

# CELEBRATING SHARED PURPOSE

IMPROVEMENT STORIES FROM  
**NINE TEAMS** WHO HAVE ALIGNED  
CORPORATE AND CLINICAL TEAMS  
AS PART OF A **LARGE-SCALE**  
**IMPROVEMENT PROJECT**

OCTOBER 2015

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# INTRODUCTION

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**Strong back office functions enable clinical teams to provide effective and efficient health care services.<sup>1,2,3,4,5,6</sup> Evaluations of Health Foundation programmes have shown that quality improvement efforts can often fall short of their ambition because back office functions, such as human resources, estates and IT, can act as a barrier rather than an enabler for improvement.<sup>7,8</sup>**

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Back office support services have an important role to play, but are often overlooked in quality improvement initiatives. Our evidence scan completed in 2011 concluded that creating multidisciplinary improvement teams with clinicians and support staff enhances buy in and sustainability.<sup>9,10,11,12,13</sup> This involves engagement and working across silos, to ensure a wide range of team members are involved in planning and implementing initiatives.

The Shared Purpose programme was designed to support projects to develop and implement ways for corporate support services and clinical teams to work together to improve quality of care. Teams were asked to deliberately create 'platforms' of alignment across corporate and clinical teams, fostering a sense of shared purpose. In doing so our aims were to:

- raise awareness of the role corporate support services can play in improving quality
- create examples of best practice through aligning people in clinical and corporate support services around a shared purpose to improve quality

- develop the evidence base of what works in improving care through aligning corporate support and clinical services around common quality goals.

Over the last two and a half years nine Shared Purpose projects have implemented and evaluated an innovation project, at scale.

This publication contains case studies from all of the Shared Purpose projects. These case studies demonstrate how collaboration between clinicians and corporate services can contribute to the development of sustainable change and improvement. Each case study contains information about the journey the project team has been on, including the original challenge and what the project wanted to achieve, their intervention, learning and results.

For more detail on the programme or to read the Shared Purpose full project reports, visit the Health Foundation website:

[www.health.org.uk/sharedpurpose](http://www.health.org.uk/sharedpurpose)

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# SHARED PURPOSE

## IMPROVEMENT STORIES

# BRINGING HEALTHCARE HOME

- Led by Airedale NHS Foundation Trust, supported by partner organisations, including Airedale, Wharfedale and Craven Clinical Commissioning Group and Sue Ryder Manorlands.
- Project that ran across Airedale, Wharfedale, Craven and Bradford.

## INTRODUCTION

Most people say they would prefer to die in their own home, yet the majority die in hospital. Recognising this, Bringing healthcare home was a project designed to improve the quality of care for end-of-life patients.

In Bradford and Airedale, an electronic palliative care coordination system has been developed to record key information, including patients'

preferences for care for those identified as being in the last year of their life. All of these patients are offered 24-hour access to clinical opinion and support in their own home via a telephone helpline or video consultation.



## WHY DID THEY DO THIS PROJECT?

There is a growing recognition that the care of people approaching the end of life needs to be improved, and that people need to be better supported at home during this time. The majority of people would prefer to spend the last year of their life at home, but in reality most patients at the end of their life spend a significant amount of time in hospital, and two out of three patients die there.

The national End of Life Intelligence Network reports that currently in England 58% of people die in NHS hospitals, with around 18% of deaths occurring at home, 17% in nursing and residential care homes, 4% in hospices, and 3% elsewhere.

If these trends continue, inpatient facilities will need to be increased by 20% by 2030 to meet the demand. With growing pressure on resources, hospital trusts need to develop new, higher quality, more efficient integrated models of care.

A significant proportion of hospital admissions are potentially avoidable. By providing extra support to patients, families and carers in their own home, the number of avoidable hospital admissions and visits from medical services can potentially be reduced.

## WHAT DID THEY DO?

Bringing healthcare home has involved working with patients with advanced cancer or with long-term conditions and thought to be in their last year of life.

The project team started by looking at existing end-of-life pathways and assessing the gaps in services and barriers to their implementation. Following stakeholder events involving patients and carers, three work streams were identified:

### **Palliative care coordination**

A central electronic register of patients thought to be in their last year of life was set up. Key information, including the future care wishes of these patients, is included in a template held within the electronic health records of these patients.

### **Communication skills training**

Health care staff underwent training in communication skills so that they would feel competent and confident in having sensitive conversations with patients in their last year of life. This enabled staff to start conversations around death and dying with patients, and to deal with patients or carers in distress.

### **Telephone helpline**

A 24 hour, seven day a week telephone support line (Gold Line) was set up for patients identified to be in their last 12 months of life, and their carers. The calls are answered by senior nurses who can assess, advise and support patients and carers, as well as having access to a range of services which they can coordinate on behalf of the patient. These nurses have had training in palliative care and communication skills.

To explore the potential additional benefits of telemedicine, 30 iPads were offered to a proportion of these patients to enable them to have face-to-face video consultations.

## WHAT IMPACT DID THEY SEE?

In early 2015, the Gold Line had a caseload of around 950 patients (and their carers) from three Clinical Commissioning Groups with a population of 500,000. Gold Line currently takes around 500 calls a month from patients over the phone or using iPads.

The project has provided high-quality, coordinated care for a large number of people facing the last year of their lives, and their carers. Reports suggest significant reductions in the use of primary and secondary care services following the implementation of the Gold Line service. Analysis has shown that 13% of patients who were registered with Gold Line and died between 1 April 2014 and 31 March 2015 died in hospital. This is significantly lower than the national average of 58% dying in hospital.

Over 300 staff and volunteers have received communication skills training on how to support patients and carers in distress.

Having to tell their story ‘over and over again’ has been described by carers as one of the most draining parts of caring for someone in their last year of life. The electronic register set up via this project has enabled access to patient records by hospital staff, GPs and community nurses so that they can give advice and treatment when required, without the patient or carer having to give their details to a number of different people.

## WHAT DID THEY LEARN?

### Changes in scope

The original objective was to set up a discreet project to help patients in the last year of their life to remain at home where possible. However, following stakeholder consultation and patient and carer feedback, the team found that the project was much more complex and so the scope was changed.

For example, it soon became clear that the actual identification of the cohort of patients needed to be in place first; as the foundation on which to build all other services. In addition, it was soon recognised that support for professionals was needed in having sensitive conversations with the identified patients.

### Keeping stakeholders informed

Due to the nature of this project, gaining stakeholder buy-in was not difficult, but ensuring that all stakeholders were fully informed every step of the way was more challenging as the messages needed to be open and informative while being appropriate for the audience. As a result, two overarching project group meetings were arranged each month; one to support the strategy and direction of the project, and the other to identify any operational issues.

### Passion and engagement

The project attracted a number of health care staff who have experienced personal loss, and, as such, the level of passion and commitment has been unparalleled, and has clearly been a factor that has driven the project forward. However, there were also obstacles that needed to be overcome, in particular with ensuring the various clinical teams were properly engaged.

## WHAT ADVICE WOULD THEY GIVE TO OTHERS?

### Take time to plan and design

Many projects are rushed in the planning stages. Take time to think about what changes would have the most beneficial impact on the service, and what measures need to be in place to show if this change has been of benefit or not.

### Ensure strong leadership

A strong executive lead and dedicated clinical leadership has been critical to the success of this project. Strong executive support has allowed the delivery of the project to run a lot more smoothly than most projects, and the clinical leads have increased the ability to gain clinician buy-in from the outset.

### Fully consider patient and carer impact

Patient and carer representation ensured that the project team fully considered their perspectives and that they were aware of the impact the project could have on the lives of patients and carers.

### Use appropriate and up-to-date technology

Engaging with the most appropriate technical partner has also meant that the project could offer the most suitable use of up-to-date technology possible for maximum impact and ease of use for patients and carers.

### A shared IT system is a major enabler

The shared IT system across primary and secondary care that was in place was a major enabler for joined-up care.

# DEVELOPING A 'DESIGN OF SPACE' INTERVENTION USING LEAN THINKING

- 
- Led and coordinated by the North East Transformation System team, hosted by Gateshead Health NHS Foundation Trust.
  - Pilot sites from across NHS North East in acute, mental health and primary care settings.
- 

## INTRODUCTION

Lean is a philosophy that aims to reduce waste and improve processes. Processes, however, can be constrained by the space they operate in. Redesigning space offers unique opportunities for step change improvements using Lean thinking. A significant proportion of NHS capital budgets is spent on developing new premises or improving premises.

However, guidance to support these projects does not currently incorporate information on how to design in Lean concepts and flow.

This project by the North East Transformation System team has helped NHS trusts to reduce waste and improve processes by redesigning space more effectively.

## WHY DID THEY DO THIS PROJECT?

The physical environment in which health care is delivered is an important dimension of quality of care. Good layout of work areas can free up time through reduced motion and searching for required items. Achieving such improvements requires the help of estates and facilities departments.

Despite cuts in NHS capital budgets of around £4 billion a year, a significant proportion is still spent on improvements to premises or development of new premises. Although guidance is available to support estates projects, for example building notes, health technical memoranda and health facilities notes, this does not incorporate information on how to design in Lean concepts and flow.

The Shared Purpose project team from the North East Transformation System believe that this represents a significant gap.

By prioritising service flow, improving processes and reducing waste, their project aimed to help staff to create facilities designs that would improve patient experience, safety and effectiveness of care.

The project set out to address gaps by bringing together the estates and quality improvement corporate functions with clinicians to design and test a Lean facilities design intervention that could be applied to new or refurbished spaces/premises.

## WHAT DID THEY DO?

The project involved working with two acute NHS foundation trusts, first piloting the Lean design approach in two different settings in one trust (endoscopy and maternity) and then replicating the approach in a similar setting (endoscopy) in the second trust. This allowed the team to iteratively improve the intervention, as well as observe the responses of different stakeholders.

The project team developed a method for Lean design of space that brings together estates, clinical teams, management and people who use the service. The intervention used a workshop-based approach to improvement and change through facilities design,

inspired by the Lean 3P method – an approach to product and process design for Lean manufacturing.

The workshops were held over a number of days, during which time a collaborative design process was carried out. Participants were encouraged to come up with different concepts for the future design of the ward. These designs were then narrowed down and then 3D models mocked up.

One of the design interventions has proceeded to full business case approval and construction began in July 2015. Models of the ward showed how the design improved infection control with sterile transport routes streamlined, reduced travel for the patient, and improved effectiveness of care by reducing the distance clinical staff walk.

## WHAT IMPACT DID THEY SEE?

The project involved two local NHS foundation trusts in three facilities design interventions. Upon successful completion of the designed buildings, these interventions have the potential to reach the following projected patient populations:

- Pilot endoscopy unit – 8,000 to 10,000 patients per year.
- Spread endoscopy unit – 8,000 to 10,000 patients per year.
- Pilot maternity unit – up to 3,000 births per year.

The designs that have been developed will significantly increase the levels of safety, privacy and dignity for patients, and minimise the opportunities for infection control risks through innovative separation of clean/used supply routes being physically built into designs.

Although none of the sites have been built yet, evidence from the modelling work in the workshops suggest that the designs will result in significant reductions in patient travel distance, process steps, handoffs, staff travel and the number of queues.

The intervention allows groups of different people to work together and has demonstrated that corporate support services can help improve quality of patient care. There were over 100 people actively involved

across the projects. Working together in this way has created better interpersonal team dynamics from different departments.

Architects also report that the project briefs are improved by applying the participative design approach, and that the approach can potentially reduce lead times for project briefs, which may reduce project costs.

## WHAT DID THEY LEARN?

The biggest challenge that the project team faced was that in order to measure and verify the outcomes of the interventions, the facilities designs that were created would have to be built. This can be a lengthy process in the NHS. To overcome this, the team encouraged staff to make extensive use of simulation using scale and full-scale models of their designs.

The team learned as they progressed through the projects that the total number of days the design workshops needed to be run for varied. For example, the endoscopy pathways were relatively straightforward, and the team was able to reduce the number of days from five to four and still achieve the required outcome. However, working on a maternity design highlighted additional system complexity, and the team felt it may have been better to take a different approach when looking at more complex systems, for example starting with macro level system design and then subsequent mini interventions for the relevant microsystems.

There was a lot of uncertainty during the setup phase. However, as the implementation phase drew to a close, the team was motivated to further test the process at a larger scale due to the positive feedback received.

In the future, particular emphasis will need to be placed on data relating to the functional content of the facilities to be designed.

## WHAT ADVICE WOULD THEY GIVE TO OTHERS?

### **Ensure strategic alignment**

Ensure there is strategic alignment when it comes to project selection. The quality improvement work needs to be seen as part of the strategy and not simply something bolted on to the side. The trust board needs to be clear on priorities and then target resources to help achieve them.

### **Remain flexible**

When working with teams of 30-plus people for up to five days, it's important to keep the destination in mind, while remaining flexible on how you get there.

### **Facilities projects take time**

Timelines for an estates or facilities project are long. Consider and plan for this, and don't beat yourself up just because things take a little longer than expected.

### **Gather adequate baseline data**

To successfully measure the effects of your intervention, ensure that you gather adequate baseline data. This can be challenging, particularly when it comes to getting corporate support services and clinicians to be open with each other. It is therefore important to build productive relationships between these two parties.

# DIGNITY IN PRACTICE:

**OUR SHARED PURPOSE  
TO PROVIDE SAFE AND  
COMPASSIONATE CARE  
OF OLDER PEOPLE**

- 
- Led by Northumbria Healthcare NHS Foundation Trust, in partnership with Age UK North Tyneside.
  - Tested across three orthopaedic wards and five medical wards caring for older people.
- 

## INTRODUCTION

People aged over 65 account for 70% of hospital bed days, and one in three admitted to hospital will experience memory problems as a result of depression, delirium or dementia.

A team at Northumbria Healthcare NHS Foundation Trust has developed a programme that aimed to bridge the gap between the principles and

rights outlined in the NHS Constitution, and the reality of care experienced by older people.

The programme involved aligning the work of the trust's corporate services in human resources and patient experience, with the work of the clinical teams in order to provide dignified and compassionate care for older people.

## WHY DID THEY DO THIS PROJECT?

Caring for older people is a major part of the work of the NHS. The number of hospital admissions is rising faster among older people than for any other age group, with recent Department of Health data showing a 37% increase in emergency admissions among people aged over 80 in the last two years.

Numerous reports have exposed shortcomings in the care of older people. In Northumbria Healthcare NHS Foundation Trust, an internal audit had highlighted that only 10% of newly qualified doctors felt confident about meeting the needs of people with dementia and delirium.

This Shared Purpose project looked to understand more about the barriers to dignified care for older people, and the learning needs of the trust's staff. They prioritised and promoted local education initiatives to ensure the workforce, environments and clinical care were fit for purpose.

They recognised that every member of the organisation has a part to play in delivering excellence in care for older people, and the scope was ambitious around supporting and developing the whole workforce to improve the care experience for older people using their services.

## WHAT DID THEY DO?

The team at Northumbria Healthcare NHS Foundation Trust brought together the work of the clinical and corporate teams to transform the patient pathway and ensure that the way care is delivered is as important as the care itself.

To promote and enable dignity and compassion in practice, a number of interventions were devised by the project team around three key areas:

- the climate of care
- supporting and developing the workforce
- improving the care experience for patients.

Following extensive stakeholder research, carefully chosen interventions were implemented and tested.

To improve the experience for older people, three nutrition assistants were recruited to promote more choice, extra snacks and sociable eating. Age UK were welcomed to observe care and feed back to staff on person-centred behaviours, and information resources and a telephone helpline were also introduced.

Peer support and resilience training were provided to ward managers and a framework for values-based recruitment introduced. Over 500 managers have been trained in values-based recruitment, and over 2,000 members of staff selected in this way. Training was also provided to 20 multidisciplinary teams on 'learning about the person.' The trust's induction programme was changed to provide an upfront message on dignity.

Tracking of patient experience by consultant was introduced, with top performers published and results discussed in appraisals. Ward objectives were set by the team. These were agreed by the board and implemented, and ward-level safety data was fed back on a weekly basis.

## WHAT IMPACT DID THEY SEE?

The impact of the programme has been felt in a number of ways. Within a highly complex programme, the gains achieved within each strand of the programme have aggregated to contribute to a 'greater than the sum of the parts' story of organisational change.

Encouraging kindness and compassion and regularly providing teams with feedback on how they are doing has encouraged novel ideas on how to improve care; from the nursing assistant who hand-knitted a poppy for each patient on Remembrance Day, to the ward team that has successfully reduced falls in older people.

Promoting sociable eating and wellbeing with the recruitment of nutrition assistants has increased the likelihood of patients gaining weight in hospital. There has also been a statistically significant reduction in length of stay – on average 8.8 days per patient – with a potential associated cost saving of just under £800,000 for one ward in one financial year.

Evidence of change can also be seen from the results of the trust's staff survey, particularly in the proportion of staff who feel that high-quality patient care is the number one priority of the trust. This has risen from 43% in 2007 to 84% in 2014.

There have been year-on-year improvements in real-time measurement scores, with patients giving an average score of 98.5% for being treated with kindness and compassion.

There has been a sharp rise since the programme was implemented in patients reporting always being treated with dignity and respect at the trust – from 82% to 90.5%.

## WHAT DID THEY LEARN?

### **New relationships**

The new relationship with Age UK brought important learning as both organisations had to understand more about how each other operated. Despite initial organisational challenges, the partnership proved successful on the wards and staff hugely appreciated the honest feedback from an external source. Their constructive feedback has provided staff with an opportunity to celebrate and improve.

### **Importance of upfront messaging to staff**

The team learnt how important it is that corporate teams feel connected to the frontline and understand how their role contributes to delivering excellent, dignified care.

By redesigning the trust's induction process, an upfront message has been delivered to staff when they enter the organisation that the trust puts patients first and values all staff, recognising that everyone's contribution counts.

### **Communication is key**

Ward-based communications proved to be crucial to the programme. This was challenging at times, as frontline staff are extremely busy. So the team worked to make it as easy as possible for clinical staff to feel engaged with the programme, and they aligned their shared purpose objectives to the business unit priorities to avoid what seemed like an additional workload.

Regular face-to-face communication on the wards proved crucial in maintaining relationships with clinical staff, and progress was fed back to the ward teams on a regular basis.

## WHAT ADVICE WOULD THEY GIVE TO OTHERS?

### **Ensure senior support**

An improvement programme of this scale is unlikely to succeed or be sustained without strong support from the executive management team. This programme was helped in this by becoming one of only five 'whole organisation' priorities.

### **Less can be more**

The team were overly ambitious at the start and it took them a while to make sense of the complexity of the intervention. Concentrate on fewer things in order to keep focused and enable flexibility. Find your 'golden thread' (in this programme it was 'dignity') and hold on to it.

### **Invest in the project team**

Invest time at the start in finding the right people, and don't underestimate the need for excellent project management skills and admin support.

### **Get the balance right between push and pull**

Be sensitive to the needs of the wider organisation and the pressure on staff who face multiple and often competing priorities – know when to step back and when to be flexible.

### **Measure well, measure the right things, measure often and share quickly**

Staff are hungry for information on how they are doing.

### **Visualise the project**

Use visual ways of presenting information. Clear infographics can be an incredibly powerful way of not only simplifying and sharing the narrative, but of helping maintain focus as a programme team.



# EARLY WARNING

## PREDICTIVE WORKFORCE PLANNING TOOL (IPLAN)

- 
- Led by Imperial College Healthcare NHS Trust, partnered by Imperial College.
  - Project carried out in three intensive care units at the multi-site NHS acute hospital trust in London.
- 

### INTRODUCTION

Being unable to anticipate workforce problems and requirements can put patient care at risk. To address this, a team at Imperial College Healthcare NHS Trust in London have developed an evidence-based workforce planning tool (IPlan) that enables teams to identify staffing level issues that coincide with deterioration in pressure ulcers and other patient safety events.

The tool allows teams to plan effectively and address fluctuating acute care needs and challenges. Use of the tool in intensive care units (ICU) improves planning and preparedness, thereby ensuring better quality of care and improved patient experience.

## WHY DID THEY DO THIS PROJECT?

Inadequate multidisciplinary team planning and anticipation of workforce problems and requirements can reduce quality of patient care and potentially increase mortality, morbidity and infection rates. Yet workforce data have traditionally been presented in dense data tables that make trend analysis difficult or impossible.

Clinical teams do not often have the right information in order to understand how staffing changes may drive variations in quality and safety of care on their ICU. This is due to disjointed corporate and clinical data.

The Shared Purpose project team at Imperial also discovered cultural and systemic problems that contribute to these issues. For example, the differing perceptions of ICU teams and senior managers about ICU performance and whether staffing guidelines were being met; different teams planning their rosters independently of each other; data being collected but not linked or fed back to staff; and data on wards not being detailed enough for statistical analysis.

By improving clinical teams' access to, and use of, effective and integrated workforce and clinical information, workforce problems – for example, due to seasonality, out-of-hours staffing and varying patient acuity – could be anticipated and responded to, thereby improving patient safety, patient experience and clinical team efficiency.

## WHAT DID THEY DO?

In order to understand the issues around workforce data, the project team began by holding stakeholder events to discuss the challenges and practicalities of finding links between workforce data and patient safety problems. Data workshops were held with ICU team members to look at what data were available and what clinical outcomes were most important to understanding quality and safety.

The team retrospectively analysed three years of staffing and clinical data at the trust and linked previously unlinked patient and workforce datasets. Through this they could then create metrics that helped in developing a preliminary interactive tool using the analysed data and statistical modelling.

The monthly trust-wide workforce data was not detailed enough for statistical calculations and so the team focused on ICU daily data instead.

The tool, IPlan, was then piloted using a Plan Do Study Act (PDSA) cycle over six months. Monthly multidisciplinary meetings were held during the pilot phase whereby staffing and ICU conditions over the previous month were reviewed, amendments to the tool were made and plans made for staffing for the following month.

The team also developed a safety scale survey containing six key questions for clinical team members to complete at the end of every shift. This captured how ICU teams felt about patient care on each shift and the results fed into the IPlan tool for comparison with the quantitative data.

## WHAT IMPACT DID THEY SEE?

The project is still in the pilot phase and so it is not possible to assess the full impact as yet. However, it is clear that the initiative has led to an improved understanding among staff of the relationship between risk and safety, and ICU staffing. The project has also enabled a dialogue between clinical and corporate teams about their data, including issues around access, timeliness, accuracy, efficacy and reliability.

The project team has worked with both corporate staff from HR and Information, and clinical staff from ICUs, on improving data accuracy. Many issues relating to missing or inaccurate data have been resolved, and inaccurate data rectified where possible. Professional groups have been helped to understand, question and evaluate data that are entered into systems by themselves or their colleagues, and the data are helping staff re-assess supply and demand for clinical services, and evaluate service improvements and developments, such as seven-day working.

An unintended consequence was realising the potential benefits to workforce planning of multidisciplinary liaison and discussion. The data was visible to all members of the multidisciplinary team, for the first time. This encouraged constructive dialogue between different professionals about their practice, and active engagement with the data managers.

The team is using qualitative and quantitative methods to evaluate the pilot study and to understand whether using multidisciplinary staff planning meetings supported by IPlan multidisciplinary data has a positive effect on outcome measures.

## WHAT DID THEY LEARN?

### **Disjointed workforce planning**

Workforce planning was previously completed by professional groups, with no multidisciplinary elements. Staff rostering and patient contact time were recorded differently for different types of staff, on different systems. The result of this variation was that it was difficult to see the relationship between the multidisciplinary workforce and other factors, without significant additional work to identify, clean and link the data across the various systems. A more standardised way of recording staff time with patients would be beneficial nationally to assist with measuring workforce impact on other factors, especially clinical data.

### **Addressing data issues**

The trust's clinical outcome data was weekly or monthly rather than daily, and overall numbers were lower than expected, so the project's predictive modelling element has focused on an area with sufficient data: identifying tipping points in relation to nursing hours per patient day.

If clinical outcome data are to be used effectively, significant improvements are needed, including clearer national definitions; spelling out how data are collected, analysed and reported; improved approaches to extraction and storage of data; the use of statistical methodologies; and more effective feedback to clinical teams.

### **Qualitative data as well as quantitative**

The development of the safety scale survey arose from interviews with staff on their perceptions of risk and safety, and it demonstrated the benefits of using and incorporating qualitative data.

### **Recruitment challenges**

Medical statisticians of sufficient calibre to run a programme of this nature are extremely rare. The recruitment process delayed the programme by one year.

## WHAT ADVICE WOULD THEY GIVE TO OTHERS?

### **Strong alignment in values is important**

Positive alignment between the improvement issue and the clinical teams' values is important, and can result in stronger commitment and enthusiasm from clinical teams. Commitment from clinical teams, for example in giving up their time, participating in workshops and volunteering for secondments, is a strong lever for change.

### **Have consistent leadership**

Having a consistent executive director and programme lead supporting the programme from application stage through to programme completion ensures consistency of approach, which is especially important when faced with barriers and challenges.

### **Engage all corporate departments**

Engaging with all corporate departments at the start of the programme to get their support and improve their understanding of the programme can encourage collaboration and openness to change. This may help to avoid bureaucratic processes slowing down the progress of the programme, from getting ethics and information governance approval, to procurement of non-standard software and recruitment to fixed-term posts.

### **Find the right software**

Excel is not sufficient to manage the type and quantity of data involved in projects such as this. Statistical software is needed to successfully manipulate such large quantities of data and match identifiers across different datasets.

# LIBERATING SISTERS TO LEAD

- 
- Run by University College London Hospitals NHS Foundation Trust (UCLH), in partnership with the Clinical Operational Research Unit at University College of London.
  - Impacting inpatient wards across UCLH's nine sites.
- 

## INTRODUCTION

The role of the ward sister is critical to improving the quality and safety of patient care. They are responsible for managing and leading their ward teams and environments. At University College London Hospitals NHS Foundation Trust (UCLH), corporate and administrative processes have been structured to support ward sisters in this role.

Despite this, these duties can take up a significant proportion of time and energy.

This project aimed to simplify ward sisters' interactions with corporate and administrative functions, making them more efficient and effective.

## WHY DID THEY DO THIS PROJECT?

UCLH is one of the largest NHS trusts in the UK and provides acute and specialist services across six hospitals, employing over 8,000 staff. The ward sisters at UCLH are the highest profile staff group for patients, with the most direct influence on quality of care. They play a vital role in the delivery of clinical excellence and positive patient experience.

Focus groups with the ward sisters revealed that they were spending too much time navigating complex corporate processes when interacting with human resources, finance, procurement and estates.

This Shared Purpose project looked to reduce the complexity of corporate processes, releasing time for clinical leadership. It aimed to free up ward sisters so that they can spend 75% of their time directing, influencing and improving patient care, and remaining visible and present on their wards.

The project team investigated whether changes in corporate services could be linked to improvements in patient care. They looked at whether releasing time ward sisters spent navigating corporate services would increase the amount of time available for clinical leadership, and whether this would have a direct impact on patient care.

## WHAT DID THEY DO?

A short-term concierge service was established that was used by ward sisters to flag when they required support from a corporate service. The concierge team then liaised with the relevant team to resolve the issue. A database was used to capture every aspect of the work involved in using a corporate service to address a local issue. Details were logged to record every interaction, such as emails, telephone calls and face-to-face appointments. This enabled the project team to take a whole-system view of corporate processes, identifying duplication and complexity.

Between March 2013 and October 2014, the concierge service desk received and resolved 802 issues. Analysis of these issues showed that they could be attributed to one of six areas: corporate overlap, complex processes, customer service, communication, culture and commercial contracts. The next step was to identify and coordinate specific and sustainable improvement interventions for each of these areas.

One of the most time consuming issues uncovered by the concierge service was the authorised signatory form, used to delegate financial authority for expenditure on a range of goods and services. The project team worked with procurement to develop an email template to replace the signed form.

It was also discovered that it was taking ward sisters around 20 hours of administration per new recruit and up to six months to ensure that all new starters had an ID badge, an IT account, a uniform and access to electronic systems. The project team worked with each of these corporate areas to map the relevant processes and streamline them.

## WHAT IMPACT DID THEY SEE?

Local data from May 2011 showed that clinical duties occupied less than 40% of ward sisters time; the project goal was to increase this to 75%. Although the major 'time releasing' projects have been delivered, the project is still ensuring that processes are sustainable, therefore data analysis focusing on how sisters' time is now spent is yet to be completed.

The project has helped to highlight the complexity of the role of the ward sisters, and it is anticipated that this learning will help to continue development of corporate services in the future.

One of the areas of significant change has been in relation to the procurement service. The data collected by the project team allowed leaders of the procurement service to gain insight into the perceptions and experience of ward sisters of their service. This has resulted in a customer focused helpdesk being established to provide support and advice, greatly reducing the effort required and time spent in purchasing essential equipment and supplies.

Changes to the authorised signatory form has reduced the time to gain access to the procurement system from an average of three months (in which time the ward sisters would spend a high proportion of time chasing) down to one day, and has resulted in fewer frustrations due to lost forms and wasted time.

The changes to the new starter process has eliminated the use of multiple forms and ensured that each new starter is work ready on day one.

## WHAT DID THEY LEARN?

### **A whole system view**

While the project team expected to be able to pinpoint where the specific points were 'broken' in particular services and aim to fix them, this has not been the case in certain areas. Processes were much more complex than first imagined and the project has highlighted the need for a strategic approach to issues, because they cross departmental boundaries.

### **Embed and spread**

The embedding of the learning from the project has been organic. For example, the productive corporate service tool that was planned has now been encompassed into UCLH Future, the trust's strategic transformation programme. However, data and learning from the project has been used to shape this.

### **Bringing corporate and clinical departments together**

The project team used the development of the principles of the concierge services as an opportunity to actively engage clinical and corporate departments. These events were well received and were attended by 99% of the ward sister population and corporate services.

### **Unexpected challenges**

One of the major challenges was encouraging ward sisters to utilise the concierge service and complete activity logs, which are vital to gathering data on how the sisters spend their time. However, it was perceived by some ward sisters as asking them to prove their competence and how they manage their time, despite being anonymous.

Another unexpected challenge was the impact of staff turnover: from the original 52 ward sisters only 10 remain.

## WHAT ADVICE WOULD THEY GIVE TO OTHERS?

### **Maintain data channels**

The planned closure of the concierge service in July 2014 meant that the project team no longer had a central point to capture data in order to be able to track improvements over time. It is important to plan for these types of situations.

### **Maintain momentum**

It is vital to be able to 'tell the story' to keep the ball rolling, especially when there are changes in personnel. Focus on engagement of staff at the frontline and senior management within departments, so that all involved are well versed on the project.

### **Take a whole systems approach**

Being able to collect and view data from a whole system perspective is key to pinpointing problems. Activity logs are vital to this.

### **Keep up to date with organisational initiatives**

Ensure that your project is not seen as yet another initiative, by keeping up to date with the strategic agenda, and being ready to adapt your own project accordingly.

# MYDAY@QEHB

## A PERSONALISED SCHEDULE OF CARE EVENTS FOR INPATIENTS

- 
- Led by University Hospitals Birmingham NHS Foundation Trust, with support from the University of Birmingham.
  - Focused on inpatients within the trust.
- 

### INTRODUCTION

There is currently no system in place in NHS hospitals that links the scheduling of services with individual care plans. This project aimed to bridge this gap by using a patient diary to coordinate activities and structure interventions around the patient's day.

Through this project, patient experience would be improved, along with

service productivity and resource management. The project team also anticipated it having a positive impact on length of stay and timeliness of interventions for inpatients.

The primary driver of the project was to put patients at the centre of care planning; empowering them to participate in their care.

## WHY DID THEY DO THIS PROJECT?

Inpatients may be told their anticipated discharge date on admission, but the project team at University Hospitals Birmingham NHS Foundation Trust found that no system exists that produces a schedule of planned interventions – for example, diagnostics, operative procedures and physiotherapy – for their stay.

They carried out process mapping and a survey of inpatients to determine the extent to which the scheduling of planning clinical events were accessible to inpatients and ward staff at the trust. They found that most inpatient scheduling was invisible to patients and staff alike. A literature search found no evidence of systems that presented patients with a logical, coordinated schedule of inpatient events.

Patients reported that they perceived ward nurses to be too busy to interrupt and only half of the patients surveyed recalled being told about the day-to-day routine of the ward.

Ward staff reported that they spent significant time finding out when patients were scheduled to receive an intervention; often having to access a number of different computer systems or make numerous telephone calls. Porters said that a lack of booking coordination often meant they experienced wasted journeys to collect patients who were unavailable.

## WHAT DID THEY DO?

MyDay@QEHB is a daily schedule of routine and planned clinical interventions for a ward. It aimed to empower patients and manage resources effectively through diarising the inpatient journey.

The project team found that there was a wide range of systems in place within the trust, which often operated in different ways.

MyDay@QEHB works by mining referrals and booked appointments from a range of different clinical systems. These are then presented within a single personalised schedule as timed events alongside regular routine ward events.

Neither the therapies nor imaging departments had a process for scheduling inpatient appointments, so the project team worked with them to redesign the way their inpatient work is managed and to introduce appointment systems that could then be published into the MyDay@QEHB schedule. The porter task allocation system was also re-designed.

Working with the IT department, the project team developed a technical specification to create MyDay@QEHB as a module within the trust's clinical portal system – this was to avoid introducing a new, separate tool to staff.

MyDay@QEHB was then prototyped, tested and deployed. Staff are able to select a ward within the module and then view and print a schedule for each patient. Schedules are given to patients each morning as part of the usual ward routine. Patients can opt in or out of receiving a schedule each day.

## WHAT IMPACT DID THEY SEE?

MyDay@QEHB has made the invisible visible. Baseline data demonstrated that only 54% of patients were told about the ward routine on admission. The intervention reduces patient anxiety and allows staff to better manage resources.

As part of the development of the intervention, service changes were made to therapies, imaging and portering, which are now embedded and continue to evolve. Staff reported improved communication between these departments and the wards.

Baseline data demonstrated that the majority of ward staff took 10-20 minutes coordinating or rearranging appointments when a clash occurred or other problems arose. And this could happen several times a day. Anecdotally staff have told the project team that MyDay@QEHB has resulted in a reduction in the number of times these situations occur, thereby improving efficiency.



Productivity has improved in imaging – fewer inpatient requests are being deferred because scheduling helps the department make best use of time and resources. The pre-implementation evaluation collected data on the number of porter journeys that were wasted because the patient was off the ward or having another intervention. Post-implementation analysis is expected to show a reduction in wasted deployments.

The project has improved patient experience as the intervention involved a face-to-face conversation and the provision of a printed schedule.

## WHAT DID THEY LEARN?

### **Manage expectations**

The design of the MyDay@QEHB schedule did not fully emerge until halfway through the implementation phase, so as not to pre-empt the work with stakeholders by developing a prototype which may then have limited creative thinking. However, not having a tangible design until so far into the project resulted in a reduction in project momentum from colleagues involved in the process redesign work.

The project team learned how to manage the expectations of colleagues and adjusted the project steering group membership to bring them inside the core project group.

### **Dealing with resistance**

There was resistance by some staff to the idea of starting to schedule procedures, so the team established clinical advocates who helped them work with colleagues who were sceptical. The team were persistent and repetitive in the messages, but applied them at a pace that could be managed by those who are trying to process and understand how to change their ways of working.

In addition, patient and staff feedback was a powerful tool for dispelling myths and alleviating fears. A common challenge from staff was around setting patient expectations. There was a fear that MyDay@QEHB might increase complaints from patients when appointments are cancelled or missed. Patient feedback helped to alleviate such fears by suggesting that a two-hour time window is adequate, rather than a specific timed appointment, and confirming that as long as they know why something has been cancelled, they don't mind.

## WHAT ADVICE WOULD THEY GIVE TO OTHERS?

### **Have a consistent and compelling story**

Having a consistent and compelling story, that is articulated well and that illustrates what you are trying to achieve, is essential. Telling the story from the perspective of the patients, achieves the best results.

### **Understand the local context**

Each ward has its own ways of working. By understanding local context, you are able to take account of differences in working practice and receptiveness to change.

### **Use storytelling**

Storytelling as a means for communication is very effective, particularly patient stories.

### **Use existing systems where possible**

Try not to introduce new information technology systems unless it is necessary. Staff will be more receptive to the intervention if it is on a familiar platform.

### **Engage with as wider group of staff as possible**

For example, setting up a stall outside the staff restaurant can help with engaging with many different staff groups.

# SHEFFIELD MICROSYSTEMS COACHING ACADEMY

- Led by Sheffield Teaching Hospitals NHS Foundation Trust, in partnership with The Dartmouth Institute Microsystem Academy, Sheffield Health and Social Care NHS Foundation Trust, and Sheffield Children's NHS Foundation Trust.
- Based within Sheffield Teaching Hospitals and the Children's Hospital.

## INTRODUCTION

The clinical microsystems methodology was developed in the USA by The Dartmouth Institute and has been used globally to develop sustainable healthcare improvements in quality of care and efficiency.

The Sheffield Microsystem Coaching Academy is an innovative initiative

where frontline staff train as improvement coaches and work with teams to help them improve the quality and value of care they deliver to patients. They do this through understanding their systems and processes, and redesigning care through testing small changes.

## WHY DID THEY DO THIS PROJECT?

As health care needs continue to increase, the systems need to adapt to changing conditions and focus on providing value in care. A key question for many organisations is how to build quality improvement work into the everyday work on the frontline – so that it is seen as ‘the way we do things around here’, rather than additional or optional aspects of work.

Clinical microsystems are the building blocks of organisations such as hospitals and can be characterised as the small units where care happens with a group of patients, for example wards, outpatient clinics and diagnostic departments.

The Shared Purpose project team at Sheffield Teaching Hospitals NHS Foundation Trust saw the potential of using clinical microsystems methodology to help build improvement capacity and capability into the everyday work of frontline staff, so that they are equipped and enabled to undertake local improvements and redesign services.

The approach is based on quality improvement thinking and methodology that not only combines tools and skills in improvement science and the practical things that can help teams make improvements, but crucially a focus on the human dynamics of change.

## WHAT DID THEY DO?

The Sheffield Microsystems Coaching Academy (MCA) uses the clinical microsystems approach to enable corporate services to collaborate with clinical teams in order to achieve continuous improvement in the quality of patient care.

The MCA trains frontline staff as improvement coaches and works with teams to help them improve the quality and value of care they deliver to patients. The MCA course is five months long and coaches are expected to actively work with a microsystem team as they train.

Coaches are trained in the art of team coaching, the science of quality improvement and how to work with frontline teams to help them re-design the services they deliver.

Four cohorts of the MCA have been run so far, with 84 coaches being trained and over 107 microsystem teams having been coached. Of those coaches trained, 62% are still actively coaching.

The team also runs a two day quality improvement course. This course introduces the key concepts and thinking about quality improvement, and is primarily aimed at clinicians and managers.

The project approach required the active involvement of the microsystem team and regular weekly meetings to work on improvement, involving representatives from those who play a part in that care. Patients are at the heart of microsystem improvement, and involving patients in these microsystem improvement meetings was essential.

## WHAT IMPACT DID THEY SEE?

Many teams have been able to demonstrate measurable improvements, including reductions in waiting times in outpatient settings; increased theatre productivity and efficiency; changes in quality of care resulting in open access services complementing booked services; a reduction in ‘do not attends’; and the redesign of systems to release nursing time.

In addition to specifically measured improvement, teams have reported better working relationships and many trained coaches return to their usual working environment and utilise their coaching skills and knowledge of improvement science to help support change and improvements in their own areas.

Additional training materials have been developed, such as booklets on key themes including measurement for improvement and team coaching. A quality improvement curriculum has been developed to attract other interested people from within the organisations, as well as to help and continue to engage existing coaches.

As the course has developed, the team recognised that team members as well as coaches require support and education. A one day course has therefore been established for staff who are to be part of a lead improvement group for them to learn more about the microsystem improvement approach before they start to work together.

## WHAT DID THEY LEARN?

### **Conditions required for a successful MCA**

A combination of executive leadership support, clinical credibility and quality improvement expertise has contributed to the success of building the Sheffield MCA. This support also allowed the project to be an iterative process – the team were able to test, make mistakes and develop through learning.

### **Conditions for successful coaching**

Although the selection of the first coaches to undertake MCA training was relatively crude, it provided the project team with the opportunity to learn about who may be more successful in their coaching and therefore what attributes they should be looking for in future coaches.

It was also important to consider the range of people to train, to ensure they reflected the wider organisation. Also key was the learning that it is preferable for coaches not to coach in their own microsystem. Not only does it appear that teams find it difficult to relate to the coach as anyone other than their professional role, the coach has difficulty separating the openness and enquiring nature of coaching from that of being heavily immersed in the microsystem either operationally, managerially or clinically.

### **Conditions for successful microsystems**

The most important learning around the microsystems work has been the conditions required for successful improvement work to happen, namely: time to meet; a leader with knowledge and enthusiasm for quality improvement; the support of a coach; a consistent method; multidisciplinary input; effective meeting skills; communication with the wider team; and the regularity of meetings and progress.

## WHAT ADVICE WOULD THEY GIVE TO OTHERS?

### **Start small**

The MCA as a concept evolved over time and was initiated after testing microsystem improvement methodology on a small scale, with a few teams and by training two individuals as team coaches. As confidence and interest grew, the logical step was to train coaches at scale to start building improvement capability within the frontline staff.

### **Consider your own context**

Consider the habits and cultural attributes of your organisation, and the levels of will and engagement present in relation to change.

### **Focus first on those who are enthusiastic**

Focus first efforts with teams who are enthusiastic and have a high degree of will and energy to undertake local improvements.

### **Consider the conditions needed for success**

For successful microsystem improvement, teams need time and space to meet regularly, and they need to have effective meeting skills.

### **Be consistent and keep it simple**

Be consistent in methodology, language and aims, and keep it simple and easy for frontline staff to understand and engage in quality improvement.

### **Be responsive**

Be responsive in providing support and building quality improvement in teams, coaches and leaders.

# USING VALUE-BASED INTERVIEWING (VBI)

TO DELIVER HIGH QUALITY  
HEALTH CARE AND IMPROVE  
PATIENT EXPERIENCE

- 
- Led by Oxford University Hospitals NHS Trust, in partnership with the NSPCC and the Oxfordshire Adult Safeguarding Board.
  - Working across the trust, which covers four hospitals.

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## INTRODUCTION

Value-based interviewing is a way of helping organisations recruit the most suitable people to work within their organisational values. It focuses on how and why the applicant has made certain choices in their work.

This project involved designing and delivering a value-based interviewing system tailored to Oxford University Hospitals NHS Trust, based on the

priorities of the organisation and its patients.

It aimed to increase staff engagement and improve patient experience by absorbing the core values of the trust into the recruitment process in order to recruit staff who share these values and are dedicated to delivering excellent care.

## WHY DID THEY DO THIS PROJECT?

Like many other NHS organisations, Oxford University Hospitals NHS Trust experiences challenges around the recruitment and retention of high-performing employees to deliver high-quality patient care. Within the trust, performance management issues were too frequently based on an employee's attitude and behaviour rather than technical ability.

Staff values and attitudes can have a major impact on the quality of care and patient experience. When recruiting new staff, incorporating information on the values, motives and attitudes of applicants, alongside their experience, skills and competencies, helps to gain a wider and more comprehensive view of the applicant.

Value-based interviewing (VBI) focuses on 'how' and 'why' an applicant makes choices in the workplace and seeks to explore reasons for their behaviour. It provides managers with a true understanding of, and insight into, candidates' values and behaviours, and how they are aligned with those of the organisation. By appointing people using VBI, an organisation is demonstrating its ongoing commitment to the values and behaviours which help create a safer environment for patients.

VBI is underpinned by robust research. It has been proven to facilitate the recruitment of people more aligned to organisational values and behaviours, and helps recruit high performing and effective staff.

## WHAT DID THEY DO?

Through adopting a value-based approach to recruitment, the project team believed that the trust would have more staff who adopt a person-centred approach to providing safe and compassionate care. Staff recruited through the process would be able to demonstrate the trust's core values through their behaviours, in particular excellence, compassion and respect through kindness, empathy and courtesy.

The project team aimed to demonstrate that VBI enables recruitment decision-making aligned with the trust's values; provides robust evidence to minimise gut feel about candidates; helps obtain more information about candidates' suitability; and contributes to safer recruitment and selection practice.

VBI training for employees (those who carry out interviews for prospective staff) was introduced into the six divisions in the trust, for recruiting to roles including nursing staff, medical consultants, administration staff, allied health professionals and executive appointments at board level.

The training sessions with interviewers were run over two full days, off hospital site, giving delegates an opportunity to step away from the working environment. Delegates were provided with information on what VBI is, and role play was used. Delegates' interviewing capability was assessed by the course trainers and feedback given to ensure that interviewers left the training with confidence in using VBI in their recruitment activity.

## WHAT IMPACT DID THEY SEE?

Since this Shared Purpose project began, over 300 employees have been trained in VBI technique, with a further 144 booked onto training. VBI is now being used across all six divisions within the trust, and for recruiting to many different roles.

Feedback from staff on the training shows that the introduction of VBI has led to improvement in the quality and effectiveness of the overall interview process at the trust. Qualitative feedback from line managers reflects an improvement in patient experience as a result of assessing values and behaviours at interview.

A predictive validity study provided statistically significant quantitative evidence that VBI was able to predict how individuals who were recruited as nurses and midwives would perform in post in relation to demonstrating the trust values. A predictive validity co-efficient of 0.38 was achieved.

Changes have been made to HR processes within the organisation, and the recruitment and selection policy and procedure for all groups of staff was amended to reflect VBI as an organisational-wide recruitment tool. Additionally, the weekly induction for new starters to the trust now includes an introduction to the trust's values and how the organisation hopes to live the values through delivering compassionate excellence.

The project team has received enquiries from over 80 other organisations that are interested in implementing VBI, and representatives from over 20 organisations have observed the VBI training so that they can understand the practical implications of implementing VBI.

## WHAT DID THEY LEARN?

The project objectives were set at a very early stage of the project planning process. The VBI project subsequently evolved and matured as the organisation grew its knowledge and experience of VBI.

### **Giving managers autonomy**

As the project developed, the project team's belief that the intervention should not be posited as mandatory was reinforced. There was a temptation in the original project roll out to set a deadline for when all appointments should include a VBI. However, as the project progressed this position changed. The main reason for the change was the response of managers through course evaluation and feedback post-course. All managers conveyed their desire to make the VBI intervention 'their own' and mandatory VBIs would take this decision out of their hands.

### **Consultation and communication**

At the start of the project the team didn't anticipate how important the development and communication process of the organisational values was. The development of the values with staff and the approval by the board enabled the project team, the trainers and the VBI champions to clearly position the work as being developed in consultation with, and with the support of, the whole organisation.

### **The value of partnership working**

Partnership working with the NSPCC, Age UK, King's College and other local partners brought untold learning from a number of areas. The value of different perspectives helped to shape the VBI project and its direction across the organisation, and has also increased credibility of the messages.

## WHAT ADVICE WOULD THEY GIVE TO OTHERS?

### **Get senior leadership buy-in**

Senior leadership buy-in should not be underestimated, particularly in light of the credibility that such support brings to a project.

### **Use storytelling**

Use powerful stories from those using the intervention to inform communication of the messages – these stories make it more relevant to stakeholders and more clearly demonstrate the benefits of the project.

### **Take time to reflect**

Take time to think and reflect before acting. Through reflection the project team can see how good ideas can grow into great ideas, and how what they believed to be the right direction was actually the wrong direction.

### **Mistakes are invaluable**

While it is tempting to focus on areas of the project that have not gone to plan and see them as failures or errors, the reality is that these help shape and inform the project.

### **Think about project ownership**

If a project has a strong association with the project lead, steps need to be taken to mitigate any risk around this, and to facilitate a smooth transition from project to 'the way we do things around here'.

# VALUE-BASED REPORTING AND MANAGEMENT

- 
- Led by King's College Hospital NHS Foundation Trust, partnered by Guy's and St Thomas' NHS Foundation Trust, and South London and Maudsley NHS Foundation Trust.
  - Based at King's College Hospital in three services: cardiac, liver and stroke.
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## INTRODUCTION

Improvement projects in the NHS often focus more on process targets and financial measures than on care outcomes. A team at King's College Hospital NHS Foundation Trust has developed a system that uses 'value' – health outcomes divided by cost – as the key performance metric.

The main components of the project were the development of a new method of value data capture, a set of value-based reporting tools and a value-based management system.

The approach enabled access to data that are more meaningful and comparable, less at risk of distortion, and could account more effectively for clinical and patient-specified outcomes.



## WHY DID THEY DO THIS PROJECT?

The NHS faces great pressures to save money, change models of care, restructure systems and join up the services it provides. However, at present, the focus is often on short-term process and financial targets rather than care outcomes. This doesn't always achieve the best care for patients, doesn't necessarily engage clinicians and can create organisational confusion around targets.

In 2012, a group of staff from King's College Hospital NHS Foundation Trust went to hear a Harvard Professor, Michael Porter, speak about how health services should measure and report the holistic 'value' – defined as health outcomes divided by cost – of what they do, rather than focusing on standalone process, financial and quality targets. His belief is that this is a more useful indicator of how well health systems are doing their job.

Through the Shared Purpose programme, the project team aimed to put the theory of value in health care into practice. They wanted to use value as the key performance metric to:

- show that value is a better unifying concept than segregated data
- test emerging theories about value in health care and show it can be operationalised
- deliver service improvements that matter to patients.

## WHAT DID THEY DO?

The team's central proposition was that management based on value – the outcomes for patients delivered for each pound spent – drives faster, better innovation and unites the interests of payers, providers and patients.

Making value meaningful to clinical teams meant monitoring costs and outcomes across a pathway and reporting them cohesively. It meant creating a data system that everyone was interested in – clinicians, managers and patients – and involving everyone in a discussion about how the system could work better.

The first stages of the project involved prioritising those clinical outcomes that were the best overall indicators of success, and identifying a set of outcomes that mattered to patients. Evidence was gathered from evidence reviews, surveys and patient focus groups, and sources of data were identified.

Hepatitis, endocarditis and stroke were established as those areas upon which to initially focus. Outcome measures were developed for all three conditions, along with cost data analysis following the whole care pathway. Activity and value stream maps for each condition were also drawn up to understand how patients flow through the system.

The value-based reporting tools included easy-to-read graphical and tabular information for all providers and commissioners, and changing from department-based cost centres to longitudinal calculations of total cost from all sources along the condition pathway.

The value-based management system provided reporting tools and a framework that enabled multidisciplinary teams to optimise team performance and accountability, and identify innovation opportunities.

## WHAT IMPACT DID THEY SEE?

The project has enabled remarkably effective collaborations between finance, management and clinicians. Each professional group has developed knowledge and appreciation of others through the work. Clinicians have reported a greatly enhanced appreciation for the cost implications of clinical activities, and the finance team have reported having a greater understanding of the actual processes that they are costing.

The patient engagement process influenced all teams to develop a better understanding, not only of their service, but of who their patients are and how best to communicate with them.

Work with the clinical teams in the three specific service areas has had significant impact. For example, reporting on the endocarditis cohort of patients allowed the teams to gain a quantitative

understanding of how their service behaves, to complement the qualitative information from patients, and monitor the impact of service changes.

The establishment of a permanent endocarditis team allowed a new focus on understanding the condition. The consistent collection of data and the regular multidisciplinary team meetings will continue beyond the life of the project and will provide the basis for ongoing service monitoring and research publications. Recent focus groups suggested that the quality of care and information provided to patients treated by the endocarditis team exceeded other areas.

Financial analysis of the project indicates that it is expected to cover its costs by the end of 2016, and deliver a 37% return on investment over five years.

## WHAT DID THEY LEARN?

### Collaboration and patience

The initial project concept was subsequently explored by the clinical teams so that they could understand it for themselves. This meant revising some of the plans in a process of co-creation. Although this took patience and time, it was an essential building block for trust and collaboration.

It took a long time to identify measures and costs, to collect and process data, to produce dashboards, and to start improvement dialogue and cycles of action. It is a complex process and took a lot of expert data knowledge and creativity. The clinical teams had a tendency to become impatient for the outputs, and this stage did take longer than had been expected.

### Adding value

The value metrics that were developed through the project drove improvement by providing evidence from which to hypothesise and investigate potential improvements. These were often improvements that teams were not even talking about before. The model produced the type of dialogue and action that was envisaged at the start of the project.

### Importance of historical data

There is a tendency to disregard imperfect data, but this project offers the opportunity to understand and improve data quality through clinical input and analysis. The default position should not be to dismiss historical data and solely concentrate on improving data collection.

## WHAT ADVICE WOULD THEY GIVE TO OTHERS?

### Forge understanding amongst others

When the concept is introduced to new teams, project leads must be prepared for the fact that the teams themselves will need to explore and make sense of it in their own way.

### Ensure access to data and data expertise

Establishing good access to all trust systems and maintaining good relationships with data processing teams is essential, as is having a data expert who is familiar with systems, data processing, information presentation and the interpersonal skills and persistence to work with, through and around entrenched data silos.

### Enable understanding of key concepts

The data and how they are used are significantly different under the value proposition to the normal use of data in the NHS. Workshop sessions guided by data and improvement experts can accelerate progress and understanding.

### Understand how data are presented in different ways

Improvement data are different in both intent and presentation to performance or reporting data. Teams need to understand why data are presented as they are and how to act on this to move towards identifying opportunities for improvement (without improvement expertise, there is a tendency to feed intrigue with more data).

### Pay attention to teambuilding

It is important to pay close attention from the start to how relationships are working, to teambuilding, to the needs and skills of individuals, to group dynamics, and to succession planning as individuals leave and join the project.

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## ABOUT US

The Health Foundation is an independent charity working to improve the quality of health care in the UK.

We are here to support people working in health care practice and policy to make lasting improvements to health services.

We carry out research and in-depth policy analysis, run improvement programmes to put ideas into practice in the NHS, support and develop leaders and share evidence to encourage wider change.

We want the UK to have a health care system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable.

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