NHS Improvement 2018c).

The Organisation for Economic Co-operation and Development (OECD) has estimated that 10 per cent of hospital expenditure is directed at correcting preventable errors in treatment and that up to 20 per cent of health spending could be used more effectively. It has noted that a significant share of health spending in OECD countries is at best ineffective and, at worst, wasteful due to unwarranted variation, underuse, overuse and misuse (OECD 2017) – examples of which we compiled in our previous report on better-value health care (Alderwick *et al* 2015).

The second reason why it is time for a renewed focus on value is the opportunity it provides for engaging clinicians more deeply in systematically improving how care is delivered to patients. Since the 2008 financial crisis, one of the dominant narratives in the NHS has been the need to control costs. This has often led to a perception that improving value is a euphemism for cost cutting, rather than trying to find a better balance between both the quality of care and the cost of delivering care. A genuine focus on the 'value equation' may be a more powerful motivating force for clinicians, as it seeks to engage them in a discussion about improving the outcomes that are delivered for a given level of resources, rather than simply trying to take costs out of the health and care system.

In response to the current financial and operational pressures in the NHS, a number of national programmes have been developed that are relevant to the pursuit of better-value health care services. For example, NHS England has set out a 10-point

efficiency plan to help the NHS 'cut waste and increase efficiency in the NHS… [to ensure that] every pound of waste saved is a pound that can be reinvested in new treatments and better care for the people of England' (NHS England 2017, p 39).

NHS England's 10-point efficiency plan

- Free up 2,000 to 3,000 hospital beds.
- Further clamp down on temporary staffing costs and improve productivity.
- Use the NHS's procurement clout.
- Get the best value out of medicines and pharmacy.
- Reduce avoidable demand and meet demand more appropriately.
- Reduce unwarranted variation in clinical quality and efficiency.
- Improve estates, infrastructure, capital and clinical support services.
- Cut the costs of corporate services and administration.
- Collect income the NHS is owed.
- Improve financial accountability and discipline for all hospitals and clinical commissioning groups (CCGs).

Source: NHS England (2017)

Since March 2018, the Care Quality Commission (CQC) and NHS Improvement have introduced a Use of Resources assessment for hospitals, alongside the CQC's existing assessments of the quality of care (NHS Improvement 2018a). This assessment will look at how effectively hospitals use their resources, such as finances, the workforce, estates and facilities, and technology. The CQC and NHS Improvement hope that the assessment will be a useful improvement tool to help hospitals demonstrate that they are delivering services efficiently while simultaneously providing care that meets the CQC's five domains of the quality of care – safe, effective, caring, responsive and well led.

In recent years, several other national NHS programmes have been developed that are also relevant to the pursuit of better-value health care, even if they mainly focus on one element of the value equation (such as cost reduction or quality improvement). These are as follows.

- **Model Hospital** – a programme that provides benchmarking data to help providers identify areas of clinical and service practice that they can improve on. This came about as a result of Lord Carter's national review of the operational productivity of hospitals and opportunities to improve it (Lord Carter of Coles 2015).
- **Getting It Right First Time (GIRFT)** – a programme aimed at reducing unwarranted variation in clinical practice. This programme is made up of more than 30 medical work streams (from vascular surgery to mental health), which are led by a senior clinician and focused on identifying opportunities to standardise clinical practice and reduce costs associated with low output (eg, relatively few cases on a procedure list) or high expenditure (eg, use of expensive surgical implants).
- **Quality improvement and 'Lean' methodology** – a range of approaches that allow organisations to adopt a systematic approach based on specific methodologies for continuously improving care (NHS Improvement 2018b). For example, the Virginia Mason Institute in the United States has been working in partnership with NHS Improvement on a five-year programme to deliver continuous quality improvement based on Lean principles, which identify and tackle waste in how services are delivered.
- **Choosing Wisely** – an initiative to challenge the idea that 'more health care is better', and that just because a medical intervention is possible does not mean that it should be used. The programme includes supporting patients and clinicians to work together to determine whether an intervention is needed, by agreeing a clear understanding of the risks and potential side effects, whether there are simpler or safer options, and what will happen if no intervention is used (Choosing Wisely UK 2018).
- **NHS RightCare** – a programme of support for commissioners and systems of care that uses data on investment, activity and outcomes for whole populations to address unwarranted variation and assess the value of health care (NHS England 2018b).

- NHS England's low-value procedure programme – a list of interventions that have been identified as low value (such as varicose vein surgery), because there are less invasive or safer treatments available. The procedures identified as low value are not banned, but NHS England is consulting on plans that would require compelling evidence of patient benefits before the procedures are carried out.

The number and breadth of these programmes illustrate the complexity facing NHS organisations that are trying to deliver the best outcomes for the lowest cost. And no one programme brings together all the different aspects of the value agenda. For this reason, we have chosen to review how three NHS organisations are developing their own strategies to improve the value of the services they deliver by coherently bringing together an assessment of the quality and the cost of the services they deliver.

The structure of this report

Section 2 presents case studies of the three NHS organisations. Section 3 discusses the challenges they have faced and the steps they took to overcome them. Section 4 concludes by summarising the key lessons from our research.

2 Case studies

In this section we review how three NHS organisations are pursuing the value agenda. They are:

- The Royal Free London Group
- Bolton NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust.

Although all three organisations have a broadly similar conception of value as a balance between the cost of delivering services and the outcomes that those services deliver, the details of their organisational value improvement strategies differ substantially, as does the operating context of the hospitals that the group/trusts encompass, as outlined in the box on the following page.

Some of these organisations developed a value improvement strategy to build on their previous strong track record of delivering high-quality or efficient services. Other hospitals described the successful development of their value improvement strategy as a reaction to a 'crisis' in either finance or the quality of care. Some strategies were developed top-down (that is, with the board taking more of a development and leadership role), while others were bottom-up (with individual clinical teams developing ideas or approaches that then led to an organisation-wide strategy). In all the sites we spoke to, patient experience was a key aspect of evaluating the impact of changes made, particularly at Bradford where work was under way to understand how the virtual wards affected patient experience. However, patients were rarely involved in the design of services. We would suggest that this is the next step for all three sites in their ambition to deliver better-value services.

The organisations' value improvement strategies and operating context

- **Developing shared clinical pathways across different hospitals.** The recent formation of the Royal Free London Group of hospitals has catalysed the development of new clinical pathways that aim to deliver the best possible outcomes for patients at the lowest cost possible. Services are being redesigned across sites through clinical practice groups (CPGs), which bring together medical and finance staff to develop the best models of care across a clinical pathway, such as community-acquired pneumonia.
- **Using Lean methodologies and making them more value based.** Following a long history of using Lean methodologies at Bolton NHS Foundation Trust, and given the continued financial pressures facing the Royal Bolton Hospital, the hospital has developed a focus on activities to improve the financial position of the organisation/reduce costs, while maintaining the quality of care delivered to patients. The hospital has a central programme management office (PMO) that co-ordinates these activities.
- **Codifying and systemising a 'virtual ward' approach to cover as wide a range of hospital services as possible.** Bradford Teaching Hospitals NHS Foundation Trust has brought together separate 'virtual ward' approaches (which allow patients to receive consultant-led care in their own homes) and developed these into its value improvement strategy.

There are many common features across quality improvement and value, in terms of both why they are pursued and the conditions for success (Jabbal 2017). These include:

- a clear strategy
- developing a new (less top-down) approach to leadership
- allocating adequate time and resources
- building the capability of staff
- increasing staff engagement
- sticking to the approach consistently.

However, when pursuing value, the balance between doing the same things right and doing the right things seems starker. Trusts we spoke to for our previous project on quality improvement were more focused on whether they were delivering services in the right way (Jabbal 2017). Furthermore, while quality improvement is primarily focused on quality, on the premise that getting the service right will unlock savings, with value, the balance between quality **and** cost is important. That is why, for example, Bolton NHS Foundation Trust and the Royal Free London Group moved their strategies on from a quality improvement one to the pursuit of better-value services. For both these organisations, quality improvement as a guiding star is incredibly helpful, but not sufficient for the pursuit of value.

For this report, our intention was not to evaluate the different approaches that the organisations took and compare them with each other. We saw little evidence that one strategy or approach could be easily lifted and adopted by another organisation, or that one strategy was clearly more effective than another. Instead, we chose the organisations for the breadth of the different approaches, which may inform other organisations with different priorities or starting points who wish to develop their own value improvement strategy.

In the subsections below, we briefly describe the reasons why the three organisations decided to pursue better value, the changes they have put in place within their organisations to support this agenda, and the further ambitions they have for improving the value of their services.

The Royal Free London Group

The Royal Free London NHS Foundation Trust is a major teaching hospital group in north London. It is one of the largest trusts in England employing more than 10,000 staff and serving 1.6 million patients each year.

The trust is one of the pioneers of a new 'group model' in the NHS (NHS Confederation 2017). The group model brings hospitals together to share services and resources, with the organisations connected by a single 'group centre', which takes responsibility for overarching strategy and group provided services, such as back and middle office functions.

The Royal Free London Group was formally established in 2017. Hospitals in the group function as autonomous units with their own boards (in the case of clinical partners) and leadership teams (in the case of all members), but benefit from:

- access to shared services (for example, shared human resources functions)
- knowledge from other parts of the group, such as good practice in delivering clinical care
- savings from delivering clinical or back-office services with greater economies of scale across the group.

What was the impetus behind the Royal Free London Group's value agenda?

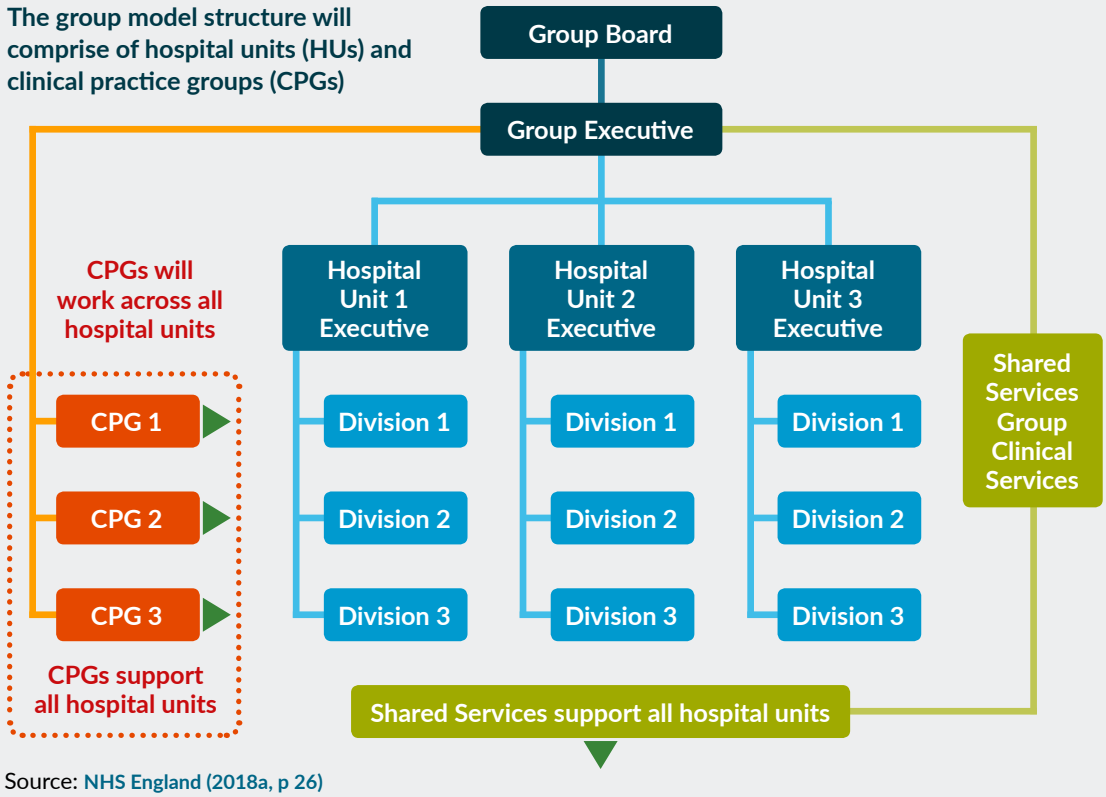
The Royal Free Hospital has developed a focus on value over several years, but the establishment of the Royal Free London Group provided fresh impetus to develop an overarching value improvement strategy that would deliver high-quality services to patients and populations at the lowest possible cost.

What are the key elements of the Royal Free London Group's strategy for improving value?

The overarching Royal Free London Group strategy includes several work programmes that are relevant to value improvement. In reviewing the strategy, two elements stood out as distinct from the strategies of the other organisations we visited. The first element was the group's emphasis on standardising and improving clinical practice across the organisations that make up the group. It has developed multi-professional 'clinical practice groups' (CPGs) to take the lead on this.

In effect, CPGs are tasked with tackling unwarranted variation in how care is delivered across the Royal Free London Group. As can be seen in Figure 3, the CPGs work across all the different hospitals that make up the Royal Free Group. CPGs are expected to define appropriate clinical standards and the processes that will help meet these standards, and then implement any changes to clinical practice that are required. CPGs will also monitor and review data to ensure that the group is making progress in reducing unwarranted variation and improving care for patients. CPGs cover some of the most common reasons why people go to hospital, such as for the induction of labour, a hip replacement and asthma (NHS England 2018a).

Figure 3 Royal Free London Group structure



Source: NHS England (2018a, p 26)

The divisional directors who chair each CPG have full day-to-day responsibility for the financial and operational performance of the services covered by the CPG, and their strategic development. This brings together both the cost and quality of services under a single remit, so that they can be looked at together in a more systematic way. That is, rather than beginning from the proposition of having to make annual cost reductions and ensuring that these changes do not have a negative impact on the quality of services, the CPG will continuously focus on the long-term balance between the cost and quality of services.

The second key element of the value strategy relates, once care is standardised, to economies of scale. If care is standardised across all hospitals, the argument is that this will unlock better-quality care for more patients and at the best possible cost. The group anticipates that, through working together, the hospitals within the group will realise the benefits of economies of scale that would otherwise be beyond the reach of individual organisations.

For example, clinical support services (such as imaging and pathology) and corporate services (such as finance and human resources) could be brought together to provide consistent support to all the different parts of the group and to reduce duplication. Procurement of goods and services (such as medicines) is another area where the group could benefit by pooling resources and purchasing power.

The Royal Free London Group's strategy is distinct from previous attempts to merge NHS organisations together. This is because of several factors, including:

- scope – the CPGs focus on pathways of care rather than on individual services
- breadth – the CPGs look strategically across all the individual hospital units in the group
- staff input – the CPGs are led and developed by multi-professional teams
- remit – the CPGs are tasked to focus on value improvement by looking at the quality and cost of services together.

How is the strategy resourced?

As part of the acute care collaboration stream of NHS England's 'vanguard' programme, the group received £16 million of 'seed' funding, which has been heavily used to resource the creation of CPGs and training and development for the new roles within them, and to learn from other health systems that have developed similar group models, such as Intermountain in Utah in the United States (Royal Free London NHS Foundation Trust 2016).

The group has also invested in staff and staff time to support the development of CPGs. CPGs are chaired by divisional directors and supported by full-time programme managers for surgery and associated services; medicine and urgent care; women's and children's services; and transplant and specialist services. These programme managers work with the clinicians and operational teams in their divisions to develop the new approaches to delivering care. Across all the CPGs there is also dedicated data, analytical and finance support (Royal Free London NHS Foundation Trust 2017).

Future ambitions

The focus of the Royal Free London Group's value strategy has understandably been on their current range of hospital services. But it is clear that they are thinking about how they can deliver better value for their local population by working more closely with other organisations in their local area and by conceptualising 'value' even more broadly. One interviewee described how the current group model could be extended beyond hospital services in the future:

> *We think quite strongly that this is a whole-system thing… if you think about it at the moment, hospitals are organised and primary care and social care are all organised in a uni-organisational way and each hospital delivers patient care, it has its own support services, and it has its own corporate support services… So, what we're trying to do is bring all that together. At the moment we've got three hospitals doing patient care but… and then sharing clinical support services and corporate support services… consolidation doesn't have to be just hospitals, it could be mental health, it could be primary care.*
>
> (Executive director)

Bolton NHS Foundation Trust

Bolton NHS Foundation Trust, in the north-west of England, provides acute and community services from the Royal Bolton Hospital and more than 20 other sites across Bolton. In July 2016, the CQC rated the hospital as 'good' overall. The hospital is a major provider of hospital services in the Greater Manchester area, and is the second-busiest ambulance-receiving site in the region.

The hospital is also part of the Greater Manchester devolution plan. Under this plan, the hospital is working to deliver more integrated services with partner organisations, including the local council, mental health foundation hospital and GP federation.

To support its value strategy, the hospital developed a programme management office (PMO) to co-ordinate and provide oversight of the value improvement work across the organisation.

What was the impetus behind Bolton's value agenda?

When asked what the impetus was for their current approach to value improvement, the leadership of Bolton NHS Foundation Trust had a clear answer: 'crisis'.

In 2012, Monitor – then the regulator for NHS foundation hospitals, now a part of NHS Improvement – put Bolton NHS Foundation Trust in breach of its authorisation because the hospital was failing regulatory standards on performance and financial management. This included the hospital failing to meet A&E waiting-time targets and reporting an unexpected financial deficit of £1.9 million in 2011/12 after originally forecasting a £1.7 million surplus (National Audit Office 2014).

Following the breach of authorisation, a new leadership team was put in place at the hospital and Jackie Bene, a former registrar, consultant and medical director within the hospital, was appointed as chief executive. The current hospital leadership said that breaching their terms of authorisation was a 'burning platform' that spurred a new imperative to improve the financial performance of the hospital.

In the period immediately after the hospital breached its authorisation, the hospital went through what it describes as 'the normal turnaround process'. This involved a 'brutal' focus on cutting costs, with the support and guidance of turnaround directors appointed by regulators, and management consultants. The hospital had a long history of using Lean methodologies. These had been regarded as effective for engaging clinicians in the value improvement agenda, but the work to date had focused more on quality improvement than on cost savings. Given the financial challenges that still faced the hospital – despite its successful exit from its period in breach of authorisation – the hospital leadership chose to focus on activities that would improve the financial position of the organisation while maintaining the quality of care delivered to patients. These measures were effective enough for the hospital to be taken 'out of breach', and for the hospital leadership to gain greater control over the organisation's destiny.

Once the hospital had exited its period of regulatory breach, the hospital leadership wanted to create a new focus on improving the value of their services. This focus would attempt to marry the urgent recent work on cost reduction that had taken place, with longer-term work on quality improvement and Lean methodologies that the hospital had been pursuing.

The hospital worked hard to obtain clinical engagement with its new value improvement programme, which, compared with the previous Lean programme, had a more balanced focus on reducing the costs of care alongside maintaining the quality of care. The hospital leadership identified two factors that made this process easier.

First, a large proportion of the clinical workforce had a long history with the hospital and 'felt a sense of pride in doing their bit to turn the organisation around' when it was faced with substantial financial challenges – one leader spoke of how the value improvement programme was about maintaining the 'integrity' of the organisation.

Second, the stigma of being in financial difficulty was much stronger at the time the hospital began its improvement work, because fewer hospitals were in deficit then compared with now. The hospital leaders noted that this 'gave our burning platform a bit more of an edge' as the hospital was seen as more of an outlier in need of significant remedial action.

Clearly, not every hospital will be able to replicate these conditions, but they are important in explaining the context facing the hospital, which helped it to engage clinicians in a programme that involved a focus on both the cost and quality of care. As one interviewee noted:

> *I guess I wouldn't advocate to go and burn your own platforms, but I think the world now, the NHS now, there's quite a lot of burning platforms out there, particularly financially. I think it's how you approach your workforce in general around these issues. And when everybody's in the same position you can't necessarily get the traction that you'd like to get. Same is true of A&E and the difficulties around A&E at the moment. But I suppose my advice would be to another organisation, I don't think you can achieve what we did without some sort of burning platform, because there has to be some drivers in there to culturally bring about that change.*
> (Executive director)

What are the key elements of Bolton's strategy for improving value?

The hospital's strategy for value improvement is based on a central programme management office (PMO) that co-ordinates activities to reduce cost and improve quality across the hospital. The PMO maintains oversight of the financial improvement work across the organisation, working directly with clinical teams and providing assurance to the hospital board.

Each clinical team is supported to develop an annual financial improvement scheme, which sets out the measures they will take to reduce costs in delivered care. Each scheme is accompanied by a quality improvement assessment to provide assurance that the actions will not have a negative impact on the quality of care. At the time of our interviews with the hospital, approximately 260 schemes were being overseen across the hospital.

As one interviewee noted, the quality impact of every scheme must be assured, regardless of whether it saves £90 or £90,000. The medical director and nursing director see every single quality assessment for a cost-saving scheme. The schemes are also sent to the Bolton Clinical Commissioning Group so there is external assurance that the hospital has not, as one interviewee said, 'stripped out loads of money to burn quality for the sake of it'. From our interviews it was clear that these quality impact assessments were not seen as a box-ticking exercise, and they had often led to proposed cost-saving schemes being halted or significantly amended.

The PMO also provides service leads with data on the quality and cost of their services. This was described as a 'non-threatening challenge' to present clinical leads with the information they needed to interrogate the performance of their own specialty. In this way, the work preceded and anticipated much of Lord Carter's Model Hospital approach to presenting quality and cost information back to clinical teams to provide actionable intelligence (Lord Carter of Coles 2015).

The framework that the Royal Bolton Hospital has adopted means that any new national guidance or reporting requirements can be integrated into the existing work of the organisation, rather than being seen as disconnected 'extra' priorities. For example, when NHS Improvement issued new spending rules on temporary staff (NHS Improvement 2015), the hospital was able to quickly include this in its benchmarking performance reports.

In reviewing Bolton's strategy for improving the value of its services, three key elements stood out.

The first element was the hospital's decision to do things 'in house'. It had a long history of using management consultants and turnaround directors to deliver savings. But the hospital leadership came to the view that work programmes to improve the value of their clinical services would require investing in permanent staff to support a spirit of continuous improvement, and to build strong and stable relationships with frontline clinical teams – staff who could, as one interviewee put it, 'not be disconnected from the reality of what's happening in the hospital'.

The second element was what the hospital described as its 'devolved accountability model'. In this model, the hospital leadership and PMO play a supporting and co-ordinating role, but it is the frontline clinical teams who develop and deliver the value improvements. In this approach, ideas for improving care and reducing costs mainly come from frontline staff, but can be stimulated by the benchmarking data that the PMO provides. The interplay between a PMO that provides central co-ordination and support, and a devolved accountability model in which service improvement is led by frontline staff, was one of the factors that several interviewees identified as crucial. One interviewee described this model as 'clinically driven and managerially supported', noting:

> *We are making sure everybody else is set up to deliver and they're the accountable owners. So that was a big switch. What we've really worked on in the last four years was making sure that we have this accountability for delivery sitting within divisions and directorates and leads, and then what we're doing is assuring that they are capable.*
> (Executive director)

The third element was the timeliness with which data is shared with clinical teams. The hospital's finance team were concerned that financial information was often out of date by the time it was presented back to senior managers and budget holders. It was one of the first in the NHS to achieve 'working day one reporting' (Bolton NHS Foundation Trust 2015). Under this scheme, results and comprehensive budget statements for a given month are issued by 5pm on the first working day

of the next month (eg, data for September is available on the first working day of October). This meant that clinical teams would wait one day, rather than 15 days, for financial information to be available. This gave clinical teams two extra weeks to scrutinise their financial position and make more proactive business decisions, and created a virtuous cycle of sharing information between clinical and financial teams.

In describing the Bolton model, there is a risk that it is seen simply as a well-run cost improvement programme that every hospital would be expected to deliver routinely. What distinguishes the Bolton approach, however, and contributed to its finance team winning awards to recognise their work, are the rigour with which programmes have been co-ordinated, the clear balance in focusing on the impact of cost improvements on the quality of care, the devolved accountability arrangements required, and the strong partnership working within the hospital between the PMO and clinical teams, and between the hospital and its CCG (Bolton NHS Foundation Trust 2015).

How is the strategy resourced?

The main dedicated resource for the strategy is the two-person PMO, which co-ordinates the hospital's value improvement work. However, other parts of the organisation dedicate significant time to assuring or contributing to the value improvement work. For example, the medical and nursing directors review all the quality impact assessments that accompany cost-savings proposals from clinical teams.

And the clinical teams themselves clearly dedicate substantial time to developing and implementing the improvement initiatives. Bolton has structured its services into four clinical divisions. Each of these is led by a triumvirate group: a divisional director of operations, a clinical director and a divisional nursing director. This triumvirate structure is mirrored in the business units and specialties that sit within each division, for example with a specialty clinical lead, a nurse matron lead and a business manager. These triumvirates are the main audiences for the work of the PMO, and they are the engine that is driving performance improvements throughout the hospital.

Future ambitions

The Royal Bolton Hospital has seen significant benefits from its value improvement strategy. It has reported better infection prevention performance and lower waiting times for accessing care (Bolton NHS Foundation Trust 2018) and it has continued to deliver strong financial performance (NHS Improvement 2018c).

To build on this success, the hospital has two priorities to expand its value improvement work. The first is to rebalance the focus of the work more evenly across quality and cost improvement. The hospital acknowledges that its value improvement work can seem quite financially driven at times, partly because of its history and being rooted in the breach of authorisation that was the original impetus of the work programmes. The hospital leadership recognises that the desire to improve the quality of services is a far stronger motivating force for clinicians and is now seeking to reinvigorate its quality improvement work.

The second area of focus for the hospital is extending its approach beyond the four walls of the organisation. The rigour and principles that have been applied to managing the finances of and quality of care within the hospital could be adopted for use in the Bolton locality plan that is being developed as part of the Greater Manchester devolution agreement. This will involve close working with other providers, and between providers and commissioners of care in the local area. This work will build on the existing strong partnerships that have been developed between Bolton NHS Foundation Trust and Bolton CCG, which include the agreement of risk-sharing financial arrangements between the two organisations (Ward 2016).

Bradford Teaching Hospitals NHS Foundation Trust

Bradford Teaching Hospitals NHS Foundation Trust is an integrated trust providing acute hospital and community health services. It is responsible for providing hospital services for the people of Bradford and communities across Yorkshire, serving a core population of around 500,000 people and providing specialist services for some 1.1 million people.

The central premise of the trust's clinical service strategy is to deliver continuous quality improvement in patient outcomes, which will be affordable and provide

value for money (Bradford Teaching Hospitals NHS Foundation Trust 2017). To support this, the leadership team at Bradford have supported the development of a series of 'virtual wards', which allow patients to receive consultant-led medical care in their own home rather than in hospital.

What was the impetus behind Bradford's value agenda?

The development of Bradford's value improvement strategy was more gradual than that of Bolton NHS Foundation Trust and the Royal Free London Group. One could go further and say that the Bradford strategy was successfully retrofitted around existing work that the hospital had already embarked on.

In our interviews, three distinct themes re-occurred when discussing the genesis of the strategy. First, the strategy was developed in a very 'bottom-up' way. The hospital's organisation-wide approach to value improvement started with a clinician finding a problem they wanted to solve – the clinician noted: 'You walk around a hospital, you see people pushing drips, standing in Costa [Coffee] and you've got to say, why are they in hospital, why are they not at home?' This was the germ of later ideas to deliver services through 'virtual wards', which are described in more detail in the next subsection. The use of such visual images was an effective way for clinicians to make a simple but powerful point to the board when they were reviewing the proposal for these wards: these patients do not need to physically stay in hospital, and can instead receive the benefits of hospital consultant care while at home. So the idea for value improvement came from a frontline clinician, and was supported by the board. As one director noted: 'This wasn't a strategy that we've done in the boardroom, on a couple of Wednesday afternoons, and then handed it down.'

Second, the strategy is being developed organically to cover more of the work of the whole organisation. The virtual ward programme started with elderly care services, and then expanded into other services such as diagnostics. The hospital leadership realised that having a coherent and standardised approach to value improvement would help to deliver improvements on a greater scale than would be possible if the virtual ward programme was only supported by individual clinical teams.

For this reason, Bradford has set itself the ambition of becoming a 'virtual hospital' – that is, a hospital that delivers services in a hospital setting only where absolutely necessary. But importantly, the leadership team did not decide to become a virtual hospital and then pilot the approach with individual clinical services. Rather, they built their strategy by going with the grain of the value improvements that individual clinical services were already pursuing.

Third, Bradford sees the successful development of a new value strategy as an opportunity to showcase the work of the hospital and raise its profile as an organisation delivering high-quality and efficient care. By codifying its approach to value improvement, the hospital will be able to tell a more coherent and compelling narrative about how it is delivering better services for patients.

What are the key elements of Bradford's strategy for improving value?

The keystone of Bradford's value improvement strategy is the development of virtual wards that allow patients to receive consultant-led medical care in their own home rather than in hospital. Virtual wards in the NHS have a long history. They have often been used for patients at high risk of emergency hospitalisation, where this hospitalisation can be avoided by closer monitoring and by more proactive and co-ordinated care. The virtual wards approach patient care as if the patient were really in hospital, when they are actually in their own home. For example, a multidisciplinary team will have a daily ward round where they discuss the care of patients in 'the ward' and update treatment plans to ensure that patients' health and care needs are being met.

In this subsection we describe the virtual ward programme in more detail. But it is important to note that, as described above, the key element of interest in Bradford's story is not so much the development of the virtual wards themselves, rather it is the way the hospital started to coalesce around a 'bottom-up' idea for service improvement that could then be codified and spread throughout the wider organisation with the support of senior leaders.

Although virtual wards have been adopted for more than a decade in parts of the NHS, what makes Bradford different is the scale of its ambition to expand virtual wards to a wide range of clinical services, to support its ambition of being the first virtual hospital in the United Kingdom. As indicated above, the hospital has

extended its virtual ward programmes from elderly care to other services, including diagnostics, fracture clinics and children's services.

For example, one of the clinicians in Bradford has articulated how differently diagnostic services work in a virtual ward setting in comparison with a standard ward (Williams undated). Under the standard ward approach, a patient might experience the following episodes of care:

- Day 1 – the patient is admitted to hospital following a referral from their GP, after being reported as severely anaemic in a blood test.
- Day 2 – after a consultant ward round, tests are ordered.
- Day 3 – a gastroscopic examination takes place, which returns normal results.
- Day 4 – after a consultant ward round, a computerised tomography (CT) scan and colonoscopy are ordered.
- Day 5 – a CT scan takes place and a tumour in the patient's bowel is detected.
- Day 6 – the patient waits for a colonoscopy.
- Day 7 – a colonoscopy confirms the tumour.
- Day 8 – the patient is seen by a surgeon and a multidisciplinary appointment booked. The patient is sent home to wait for surgery.

Under the virtual ward programme, Bradford clinicians will only keep a patient in hospital if they need to remain in hospital. In the above example, the patient would be sent home on Day 2 rather than waiting in hospital for their test results, and the diagnostic tests would proceed on the same timescale as if the patient was in hospital, with the results being sent to the consultant to allow the diagnostic and treatment plan to progress. This allows the patient to stay in their own home and in familiar surroundings for as long as possible.

The leadership team at Bradford note that the programme has generated considerable benefits for patient flow in the hospital. The hospital has identified substantial reductions in the number of bed days and average lengths of stay for patients for services adopting the virtual ward approach (Williams undated). It has also found that, compared with the past, there is less need to open 'escalation beds'

to cope with surges in demand, and so they do not face the associated staffing costs (including agency staff) that this would require.

The hospital has also invested in understanding patient feedback about the virtual ward programme through bespoke surveys and engagement events. This feedback has been largely positive. A recent sample of patients found 100 per cent satisfaction, with patients noting the improved experience associated with being in familiar surroundings and settings. As one patient said: 'I got three nights of much better sleep.' Where patients identified areas for improvement – for example, transport to and from the hospital for when further tests and investigations are required – the hospital is implementing Plan, Do, Study, Act (PDSA) cycles to determine where further changes could be made.

How is the strategy resourced?

The virtual ward programme has been supported through investment in both managerial support and dedicated clinician time. This has included developing a new virtual co-ordinator role, which has been expanded to a further Agenda for Change Band 3 co-ordinator role as the virtual ward programme has expanded its focus. Clinicians and senior managers have identified these programme co-ordinators as critical to the success of the programme. The co-ordinators explain how the service works to patients, ensure – with appropriate senior clinical input – that patients are eligible for the programme, and organise diagnostic tests for patients who are discharged home. The clinicians leading the virtual ward programme also dedicate substantial time to developing the service and identifying data on clinical outcomes and avoided costs, which is provided to the board on a regular basis.

Future ambitions

There are two future ambitions for the Bradford virtual ward programme. The first is to continue the phased expansion of the programme, so that Bradford continues its progress towards being a hospital that is 'short-stay by design' and where patients' length of stay in hospital is minimised to what is clinically necessary. For example, the hospital is in the process of developing new care pathways for gastroenteritis and childhood wheeze.

The second ambition is for Bradford, with its commissioners, to find an appropriate and sustainable financial framework to support the virtual ward programme. The benefits of the new model of care include reduced lengths of stay in hospital, but this can also result in less income for the hospital because of reduced inpatient activity. The collaborative approach between the hospital and its commissioners has already resulted in a local tariff that covers additional consultant time in the virtual fracture clinic appropriately, with the intention of building on this approach so that the hospital is not financially penalised for treating patients at home rather than within the four walls of the hospital.

3 Discussion

The previous section highlighted that the three organisations we have reviewed in this report have taken very different approaches to delivering better-value services. But there are also striking similarities in the factors they have identified as key to their success, and the factors they have identified as barriers or stumbling blocks to avoid.

In this section, we examine these conditions for success and obstacles in more detail, to share the learning from our case study sites on what issues organisations should consider as they develop their own value improvement strategy.

A clear, consistent and coherent strategy

A successful value strategy provides a single vision for how better value will be delivered across an organisation, and how the day-to-day activities of each part of the organisation fit into achieving that aim. Stepping back and looking at the case study sites together, their value strategies were:

- clearly articulated – well-defined goals were set out that were easy to understand
- consistent – goals did not change from year to year
- coherent – taken together, the different actions for achieving value improvement set out a clear road map to the overarching goals.

The case study sites used similar language when describing their value strategies – references to 'shared purpose' and 'guiding northern stars' were common – which reflected the strategic clarity that the development of their approach to value had brought. One interviewee articulated the benefits of a clear strategy in giving the organisation a core narrative and medium-term goals: '[Our strategy] enables you to always get back to something or to work out, does that fit with what we're trying to do? So, we've got a set of goals that are measurable, and we'll know if we've hit them in four years' time' (executive director).

We also observed that, despite being time-consuming to develop and implement, the value improvement strategies were rarely seen as additive corporate initiatives that staff were being tasked to deliver. If anything, they helped to bring a sense of coherence to the various improvement initiatives that are taking place in the NHS.

For example, in Bolton NHS Foundation Trust, the additional benchmarking information from the Lord Carter national programme (Lord Carter of Coles 2015) was quickly integrated into the data packs that the central programme management office (PMO) sent to clinical teams. Rather than being another set of disconnected data to look at, the data could be connected to existing improvement work. This also fostered a clear sense of agency in the staff we spoke to, rather than being used as a response to a national regulatory programme. As one executive director noted, this coherence was an added benefit to developing an organisation-wide approach to value improvement and was a substantial change to their previous approach where they felt 'we were trying to solve one problem at a time'.

Long-term senior executive commitment to the better-value strategy

At its core, a value strategy is about delivering change that is both large-scale and long-lasting. This can only be achieved with a long-term commitment to the purpose of the strategy, including from the leadership of the organisation. This requires leaders to be both visible in their commitment to the strategy, and explicit in their understanding that change may take several years to be delivered.

In all three case study sites, the value improvement strategy sat within the portfolio of one of the most senior board members, and it was clear that this was not seen as an 'add-on' to their day job or portfolio. One medical director spoke of how this was important in demonstrating the whole organisation's commitment to the strategy: '[A]s the leader of the doctors, it's about espousing those values day in, day out, and convincing… and working with my medical teams, you know, either within my office corporately or within the medical management structure, and also out and about on the shop floor. It's visibility, it's accessibility.'

Having a dedicated board-level commitment to better-value services was an important sign that the organisation was taking the issue seriously and provided greater coherence across its wider work. For example, in one hospital, a clinician

suggested that the value improvement work only really took root when it became one of the key priorities for a board-level director: '[The strategic plan] has been a little bit of an orphan but [now] we've got a new director who is responsible. Because what we were missing was the top-level cement to hold all these various initiatives in various areas together.'

The long-term nature of value improvement initiatives also requires senior leaders to be brave (the phrase 'hold your nerve' was common across all the case study sites we visited) and to be realistic in their assessment of how and when their value improvement strategy will reap dividends. This is not an easy task, and one director noted the challenge of having meaningful conversations about better-value services when the focus of most organisations is on performance against national targets:

> *Four-hour waits in A&E is the drumbeat of an acute organisation. It doesn't matter how much happens outside of the emergency department, on the wards, and you know, in the community, and everything else. Actually, the reality is, [organisations are] absolutely driven by 'four-hour numbers'. And in that context, trying to have a meaningful conversation about your strategy, and all of the things that go into it, and you know, teaching, and research, and flow… and you just know that the people you're talking to, in the back of their mind are thinking, yeah but I've got to deal with that thing, you know, four hours.*
>
> (Senior manager)

Supporting value improvement may require a new 'compact' – both within NHS organisations and between NHS organisations and the national bodies – that recognises that changes will not happen overnight. As one interviewee noted: 'So there's an element of being able to try and keep to that course and persuade the important stakeholders that this is… this will deliver. We told you it wouldn't deliver overnight but this is why it will deliver. Please don't panic' (executive director).

Having a stable leadership team was a clear asset in helping organisations to maintain their long-term strategic focus on value improvement. This was especially true as a substantial part of delivering strategic change relies on the ability to maintain effective, trusting, working relationships across an organisation and wider stakeholders (Alderwick *et al* 2017).

Our interviewees confirmed the positive impact that a stable leadership team can have specifically on the delivery of better-value services:

> *[We've had] an incredibly stable very senior executive team… there's a danger if you're a new management team coming up with a [new strategy], it's the 'latest fad isn't it, you won't be here in two years' time anyway'. [The board has] been relentlessly optimistic that [the value strategy] is a brilliant thing… you just have to keep going, even in the days when you're thinking it's all dreadful, it's the optimistic message and people want to hear that more than anything at the moment. They want someone to say, yeah, there's a plan to get out of this, the dark days.*
> (Executive director)

Empowering staff to lead improvement work

Another key enabler for organisational change is developing and maintaining a new approach to leadership that moves away from the imposition of solutions from the top down, to recognition that frontline teams, patients and their carers are often better placed to develop solutions through a process of discovery.

We found many commonalities in the skills of leaders in our value improvement case studies, and the skills of leaders in organisations pursuing continuous quality improvement programmes (Jabbal 2017). Fundamental to this is the empowerment of and respect for the staff of the organisation, who are uniquely placed to identify areas for improvement and contribute ideas. Members of the leadership teams in the case study sites were keen to stress that their role in developing the value strategy was often a supporting one, which included allocating the right level of resources to the value improvement programme and ensuring that the different strands of the strategy were connected into a coherent whole. As one executive director said: 'You know, all the credit goes to the teams. You know, they're the ones that get profiled, they're the ones that tell the story. We're just enabling enablers.'

If deciding to pursue a value improvement strategy requires boards to be brave, delivering the strategy requires no less courage. Implementing change means that leaders must demonstrate a high degree of trust in clinical teams, and allow them a sense of control and agency in developing and implementing improvements.

Executive directors we spoke to often remarked on the discipline it requires to not – as one board member said – give in to the temptation to 'pull everything in towards you and control it as financial pressures escalate in the NHS'. Another executive director further noted: 'Critically, you have to have confidence that the staff know how to run [the programme] and don't start meddling and holding them back.'

Engaging staff in the value agenda

The association between hospital productivity and the degree of co-operation and engagement between managers and staff is well documented (Jabbal 2017; Rumbold *et al* 2015). An engaged workforce is fundamental to the success of a better-value strategy. This requires listening to staff as the strategy is developed and implemented and communicating relentlessly to ensure that the strategy is clearly understood. One interviewee described the range of activities they had put in place to engage with staff:

> *And so we've been doing a lot of different pieces of work across the whole spectrum of how you engage with staff, involving them in designing their service, doing quality improvement programmes, meeting and greeting, having open forums where they come and, you know, lay out their concerns. And simply listen and, you know, work through with them how we might get better.*
> (Executive director)

This marks a shift away from the feeling that change is being 'done to' staff, towards change being developed in conjunction with staff. Staff are more likely to share their own thoughts and ideas when they feel they are being listened to and have the power to effect change. This requires being open and having honest conversations with staff about the strategy and deliverables. As one interviewee noted: 'People start to really believe, do you know what, I'll be able to redesign this the way I want it to after all, and this feels more real' (executive director).

The importance of engaging with staff and valuing their input into a new strategy to deliver better value should not be underestimated. Interviewees felt it was important to recognise that staff engagement is an unending task, which can be complex, and cannot necessarily be rushed. This has meant that our case study sites

have had to be comfortable with progress at a slower pace, as there has been a lot of input from many different members of staff with many different views. This has required 'space' for the organisations to work through those different views, rather than trying simply to force one view over everyone else.

An unintended consequence of the value improvement strategy among the case study sites was the number of staff who became interested in developing their skills or furthering their careers by becoming more formally engaged in the value improvement work. For example, in terms of the Royal Free London Group, one interviewee noted that the development of clinical practice groups (CPGs) allows the Royal Free London NHS Foundation Trust to provide more clinical leadership opportunities for clinicians at a very early stage of their careers:

> *We try and build leadership, horsepower and understanding… across the workforce, starting with someone who could step up to lead, which would be for FY1 and 2 [foundation year 1 and 2] doctors, and people at relatively early stages in other professions, where you're really learning about leading yourself… Then that is a leadership cohort that you can develop into positions of leadership both at operational and at executive level[s].*
>
> (Executive director)

Giving staff adequate resources to develop and deliver better-value services

Staff and leaders engaged in delivering better-value services require the skills to identify quality and cost problems, to test ideas for change, to measure their impact and to act on the results. NHS leaders need to invest time and resources in building the capacity and capability required for improvement within their organisation (Alderwick *et al* 2017). Delivering better-value services at scale also requires building an appropriate support structure for frontline teams, and a way of ensuring that learning from value improvement initiatives is spread effectively across the organisation.

In all our case study sites, the board had made a clear decision to build the capacity and capability of staff to support their value improvement strategy. Some hospitals within the case study sites used external funding sources, such as NHS England

vanguard funding, to support these initiatives. But they all invested their own resources in improvement initiatives as well. Several interviewees told us about the difficulty of investing in long-term change when the NHS is experiencing acute financial and operational pressures. But as one interviewee noted, delivering better-value services is not a 'nice to have', but an imperative, notwithstanding these pressures:

> *It is challenging to do when you have no money to resource this extra work, for extra staff, training and development etcetera – but there is a belief that the investment is going to pay off in the long term. It is seen as a valuable investment, and the right thing to do.*
> (Senior manager)

This included investment in developing PMOs or shifting the focus of their existing PMOs away from short-term ad-hoc projects to consistent work on the value strategy. Clinicians, including clinical directors, included work on the value strategy as part of their job planning. In one hospital, new posts were developed for analysts to support and evaluate the value improvement work. Financial support was also made available for building the capacity of staff to deliver value improvement, for example by investing in training opportunities and supporting staff to visit other organisations with a strong track record in value improvement.

It is clearly important to recruit new staff, or redesign existing job roles, so that value improvement strategies have sufficient capacity to deliver. But the people we spoke to also noted that, by allocating resources to the value improvement agenda, the board had sent a clear signal that it was 'serious' about this agenda and that the value improvement strategy was likely to be a long-term commitment. This helped to ensure that value improvement work was seen as 'part of the day job' rather than something staff should engage in as and when they could. As one interviewee noted:

> *I think there was always a recognition that if you ask a bunch of very busy clinicians to just cram this stuff in around their day job, it's not going to happen. You have to put in some additional support to help people understand what the benefits of it are but then actually help them enact whatever it is that they're trying to do.*
> (Senior manager)

Using data and analysis to support value improvement strategies

Delivering value improvement on an organisation-wide scale requires considerable support to identify, analyse and share data on the activities of the hospital. There were two aspects to this that came through strongly in our interviews: having access to reliable, timely and integrated data on the quality and cost of services, to identify where opportunities for improving value lie; and capturing information that helps to demonstrate the impact of the value improvement strategy to internal and external stakeholders. These issues proved to be some of the most challenging for the case study sites.

The first challenge was in finding the data required to understand the 'baseline' position of the hospital with respect to the value of its services. This often required the hospital piecing together quality and cost data, which had often been separately stored and analysed. An interviewee at one of the hospitals described the process of combining data sources as 'painstaking'. The hospital is now developing an 'integrated data tool' that automatically brings together relevant information on the cost and quality of services. But in the early days of the value improvement programme, this had required an analyst manually scanning data to follow an individual patient's journey, including all the episodes of care related to one condition or admittance (including diagnostic tests ordered), outcomes of care and information on readmissions.

Having sufficient analytical capacity to support the collection and analysis of data was an important consideration for our case study sites. Several interviewees noted the importance of having dedicated members of staff to collect, analyse and disseminate data on outcomes. Some hospitals had looked outside their normal recruitment pools to obtain these individuals, for example one hospital had used an Improvement Academy Fellow to support their value strategy.

But even more challenging was the task of demonstrating the impact of the value improvement programme. When asked 'How do you know the programme is making a difference, and that you are delivering better-value services?', interviewees noted that this was a question they often asked themselves. There were three common themes in their answers.

The first theme was that 'soft' indictors could be as important as hard metrics, given the long-term nature of the work. For example, interviewees pointed to high levels of staff attendance and contributions at value improvement workshops, and the demand for training in improvement science, as an indication that the value improvement work was starting to gain traction within the hospital.

The second theme was the development of dashboards that provided an integrated view of the cost and quality of services. The integration of this data was of particular importance so that a holistic picture of value could be obtained. For example, in Bradford Teaching Hospitals NHS Foundation Trust, the virtual ward team review average lengths of hospital stay as an indicator that patients are not staying in hospital longer than they have to, and they calculate the cost of bed days that would have been incurred in treating these patients. But the hospital also reviews readmission rates and conducts patient experience surveys to provide a rounded picture of quality and cost, and to monitor any unintended consequences for quality of care of patients being sent home to await diagnostic results.

The third theme was the recognition that these are the early days of value improvement work in these organisations, and that more time and investment is needed to develop a coherent framework that demonstrates that the hospital is delivering better value over time. The organisations we spoke to were not 'flying blind', and clearly had some leading indicators that they were actively using to determine whether they were on the right track (such as reducing length of stay in Bradford Teaching Hospitals NHS Foundation Trust). The Royal Free London Group have also commissioned an evaluation of their value improvement programme, to provide an independent view on the progress and challenges. But it was equally clear that the development of hard metrics to provide evidence of the benefits of value improvement strategies was an area where further work is needed.

Involving the wider health and care system

In this report we have chosen to focus on how value can be improved within individual organisations. This reflects the fact that value improvement is not the exclusive domain of the 'whole system' and that individual clinicians, clinical teams and organisations can each consider what actions they can take to improve the value of the services they deliver. But our interviews and site visits also made clear

that improving the value of health care requires a high degree of system-wide working and collaboration.

For our case study sites, this collaboration included engaging other providers of care in how services could be designed and delivered more effectively. The sites recognised that developing a CPG pathway for community-acquired pneumonia, or the development of a virtual ward for diagnostic services, for example, would have a material impact on services outside of the hospital, and that the development of these new approaches would benefit from wider clinical input from external partners.

But system-wide working also included addressing the tricky issue of 'which organisation wins?' when changes are made to improve the value of hospital services. For example, in one site, where a value improvement programme – such as a virtual ward – might lead to the hospital reducing its income from clinical activities, the hospital and commissioner were able to negotiate new payment approaches to ensure the hospital was not financially penalised for making changes to improve patient care.

A common feature across many of the case study sites was a generally positive relationship between the acute hospital and its clinical commissioning groups. The hospitals we spoke to had put considerable effort into having open conversations with their commissioners at an early stage of their value improvement programme. They said they often found these conversations easier than expected because they allowed both parties to rise above the day-to-day concerns of contract negotiations and focus on strategic long-term changes in patient services. As one executive director noted:

> *[The CCG] were more delighted about the way we were doing it, that we were saying, as a foundation trust, we're trying to get beyond the very insular, you know, immediate operational focus, and we want to talk to you about how this feels. And being able to play back their reaction gave us some extra, kind of, oomph and traction in the organisation.*
> (Executive director)

4 Conclusion

To propose that NHS organisations should seek to improve the value of the services they deliver sounds like a statement of the obvious. But the reality is far more complex and difficult. In this report we have described the approaches that three different organisations have taken to improve the value of the services they deliver. In reviewing the work of these organisations, there are three final matters worth highlighting.

First, pursuing value improvement is by no means an easy option and it requires courageous leadership. Organisations that start on this path will have to deal with considerable uncertainty, in both defining what value means to them and measuring whether they are improving. Establishing a strategy for delivering better-value services requires long-term thinking at a time when the financial and operational pressures for most organisations are mounting day by day. And at times 'improving value' may mean making decisions that benefit patients and the wider health and care system, but which disadvantage the organisation itself – for example where new ways of delivering care reduce income as well as costs for hospitals.

The organisations we spoke to had reconciled themselves to these challenges by focusing on the many positives the pursuit of better value brought. These included:

- staff who were more motivated and engaged to change and improve clinical practice – once the challenge they were presented with was one of value improvement rather than only reducing costs
- having a coherent strategic vision that acted as a 'northern star' to guide the activities of the hospital and give staff and leaders a sense of progress towards a common goal
- ultimately, a focus on how services could benefit patients and local populations.

Second, it is striking how the impetus for the value improvement initiatives in the case study sites came from within the organisations, rather than being externally imposed. We encountered value improvement initiatives that were certainly in response to an external event – such as regulatory action – but it was clear that the ownership for the value improvement initiatives was within the organisations themselves, and that there was a palpable sense of agency in how they took these initiatives forward.

Third, there was a wide variety in the approaches that the three organisations took to improving the value of their services. The organisations we looked at all provided acute hospital care, but were of varying sizes, with varying services, in different geographies and with different histories. There were certainly common principles in how the organisations were trying to think of the balance between quality and cost, but there was no shared prescriptive blueprint for designing how the value of services could be improved across the different organisations. We saw many examples of large-scale plans that encourage uniformity, standardisation and compliance to agreed clinical standards, but we also saw a desire to engage at the grassroots level and to encourage ground-level innovation, which has then been used as the embers of a strategic organisation-wide focus on value. In each case, we saw staff who were engaged and motivated in the pursuit of better-value services.

So, value improvement is neither easy nor straightforward. But for the people we spoke to, it is clearly a journey worth taking. One executive director we spoke to provided a succinct summary of the opportunities and challenges facing hospitals who wish to take their own steps down this path:

> *You need to give people permission to do this stuff. You need to invest in it and give them some time to do it. You need to give them the data… And you need to give them some tools, so effectively give them a recipe book. You need to give them some incentive, so effectively if you're going to take cost out and make your processes leaner and better, we'll give you some of the resource back… a blend of those, that allows you to actually have much more effective processes.*
> (Executive director)

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Joni Jabbal contributes to The King's Fund's research and analysis on health and social care policy and practice. Her recent work includes projects on workforce planning, patient experience, financial failure in the NHS, as well as a major audit of the NHS under the coalition government. Working with other colleagues in the policy directorate, Joni is responsible for work tracking the performance of the health and social care system through The King's Fund's *Quarterly Monitoring Report*.

Joni has a particular interest in incentives and behavioural outcomes in health care settings. Before joining The King's Fund in 2013, Joni worked at the Royal College of Physicians, focusing on the impact of the NHS reforms, developing new models of urgent and emergency care services, and leading the college's public health work.

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With an increasing emphasis on improving the value of the service it provides, how can the NHS deliver the highest-quality health outcomes at the lowest possible cost?

Approaches to better value in the NHS: improving quality and cost shares insight from three NHS hospital trusts that have developed organisation-wide strategies for value improvement, suggesting a wide variety of approaches are being taken to improve value in the NHS.

The report brings together research from interviews conducted with staff from three NHS acute hospital trusts – the Royal Free London NHS Trust, Bolton NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust. The research highlighted some common principles in how the organisations approach the balance between quality and cost:

- having a clear strategy that sets out how better value will be delivered, and how the day-to-day activities of each part of the organisation fit into achieving that aim
- developing a new (less top-down) approach to leadership
- allocating adequate time and resources to the value improvement work
- increasing staff engagement in the value improvement programme
- using data and analysis to support value improvement strategies.

The report concludes it is essential that organisations place value at the heart of an organisation to bring strategic coherence and engender staff engagement and support. It also notes that there are a wide variety of approaches trusts can take when developing their own value strategies.

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