

Decisions of Value

FULL REPORT AND FINDINGS

Academy of Medical Royal Colleges and NHS Confederation
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2 EXECUTIVE SUMMARY

The Decisions of Value project has embarked on a study of decision-making in the NHS that brings together a large amount of research and evidence from across the whole system. Decision-making in the NHS extends from Whitehall to the bedside. This study does not focus on national policy or individual clinical decisions, but rather on those decisions in the middle of the spectrum aimed at making the most of the capacity and functioning of individual organisations. This includes, for example, decisions to embark on cost or service improvement plans and decisions to increase or decrease workforce levels.

There is a need for a culture shift in health care towards better value and this study demonstrates where this is currently taking place within many NHS organisations. “Decisions of Value”, i.e. those that balance quality, financial and operational considerations, rely on having the right relationships, behaviour and environments in place. As such, there is a particular importance to understand how humans interact and the factors affecting how they operate within a particular context.

Six important factors are highlighted in the study, based on detailed exploration with staff across the NHS:

1. Stronger clinical and financial rapport

- Balancing quality and finance depends on strong clinical and financial relationships, yet around three quarters of clinicians feel they are rarely or never involved in big financial decisions
- The mind-set of some clinicians is preventing them from engaging, but time and skills are the most common barriers identified
- Where clinical and financial engagement is strong, our study demonstrates how far this improves the decisions that are made and the strength of the value underpinning them

2. Greater patient involvement

- Putting patients at the heart of care will demand they be involved in the decisions organisations make
- Many patients do not feel their views are sufficiently considered and genuine involvement requires organisations to be clear about patient engagement and how it impacts on their decisions
- A mind-set that can see input as unhelpful or disruptive will need to be challenged to encourage those receiving care to shape how it is delivered

3. Deeper values-based behaviour

- Values are important for defining how people should behave and in supporting decisions that are made more on instinct than experience
- Most decisions are made using experience, rather than instinct, but where instinct is used decision-makers feel less comfortable with how reliable it is

- For values to be established as a core part of the NHS, communicating and upholding those values needs to be prioritised even when times get tough

4. More information-driven decision-making

- Information and data drives many decisions, but there is a particular need for it to have a greater role in evaluating decisions after they are made
- More than half of people feel they spend little or none of their time monitoring and evaluating a decision, while front line clinical staff are less comfortable with the reliability of data and information
- Clarity and accuracy of the data and information available will need to be improved to overcome an instinctive distrust that some people have for the data used to make decisions

5. Increasingly supportive environments

- Environments have a big impact on how decisions are made and the ability people have to consider quality and finance in decision-making
- Most people feel they are making some or most of their decisions in a busy, distracting environment and while feeling stressed and physically tired
- Some of these environmental factors are natural, but more needs to be done to improve staff health and well-being as part of a strategy to enhance decision-making

6. Larger networks of peer support

- Peer support is a regular feature of the NHS and is often used to support decision-making, particularly amongst clinicians
- Almost all people find the informal support of colleagues useful when making decisions and most believe it is essential for that support to offer a constructive challenge
- There is a role for peer support as part of making decisions that balance quality and finance, but the balance of burden to benefit of any programme needs to be considered

The findings from this study inform us of the main factors for supporting decisions of value and highlight the progress being made in these areas. It doesn't therefore define good decisions, but rather gives an insight into the principles of good decision-making. Furthermore, there are many tools and resources being developed to help decision-makers further. Part of this study's recommendations is to share its findings further and look to input the conclusions from it into other relevant work.

Added to the findings in this report are the recommendations from the literature review we commissioned to look at the factors influencing decisions of value in health care, produced by the University of Birmingham's Health Services Management Centre. This report provides a strong evidence-base to many of our findings and highlights the important concept of rationality in decision-making, including enabling factors. Certainly, the complexity of making decisions in

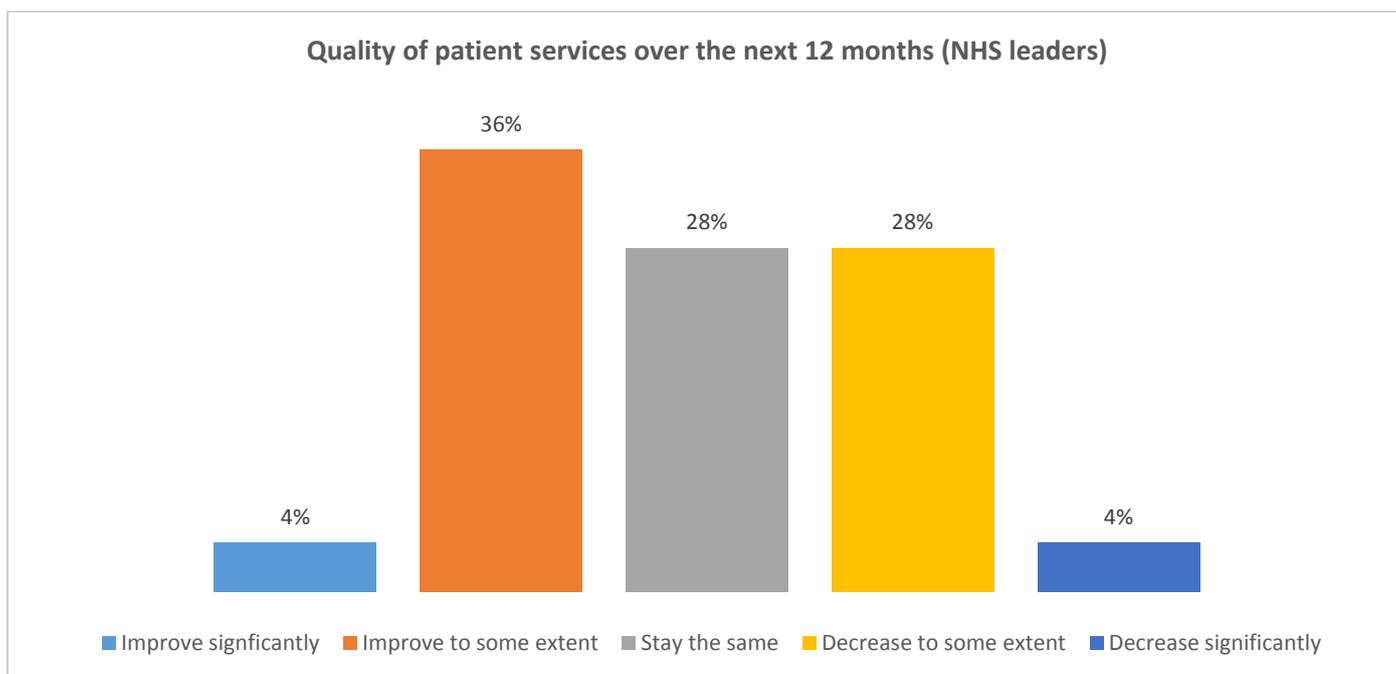
the NHS that we found in our study and which is demonstrated by the case studies in the literature review provides a big challenge for rational approaches, but we hope our study highlights where this can be enabled.

One aspect of work where our study suggests creating a specific tool or resource is on peer support, where there does seem to be a real need to bring likeminded professionals together to share expertise and experience on balancing quality and finance. As such, we recommend creating a programme with experts to do just this and support them to get the right relationships, behaviours and environments. This programme would focus on drawing together those with something to share with those looking for something to learn.

3 INTRODUCTION

It is sometimes believed that plans to improve care will always cost more money and that attempts to balance the books will ultimately come at the expense of quality. Yet, the 2013 NHS Confederation member survey highlighted a belief among NHS leaders that quality of care can in fact improve within a tougher financial environment. In that survey, 68 per cent of NHS leaders said quality of care would stay the same or improve over the next 12 months (up substantially from 15 per cent in 2012), while 83 per cent felt the financial pressures would get worse over the same period.¹ The way in which NHS organisations achieve this is by balancing the desire to improve quality of care with the pressure to reduce the costs of health care overall, i.e. getting greater value from the resources available.

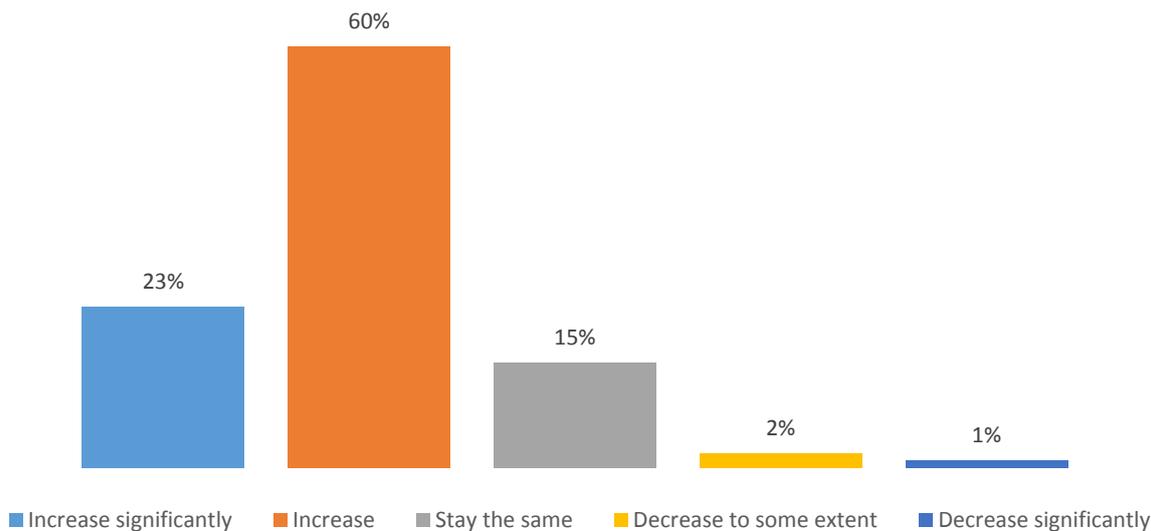
This optimism about the NHS's ability to deliver better value is in contrast with a growing public perception that smaller increases in health spending will have a negative impact on quality of care. In a recent public survey, 50 per cent of respondents disagreed with the idea that quality of patient care could be increased while reducing costs (up from 47 per cent three months earlier). One of the toughest challenges the NHS faces right now then is having to deliver greater value with many people, including patients and staff, unconvinced it is possible.²



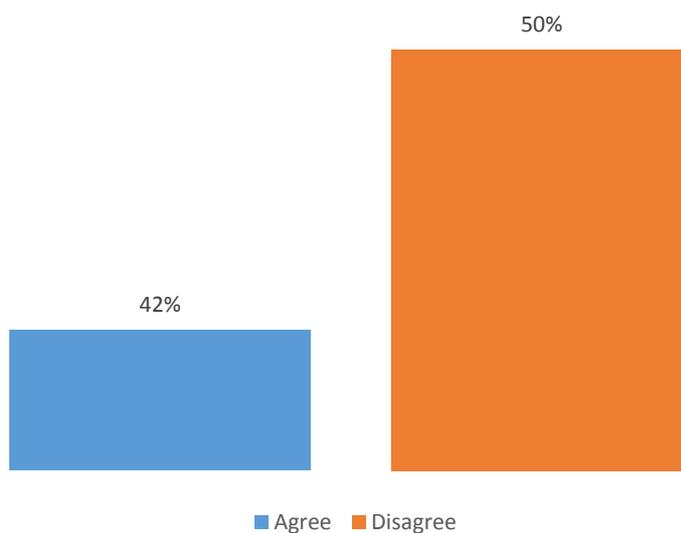
¹ NHS Confederation (2013) – *Member Survey 2013*. The survey had 185 respondents that were either chairs or chief executives of NHS Confederation members.

² : Ipsos MORI and Department of Health (2014) - *Public Perceptions of the NHS and Social Care Tracker Survey - Winter 2013 wave*

Financial pressures over the next 12 months (NHS leaders)



Can increase quality while reducing costs (public)



Sources: NHS Confederation/Ipsos Mori and Department of Health

Also, fresh in the minds of many are the conclusions and recommendations from a series of reports published in the last year, starting with the findings from the Francis Inquiry. These reports highlight a number of failings and recommend a clear course of action for those in health care to take, sections of which are featured below. The Secretary of State for Health recently made reference to a “Francis effect” and nothing we heard calls this into question.³ The NHS is certainly mindful of the lessons expressed by Robert Francis QC and people working in the service are determined to demonstrate their motivation to deliver the highest quality of care possible, now and for the future. Three months after the *Francis Report* was published, the NHS Confederation member survey highlighted that 91 per cent of NHS leaders felt their organisation had made progress in setting out how it intended to respond to the Francis

³ Jeremy Hunt (2014) – “Why the NHS is crossing the Rubicon” in *The Telegraph* (04/02/2014)

Inquiry's conclusions. Furthermore, 89 per cent said their organisation had taken sufficient steps to ensure staff were aware of their individual responsibilities to speak out if they have concerns over patient safety or quality of care.⁴

Yet, they did not need a report to elicit this response. Many organisations have been working for some time on shifting culture, and the findings of this report highlight many actions predating the *Francis Report*. Francis has, however, given those organisations encouragement that these are the right moves and highlighted the serious consequences of not making sufficient progress.

Relevant reports

“The focus of the system resulted in a number of organisations failing to place quality of care and patients at the heart of their work. Finances and targets were often given priority without considering the impact on the quality of care. This was not helped by a general lack of effective engagement with patients and the public, and failure to place clinicians and other health care professionals at the heart of decision-making. Complaints were not given a high enough priority in identifying issues and learning lessons. Patients, clinicians and the public need to be at the heart of the health service and the decisions being made.”

Robert Francis QC, 2013⁵

“The NHS in England can become the safest health care system in the world. That will require unified will, optimism, investment, and change. Everyone can and should help. And, it will require a culture firmly rooted in continual improvement. Rules, standards, regulations and enforcement have a place in the pursuit of quality, but they pale in potential compared to the power of pervasive and constant learning.”

Prof Don Berwick, 2013⁶

“We found that, while trusts in the main complied with quality and safety processes, they were slow in learning lessons when things go wrong and embedding that learning in improved ways of doing things. A common finding was that the feedback loop back to staff who reported quality issues was ineffective – they reported an issue, but did not know what action had been taken as a result. Sometimes staff did not feel empowered to take action when they had identified an issue and in a few cases, staff felt uncomfortable raising issues with senior management.”

Prof Sir Bruce Keogh, 2013⁷

“In emphasising the importance of culture, we would caution against an overreliance on external regulation as a defence against poor standards of care. Smith and Reeves (2006) made an important distinction between ‘regulated trust’ and ‘real trust’ in creating environments that nurture desirable behaviours and practices. Real trust relies first and foremost on self-regulation and peer review, and is found in organisations which support staff to ‘do the right thing’”

The King's Fund, 2013⁸

⁴ NHS Confederation (2013) – *Member Survey 2013*

⁵ Robert Francis (2013) – *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*

⁶ Prof Don Berwick (2013) – *A promise to learn – a commitment to act*

⁷ Prof Sir Bruce Keogh (2013) - *Review into the quality of care and treatment provided by 14 hospital trusts in England*

⁸ King's Fund (2013) - *Patient-centred leadership: Rediscovering our purpose*

“Post-Francis, senior managers, clinicians and boards will need sustained support as they grapple with the tensions of managing for both quality and productivity. Without such support, the hostile and blame-laden culture that led to the events at Mid Staffordshire in the first place is likely to be re-created.”

Nuffield Trust, 2014⁹

The Decisions of Value project is intended to support the NHS to respond to these recent reports, but it is not just about them. The progress made in delivering greater value in the NHS follows a trend that has developed over time but has been pushed more recently into the foreground by Francis and others. Its greatest strength lies in its lasting significance because a focus on value benefits the NHS regardless of the quality or financial environment. At all times, a value-driven NHS could provide the public with the assurance that public resources are being maximised to the greatest societal benefit.

⁹ Nuffield Trust (2014) – *The Francis Report: One year on*

4 DECISIONS OF VALUE

The Decisions of Value project looks to help the NHS meet the challenges they currently face, and will likely face in the future, by delivering greater value. It does this by looking at the process and rigour of decision-making in the task of balancing quality and finance at the current time. Our aim is to provide support for better decision-making processes at a local level, not to suggest what the right decisions are. In particular, we explore how NHS organisations might be supported to deliver greater value and how our two organisations, the Academy of Medical Royal Colleges and the NHS Confederation, could develop and facilitate this support.

Definitions

Both 'quality' and 'finance' are referred to regularly in this report and sometimes they are used as catch-all terms. High quality care is an output wanted across the NHS. It is not always easy to define or measure, but many services are improved to maintain this standard or else to aspire towards it. In our short-hand, finance relates to the management and allocation of resources, in particular money. The NHS must manage resources in a sustainable way to continue to deliver services now and in the future, and must also maintain or improve quality of care. A quality/finance balance therefore mainly relates to how NHS organisations are able to improve or maintain the standard of services while managing resources in a sustainable way. A third aspect of this is service provision, which would relate to the operational challenge in delivering care. It therefore recognises the determination to ensure models of care meet the needs of patients and are operationally sustainable. The challenge for the NHS is how it can balance these demands, which can often be in tension.

About us

The Academy of Medical Royal Colleges comprises the 20 medical Royal Colleges and Faculties across the UK and Ireland and speaks on standards of care and medical education across the UK.¹⁰ The NHS Confederation is an independent membership body for all organisations that commission and provide NHS services and is the only body that brings together and speaks on behalf of the whole of the NHS.¹¹ We have a strong track record of working together on important health care issues. Last year we worked together, along with National Voices, on a project to explore the barriers and enablers to service reconfiguration and published an influential report summarising our main findings and conclusions.¹² We have also recently worked together on the issue of value and in April 2014 published a briefing with the Faculty of Medical Leadership and Management and the Health care Financial Management Association.¹³

The main strength of our partnership is our ability to engage senior clinical and managerial stakeholders and to offer a distinctly whole-system perspective. Certainly, these are essential requirements when exploring the issue of value in the NHS and this report is evidence of this.

¹⁰ For more information, please visit www.aomrc.org.uk

¹¹ For more information, please visit www.nhsconfed.org

¹² NHS Confederation (2013) – *Changing Care, Improving Quality*

¹³ NHS Confederation (2014) – *Two side of the same coin: Balancing quality and finance to deliver greater value*

At the outset of this project, we established three collective principles to be maintained throughout, which are:

1. **Sector-led support** – we want to understand what the NHS thinks it needs to help deliver value. As such, our work will focus on resources that have been produced by the health care system for the health care system.
2. **Collaborative working** – our national partnership signifies the importance of working together to respond to challenges in health care. Our work therefore must take advantage of the opportunity to enable productive interactions of the different parts of the health care system.
3. **Continual improvement** – this project is not focused on finding a solution to one-off problems that exist today. The outcome from what we do needs to establish a lasting legacy that builds resilience in the NHS to meet the challenges of the future.

5 METHODOLOGY

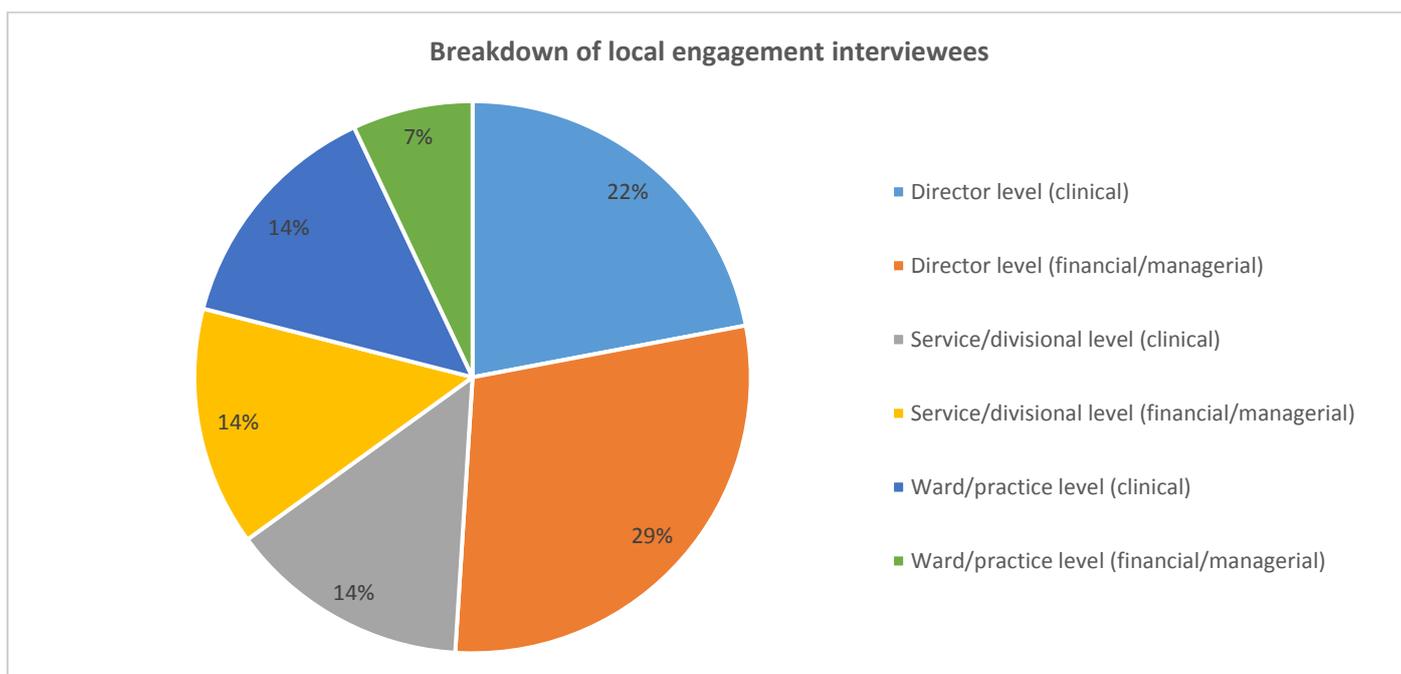
We came together to undertake a study of how the NHS might be supported to deliver greater value, by balancing quality and finance. To reach the conclusions presented in this report, the study has undertaken research at a number of different levels:

- Direct local engagement
- Wider national engagement
- Targeted expert and stakeholder engagement

Direct local engagement

We have conducted site visits and interviews in four NHS organisations. Given time restraints, these were chosen on the basis of willingness and availability to participate. They included providers within different sectors of the NHS and included a GP practice. We visited each organisation and held face-to-face meetings with people from across different levels of the organisation. In most instances, we intentionally interviewed people connected to one another within a specific decision-making area, for example workforce planning. This allowed us to explore relationships between the different people we spoke to.

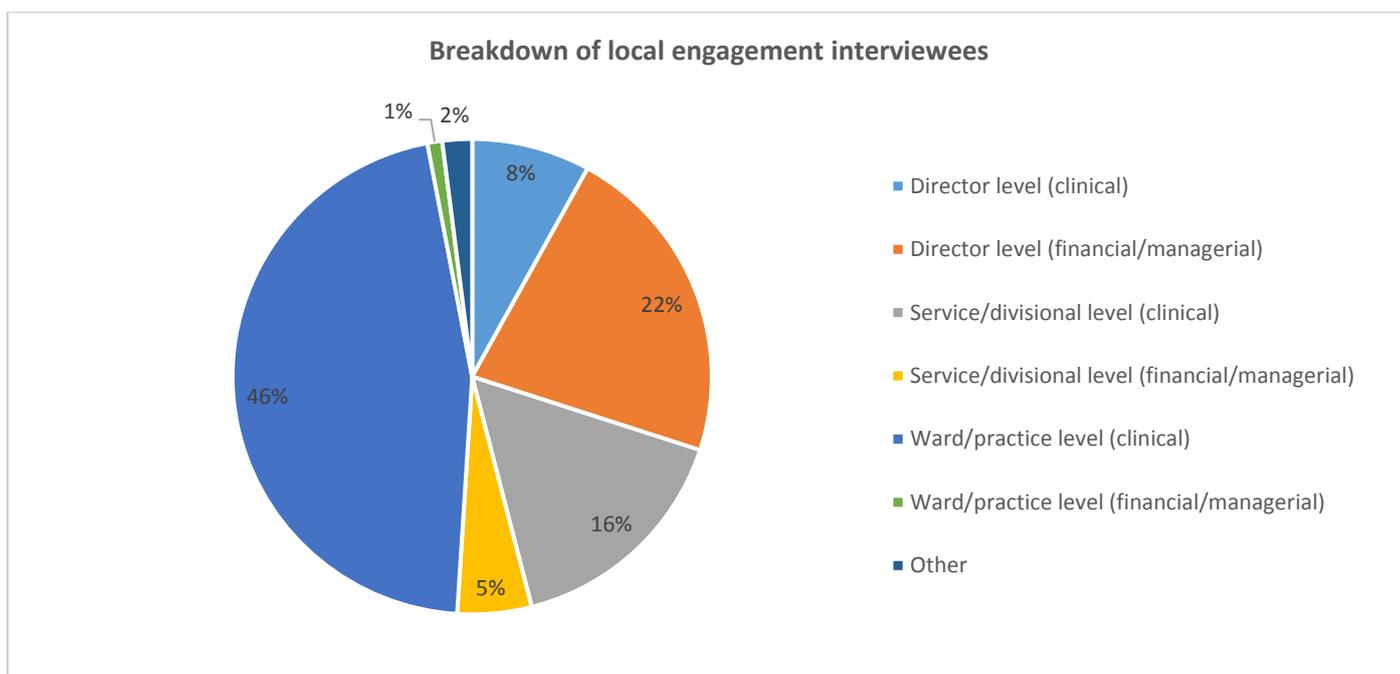
In addition to site visits, we also spoke to other senior leaders in NHS organisations who were interested in the project and put themselves forward to be contacted. In total, 28 people were interviewed as part of this project. The chart below gives an overview of the people we spoke to as part of the direct local engagement. It shows that half of the people we spoke to had a clinical background and the other half were speaking from a financial or managerial perspective.



Wider national engagement

To support the local engagement, we conducted a national survey that looked at a number of themes related to the project. This survey was distributed through the networks of the NHS Confederation and the Academy of Medical Royal Colleges, and was open for 45 days between March and April 2014. Respondents were asked to identify what level they worked at within their organisation and their primary perspective on decision-making. It was also made clear at the beginning of the survey the types of decisions the project was focused on and those they should consider when responding to the questions.

The chart below gives an overview of the people that responded to our survey as part of the wider national engagement. Respondents were predominantly from acute trusts and our attempts to balance this out had some impact but were not enough to bring about a complete balance. In total, 285 people responded to the national survey, of whom two thirds had a clinical perspective on decision-making and one third had a financial or operational management perspective. A full summary of the survey results, including a more detailed breakdown of respondents, can be found in the annex of this report.



Targeted expert and stakeholder engagement

As part of our study, we commissioned a literature review to explore the evidence base for decision-making, specifically in balancing quality and finance. The review was conducted by the University of Birmingham's Health Services Management Centre and looked at evidence both in health care and in other relevant settings. This report contains many of the findings of that review, although the full review is also available in a separate document.¹⁴

In addition, we engaged a number of experts and national stakeholders in the project. We have hosted two expert meetings in March and April to discuss and test the early findings for the study, as well as to explore more broadly

¹⁴ University of Birmingham Health Services Management Centre (2014) – *Factors influencing decisions of value in health care: a review of the literature*

how the project might support the NHS. The expert group meetings were well received and described by Prof Sir Muir Gray, who attended one of the meetings, as the most encouraging meeting for a decade.



The expert and stakeholder engagement has involved representatives from the following organisations and people:

- Academy of Medical Royal College's Patient/Lay Group
- Care Quality Commission
- College of Emergency Medicine
- Department of Health
- Foundation Trust Network
- Health care Financial Management Association
- Local Government Association
- Mental Health Network
- Monitor
- NHS Employers
- NHS England
- NHS Clinical Commissioners
- Prof Gwyn Bevan, London School of Economics
- Prof Sir Muir Gray, NHS Right Care
- Royal College of Anaesthetists
- Royal College of Nursing
- Royal College of Pathologists
- Royal College of Physicians
- Royal College of Psychiatrists
- Royal College of Radiologists

6 SCOPE OF STUDY

This study emphasises the importance of decision-making in the NHS. There are many thousands of decisions made every day in the NHS and they vary in their nature. This project focuses primarily on balancing quality and finance, therefore we want to be clear from the start what types of decisions are relevant for the purposes of this project.

Decisions of value

Firstly, we established an initial definition for the decisions included in the project. This was designed to set broad parameters to focus on the aim of delivering greater value. The aspects that were included in this definition were:

- **Decisions with a clear and measurable impact on both finance (costs) and quality (care)** – it will be difficult for any decision-makers to make a value-based judgement without knowing in some part the impact on finance and quality. In many cases, the impact might not be as clear and measurable as we might like, but nonetheless a basic awareness of how a decision might affect cost or quality is necessary.
- **Decisions made by choosing from two or more possible options** – it is a fundamental requirement in decision-making that there are options available from which to choose. As such, it would not be appropriate to consider as part of this work those decisions where no realistic alternative exists and where people are unable to make a value-based comparison.
- **Decisions that have a point in time where a rational judgement has been applied** – our study requires people to reflect on how they make decisions and consider the factors that impact on their ability to do so, with respect to balancing quality and finance. The decisions they consider therefore need to be those made rationally, which would also include the concept of bounded rationality that is referred to later in this report.

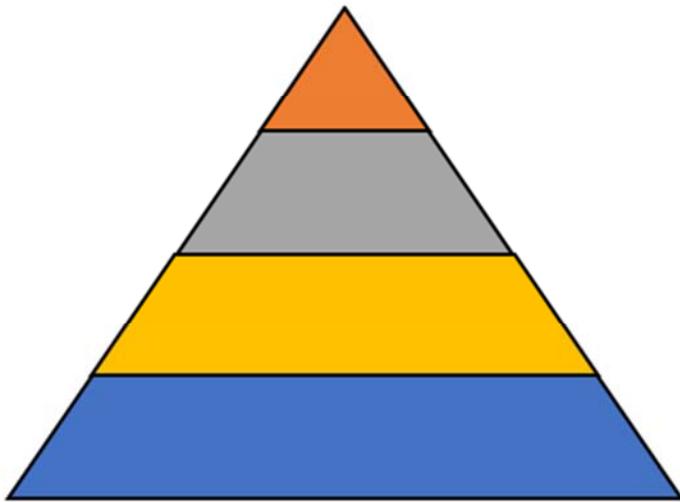
Following on from this broad definition, we were able to identify specific decisions in the scope of this study. The literature review conducted by the Health Service Management Centre at the University of Birmingham provides a strong basis for this.¹⁵

The diagram below highlights decision-making levels in the NHS ordered according to scale and scope. The middle two tiers, each of which contains a range of decision types, are the focus for this study and they will be outlined in greater detail. Decisions at all four levels imply resource allocation although the extent to which this is explicitly acknowledged varies.¹⁶

¹⁵ The below outline of the decisions is mostly taken from the HSMC's initial findings.

¹⁶ For more information about tier one (national) decisions, please see NHS Confederation (2014) – *Two side of the same coin: Balancing quality and finance to deliver greater value*. The Academy of Medical Royal Colleges is also undertaking research into tier four (clinical) decisions as part of a study into waste in the NHS from a clinical perspective

Decisions of Value pyramid



Tier one: national – macro policy interventions and national regulation

Tier two: system – commissioning strategies and local health initiatives

Tier three: organisation – choices by boards and staff within organisations

Tier four: clinical – interactions between clinician and individual patient

Tier two: System decisions

Tier two is dominated by decisions that focus on the formal allocation of resources, for example through commissioning and/or technology coverage. It also includes non-allocative decisions, such as the reorganisation of services, closure of care homes, dis-investment of business units and so on.

There is a growing evidence base with regards to the factors influencing coverage and commissioning decisions in health care systems across the world. These have traced the importance of information and expertise levels, and more recently have begun to explore the influence of political and institutional factors. The debate is largely conducted between advocates of 'rational' decision-making – i.e. based on a formal comparison of costs and measurable outcomes – and those who foreground 'irrational' factors such as cognitive biases, environmental pressures, politics and engagement, and so on.

The table provides a snapshot of the range of factors that the evidence suggests may influence decisions at tier two. The list is provisional at this stage and the full literature review will explore the relative importance of these in more detail. The factors should not be treated as independent of one another and indeed have been shown to be mutually reinforcing and/or conflicting. For example, contextual factors have been shown to affect levels of public engagement in decision-making.¹⁷

¹⁷ Abelson, Julia (2001) – *Understanding the role of contextual influences on local health care decision-making*

Factors influencing tier two decisions (as suggested by literature review)	
Decision characteristics	<ul style="list-style-type: none"> ▪ Complexity ▪ Uncertainty ▪ Controversy ▪ Precedent
Decision-maker characteristics	<ul style="list-style-type: none"> ▪ Values ▪ Bounded rationality ▪ Group dynamics ▪ Loyalties and affiliations
Technical	<ul style="list-style-type: none"> ▪ Information resources/deficits ▪ Analytical resources/deficits
Cultural	<ul style="list-style-type: none"> ▪ Received wisdom and practice ▪ Tacit knowledge
Economic	<ul style="list-style-type: none"> ▪ Resource constraints ▪ Relationship to budget (i.e. direct/indirect)
Organisation	<ul style="list-style-type: none"> ▪ Standard operating procedures ▪ Governance arrangements ▪ Relationship of decision function to wider executive and financial structures
Politics	<ul style="list-style-type: none"> ▪ Public perception ▪ Media ▪ External interest groups ▪ Government and politicians
Regulatory	<ul style="list-style-type: none"> ▪ Legal opinion and precedent ▪ Governmental and independent oversight

The literature offers descriptions of numerous prescriptive decision-making frameworks. These include, for example, multi-criteria decision tools, programme budgeting and marginal analysis¹⁸, and accountability for reasonableness¹⁹. However, these typically confine themselves to allocative decisions and less prescription is available for decisions to organise and reorganise services.

The literature on wider mergers and reorganisations suggests a disproportionate preoccupation with structural and procedural aspects. Assessment of the mergers and acquisitions data suggests that most fail in practice, and do so because they fail to attend sufficiently to the softer human dimensions of change.²⁰

Tier three: Organisation decisions

Tier three refers to decision-making at the organisational and sub-organisational level. Although this includes allocative decision-making, for example through formulary management, it is more commonly associated with decisions that relate to how best to maximise organisational capacity and functioning. This includes technology and

¹⁸ Ruta, Danny (2005) - *Programme budgeting and marginal analysis: bridging the divide between doctors and managers*

¹⁹ Daniels, Norman (2000) - *Accountability for reasonableness*

²⁰ Peck, E, Dickinson, H., Smith J (2006) – *Transforming or transacting? The role of leaders in organisational transition*

innovation adoption, workforce changes, quality improvement initiatives, and investment in public and patient engagement programmes.

The range and variety of decisions that fall into this category means that the evidence base is more disparate than for system decisions. Systematic reviews have been carried out on sub-categories of organisation decisions²¹ and other decisions have also been analysed as part of wider studies and reviews.²²

Despite this range, some key distinctive elements can be identified when compared to system decisions. These include that organisation decision-making is:

1. Typically less clearly separated from implementation
2. Decision-makers are more clearly located in the context affected by the decision. This means they will act more explicitly in accordance with prevailing structures of incentives, penalties and rewards as well as the dominant culture and relationships
3. May be less immediately understood as primarily resource decisions, particularly at unit or department level
4. Has responsibility that is at times more opaque. However, there are clear differences in terms of who is typically involved and how decision-making responsibilities are discharged.

The table below details some specifically organisational determinants that have been shown to influence decision-making at tier three.

Factors influencing tier three decisions (as suggested by literature review)	
Size	Overall scale and remit
Resource levels	Availability of slack resources for decision implementation
Governance arrangements	Extent of centralisation and/or differentiation/specialisation
Decision-making structures	Flat/participatory or top-down, degree of autonomy between constituent organisational parts
Extent of connectedness	For example, between different groups and organisational parts
Organisational culture	Predominant values and norms, levels of trust, vertical and horizontal relationships
Decision-making antecedents	Precedent and organisational memory
Absorptive capacity	Extent to which knowledge is identified, distributed and translated

As well as containing less empirical evidence on the factors shaping organisation decisions, the literature also provides less by way of prescription for how to make such decisions. This partly reflects their context-specific nature. As with system decisions, there are important temporal considerations for decisions taken at an organisational level. For example, how are decisions intended to be reviewed and revised over time? Who has responsibility for ensuring this happens? Organisation decision-makers will typically be less insulated from this revision and review process than those at a system level.

²¹ For example, Estabrooks, C and Fraser, K (2008) - *The effects of time pressure and experience on nurses' risk assessment decisions: a signal detection analysis*

²² For example, Greenhalgh et al. 2005

7 MAIN FINDINGS

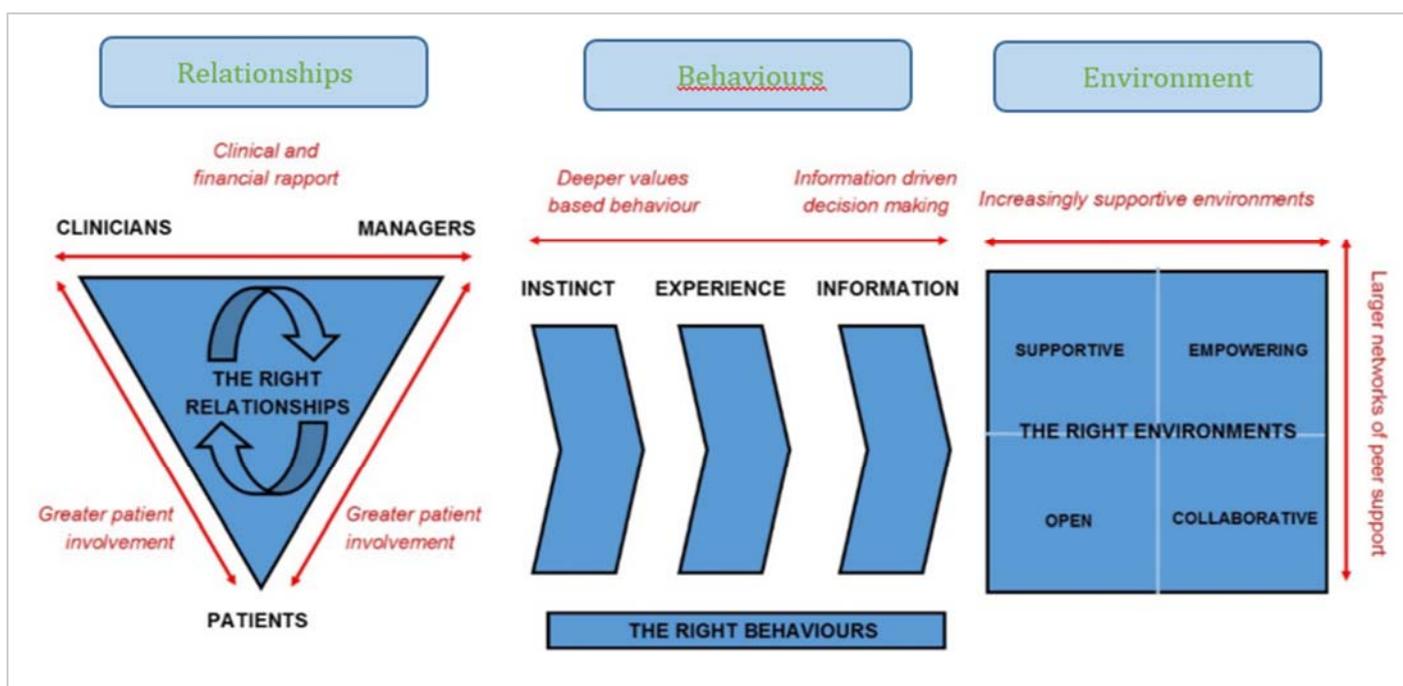
Our study highlights the importance of culture shifts, that have both happened and are in need of happening in some areas, to help the NHS to better balance quality and finance. As such, the main factors we identify in decision-making relate to human relationships, behaviours and environments. In many cases, what we find indicates a “back to basics” approach that involves a fundamental understanding of how humans interact and operate.

We spoke to people who showed us the direction many organisations are moving toward to achieve this culture shift and the rest of this document is focused on documenting this, along with the challenges involved. Ultimately, much of the NHS is wanting to establish a new norm to reflect concerns about quality of care and financial stability. This norm will guide decisions so they deliver value and ensure decisions of less value stick out as exceptions.

The diagram below gives an illustration of our findings. It highlights the main factors we identified for enabling decisions of value, which are described as having:

- The right **relationships**
- The right **behaviours**
- The right **environments**

Factors in decisions of value



The report will explain these factors in more detail and what our study has shown about their relative importance for making decisions of value. Within each factor, we also identify two directions of travel our study indicates are being made with varying degree of progress across the NHS. These directions of travel are shown as:

- Stronger clinical and financial rapport
- Greater patient involvement
- Deeper values-based behaviour

- Information-driven decision-making
- Increasingly supportive environments
- Larger networks of peer support

We are keen that these be recognised as described, that is as moves in a particular direction and part of an overall cultural shift. There are no doubt good measures to help identify if some teams or organisations are further along than others. Yet, part of an overall cultural shift in the NHS is acknowledging progress being made and ensuring it continues in this direction, rather than allowing it to regress. Certainly, we would be keen to make as much progress as possible, even though it often takes time and needs support.

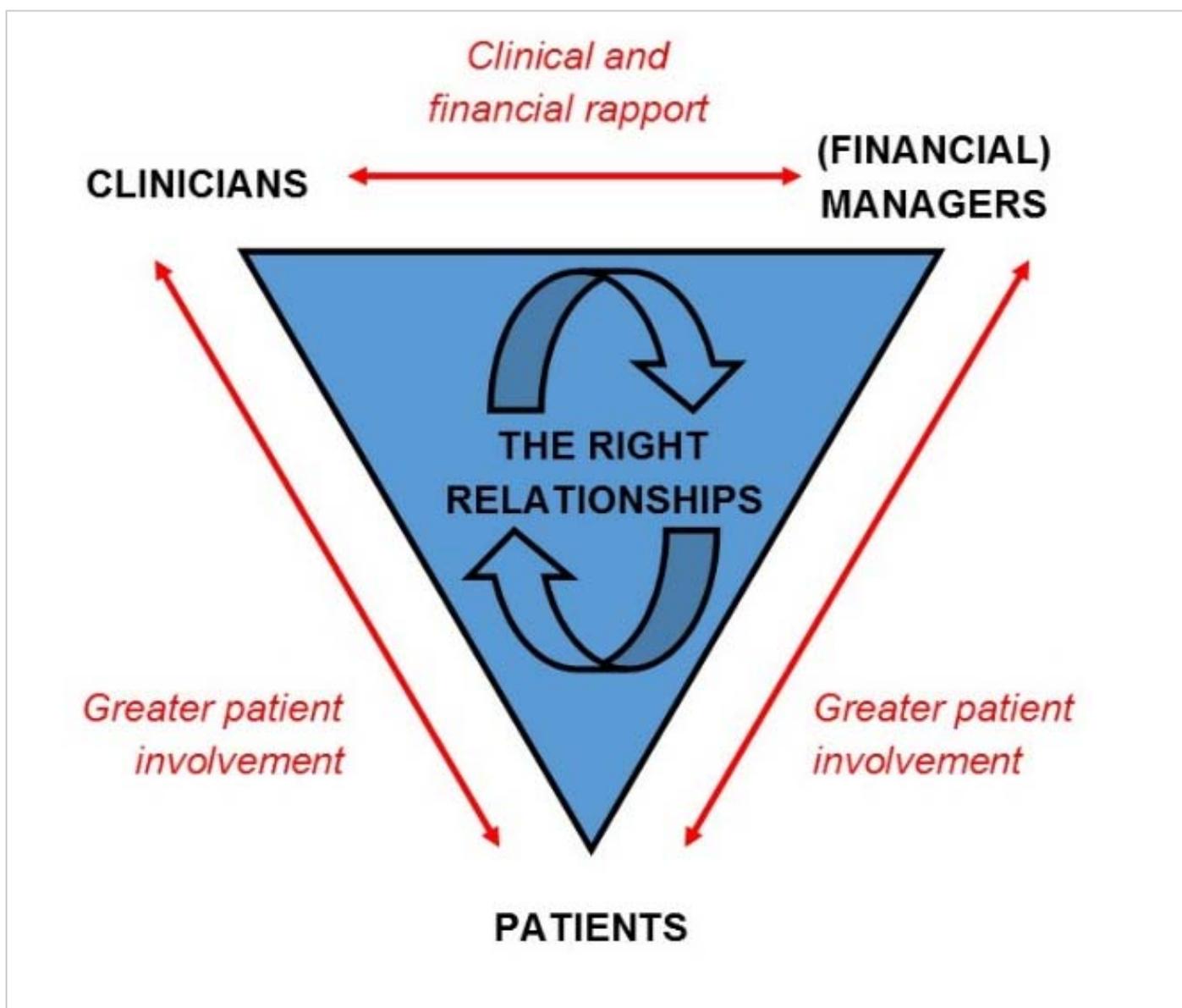
With this in mind, it is important to identify a restriction on our study and its conclusions. The culture shift we describe is mostly taking place within organisations and, to a lesser extent, across local health systems. Therefore, while we can identify what is being done to deliver value we can only acknowledge the impact factors outside of organisations have. Our study showed us on a number of occasions the challenge that external factors can have on decision-making.

A good example of this is where organisations encourage staff to be more open and reflective in the way they make decisions, in order to empower them to learn lessons and improve ways of working. Yet, if external factors, whether that be in regulation, politics or the media, allow this openness to be used against people and place blame on them or their organisation, this is likely to inhibit rather than empower. The report will indicate where this is particularly the case, but it is worth highlighting it now as an unavoidable constraint on organisations and their ability to deliver value.

8 THE RIGHT RELATIONSHIPS

Few people in health care could or should make decisions on their own. This study shows the complexity characterising many decisions, in particular those needing to fully consider the likely impact on the costs, delivery and quality of care. It is therefore important that the responsibility from these decisions be shared, so as to include as much relevant expertise and experience as possible. If a problem shared really is halved then health care offers no less important a setting than any to put this into practice.

Relationships of value



In *Changing Care, Improving Quality*, we drew attention to the importance of patients, clinicians and managers working together to make decisions about service reconfiguration.²³ This report emphasised genuine collaboration between these three perspectives and explained how this would take advantage of the insight they witness every day on how the health care system is performing. These relationships need though to be based on “real trust”, of the kind

²³ NHS Confederation (2013) – *Changing Care, Improving Quality*

described by Smith and Reeves, and everyone must believe their contribution is respected and has sufficient power within a process of co-production.²⁴

Relationships concern the way that two or more people or things are connected. In this study, we have identified an important conceptual relationship between quality, finance and also service provision in health care. More materially, this relationship implies an essential need for connection between patients, clinicians and (mainly financial) managers – as highlighted in the diagram above.

Our study explores these relationships in more detail and describes their influence in making decisions of value. It highlights two evident directions of travel for NHS organisations that will now be outlined in more detail along with the main challenges to realising a greater shift. These two directions of travel are towards:

- **stronger clinical and financial rapport**, and
- **greater patient involvement** in decision-making.

²⁴ Smith, Ed and Reeves, Richard (2006) - *Papering over the cracks? – rules, regulation and real trust*

8.1 STRONGER CLINICAL AND FINANCIAL RAPPORT

“My job used to feel like a ping-pong match between an executive that wanted you to hit targets and the ward that complained about quality of care. But now it feels different.”

Divisional director

A lot has been written about the engagement and relationships between clinical and financial colleagues.²⁵ It seems self-evident that a strong rapport between those most responsible for delivering care and those most involved in paying for it is essential for delivering value. Evidence has though been published by the Health care Financial Management Association (HFMA) indicating that 98 per cent of senior clinicians and 96 per cent of finance directors believe high quality services will only be affordable if clinical and finance colleagues are properly engaged to achieve the desired outcomes together.²⁶ Furthermore, 87 per cent of senior NHS leaders, questioned as part of the NHS Confederation’s annual survey, consider clinical support for and involvement in strategic decision-making very important for achieving change²⁷.

We heard repeatedly that the savings now required in the health care system necessitate greater involvement of clinical staff in decisions about how resources are distributed. Yet, our national survey results highlight that around three quarters of clinicians feel they are rarely or never involved in financial decisions that affect their whole organisation and, while these numbers fall as decisions have a more narrow impact, almost half of clinicians do not believe they are involved in financial decisions that affect just their service or team. It isn’t clear from our study how far these results reflect a perception among clinicians. When we asked clinicians in interviews about their involvement it was clear many did not always recognised how their input, for example into workforce planning, contributed directly to financial decision-making.

“A good relationship between me and the lead in the finance team is essential – we have both tutored each other. He has made me into a financial person and vice versa. Decisions should never be made in a silo.”

Medical director

Clinicians haven’t had much choice or agency in the savings made in the last few years, a large part of which has come from national pay restraint. Department of Health figures show that £10.8 billion savings were made in two years between 2011/12 and 2012/13. Of these, £3.4 billion were generated directly by a nationwide pay freeze, while further £1.6 billion savings each year came from pay costs within overall Tariff efficiencies. This makes the total savings from pay costs at up to 45 per cent of the total savings in the first two years of the QIPP programme.²⁸

Clinicians will certainly need to be actively involved in the decisions required as part of future efficiency savings, which are likely to demand much tougher trade-offs. Some of the clinicians we spoke to still believe they need to “make the

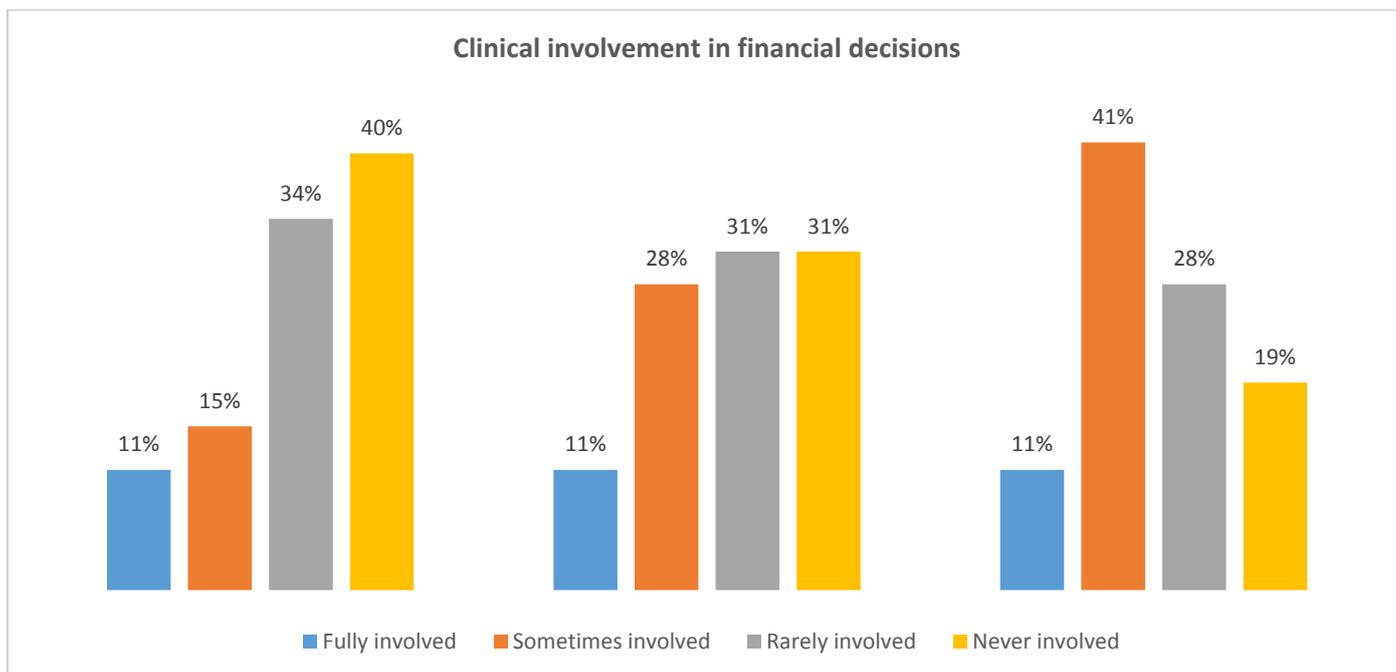
²⁵ Academy of Medical Royal Colleges, Faculty of Medical Leadership and Management, Health care Financial Management Association and NHS Confederation (2014) – *Two sides of the same coin*

²⁶ Health care Financial Management Association (2012) - *HFMA clinical financial engagement survey – clinicians*; Health care Financial Management Association (2011) - *HFMA clinical-financial engagement survey*

²⁷ NHS Confederation (2014) - *Member Survey 2014*. The survey had 547 respondents that were a mix of NHS leaders across NHS Confederation members.

²⁸ Department of Health (2012) - *Written evidence to the Health Select Committee inquiry on public expenditure on health and social care*

quality case” in the face of a financial imperative they feel is dominant and a few were even reluctant to accept that financial matters were a big part of their role as a clinician. This might in part explain why, in a recent HFMA survey, only 61 per cent of finance staff felt valued by clinicians, compared to 89 per cent who felt valued by their line manager.



Source: Decisions of Value survey

Nonetheless, most of the clinicians we spoke to understood the increasing importance that finance now played in their daily duties and recognised that they needed to become more involved in financial decision-making within their organisation. They indicated though that doing so might mean challenging a residual mind-set clinicians develop through training, from focusing on “the patient in front of you” to thinking about the needs of all patients now and in the future.²⁹ For the growing number of clinicians who move into management, it also takes a bigger adjustment with clinical priorities having to be shared with financial duties required as part of their management responsibilities. A number of clinical managers we spoke to told us they found this change difficult and they were still concerned about how far their clinical duties were diminishing.

“I found it really hard at first to separate the clinical from the managerial – for one thing, they get busy at the same time. How do you balance the needs of a patient with an important CCG meeting?”

Assistant medical director

In the course of the study we met clinical and financial professionals who believe they have come a long way in building strong relationships and who can demonstrate how this has contributed to better decisions overall. We heard testimonies from people who were confident that strong clinical and financial rapport was becoming the norm within their team. The recurring factor in each of these relationships was trust: trust from financial staff that clinicians were contributing to decision-making with an understanding of the financial context, and trust from clinical staff that finance colleagues appreciated the impact their decisions had on quality. They made it clear to us that these relationships had

²⁹ Gray, Muir (2010) – *How to get better value health care*

been established over time, particularly if previous clinical experience of not having views taken into account had contributed to a cycle of disengagement.

“I have no doubt that all the savings will now have a clinical impact. Clinical understanding of financial implications will mean they are more flexible in their approach to cuts. In one five minute meeting you can save £50,000 with no discernable clinical impact.”

Divisional director of operations

Unsurprisingly, communication was identified as a crucial factor in developing these relationships and many teams facilitate regular dialogue between clinical and financial colleagues, which in most cases takes place weekly. These meetings provide an open forum in which to solve problems as a team and offer a real opportunity to become familiar with how each other works. At the heart of these exchanges is a recognition that the experience and expertise of each part of the team needs to be shared to make good decisions. Obviously, the time resource that these meetings expend will need to be considered, but many of the people we spoke to expected the benefits across the team to outweigh the costs in most cases. These meetings will not be enough on their own to support better decision-making in most cases, unless they are complemented by real multi-disciplined team-working of those involved.

“I meet with clinicians on a monthly basis and try to attend as many clinical meetings as possible. I am always mindful not to turn down a clinical request without first understanding it and I will allow overspend if it improves quality.”

Directorate accountant

Of course, what will disempower clinicians in these exchanges will be a lack of necessary skills to engage, particular with regards to understanding basic financial information. A number of the organisations we spoke to offer explicit programmes that teach clinical and financial staff the basics of each other’s business. In 2009, the Academy of Medical Royal Colleges and the Audit Commission launched a guide to finance for hospital doctors and we discovered similar courses run by organisations to teach staff basic skills in finance.³⁰ Of course, this also works the other way round and there are examples of programmes to support a better understanding of medicine for managerial staff.³¹

“My job feels like making the clinical case against the financial one, but I don’t know the financial value aspects of it. I don’t know how much it costs for a visit, but I know it is expensive. I’d also rather know about cost improvement cuts made in other services, so I don’t feel picked on and can see the bigger picture.”

Nursing team leader

The Department of Health has established a measurement for assessing the levels of clinical and financial engagement. This highlights a greater shift in the number of trusts who believe that joined-up collaborative working between clinical and finance teams is the norm in at least one clinical specialty/directorate in their organisation, from 54 per cent in July 2012 to 61 per cent in July 2013.³² Although these figures do not indicate strong clinical and financial rapport as the norm across the NHS, as with our study it does reinforce the sense that things are moving in the right direction.

³⁰ Academy of Medical Royal Colleges and the Audit Commission (2009) - *A guide to finance for hospital doctors*

³¹ For example, please see HFMA’s *Medicine for Managers* briefings - <http://www.hfma.org.uk/hfma-policy-themes/knowning-the-business/>

³² Department of Health (2013) – *Effective clinical and financial engagement*

Lessons from the published literature

There appears frequently to be a dislocation between quality-related decisions on the one hand and finance-related decision-making on the other. There is also some evidence to suggest that the level of tension between these imperatives can be a source of division within and between health care professions and roles and in particular between clinicians and managers. Research has suggested that the role of senior finance personnel is subject to multiple interpretations ranging from a narrow accountancy role to a more strategic and proactive one (Moore 1991; Kisa et al. 2006). Clearly the role of finance offices can be central to decisions of value such as mergers, acquisitions, investment in new drugs and technologies, cost cutting and/or capital re-structuring programmes etc. Finance officers can also be instrumental in generating surpluses to invest in quality programmes.

Despite the limits of structural solutions there is some support for the notion of flatter organisational structures with more porous boundaries between units and groupings to enable sharing of learning and expertise. Greater connectedness between finance and other functions would seem to be especially important in decisions of value.

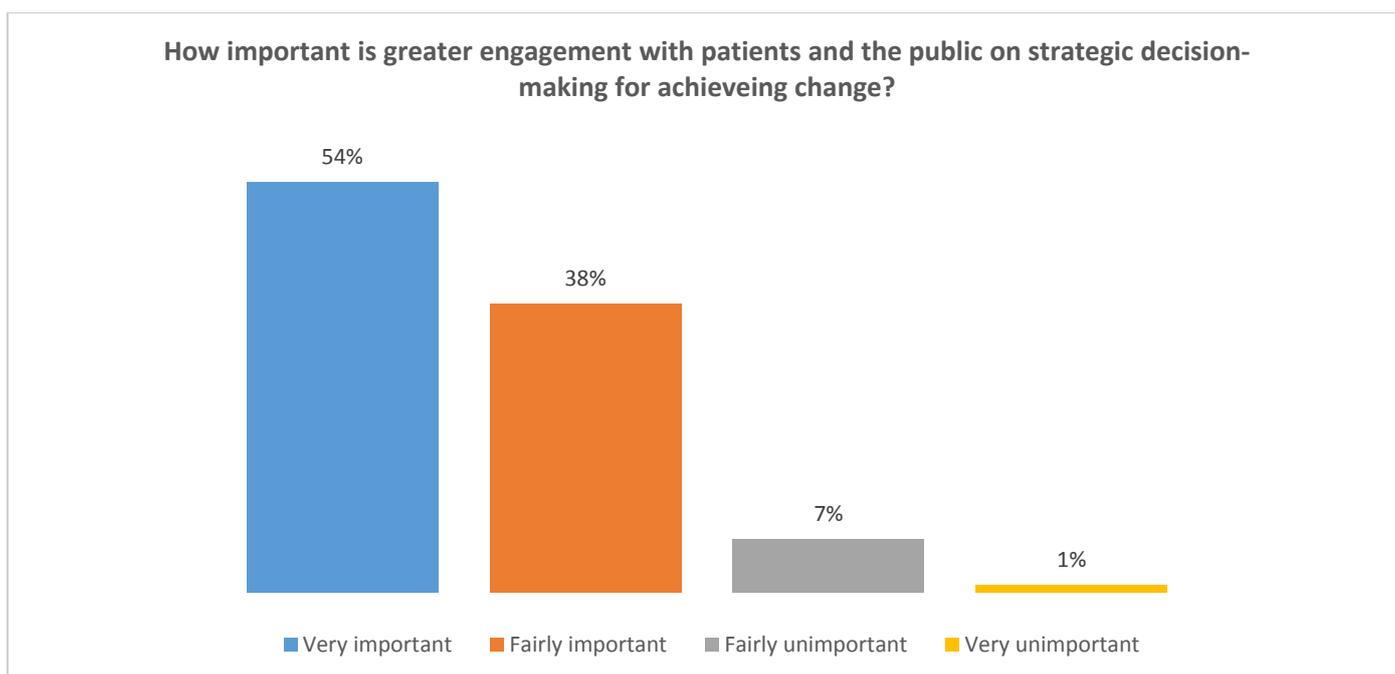
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8.2 GREATER PATIENT INVOLVEMENT

“Patient feedback should be fed into decisions, just as any other data - seamlessly.”

Clinical director

At the heart of the reports on the NHS over the last year is a comment on the way that the NHS has hitherto involved patients in decision-making. This was captured by the title of the Department of Health’s immediate response to the *Francis Report* – “Patients First and Foremost”.³³ Robert Francis was unequivocal that patients, not numbers, are what count and that it is not the system that will ensure the patient is put first day in, day out. A recent NHS Confederation survey reveals belief among NHS leaders that greater engagement of patients and the public is needed to support decisions, with 92 per cent saying it is either very or fairly important for achieving change.³⁴



Source: NHS Confederation survey

In *Changing Care, Improving Quality*, we highlighted the concept of co-production and described why it is essential to redesign services and enable people to feel part of their local health services.³⁵ If every voice is heard with sufficient interest, a dialogue between patients and the NHS offers an opportunity to create a closer association between the local community and their health services. We also explained how patients can offer a non-institutional perspective that can test proposals and challenge assumptions to see if they really are more convenient and better for patients, and not just simply for services themselves. Quality is about patient experience as well as outcomes, and decisions made with an impact on quality will need to consider the views of patients to understand this. Investigations of co-production by Nesta have shown not only a series of benefits to patient care, but also the potential to save over £4 billion from the NHS budget.³⁶

³³ Department of Health (2013) – *Patients first and foremost*

³⁴ NHS Confederation (2014) - *Member Survey 2014*. The survey had 547 respondents that were a mix of NHS leaders across NHS Confederation members.

³⁵ NHS Confederation (2013) – *Changing Care, Improving Quality*

³⁶ Nesta (2013) - *The business case for people powered health*

“For a long time, we have been working on having patients more involved in our decisions. We have patient and quality groups, which happen quarterly, and we make a real effort to get new patients along. We also have patients invited to sit on some of our interview panels.”

Service lead

However, when we spoke to patients directly they felt it was not yet the norm to involve patients in many decisions in the NHS. They did acknowledge the extensive consultations that many organisations undertake for a public response to planned decisions, but they felt this was not always genuine engagement and should go further.³⁷

Of most concern to the patients we spoke to was a belief that NHS organisations often paid “lip service” to the views of patients without actually allowing them the opportunity to influence decisions. As such, they found it difficult to recognise where they are actually influencing decisions. Many patients feel there can be a mind-set in the NHS that sees them as a hindrance and not constructive in contributing to decision-making. They felt this was an unfair perception and that patients engaged in the right way can help to understand the best way to deliver care for all patients within the resources available.

“Having patient stories at board meetings is very good, although it can be unclear from my point of view how much patients are engaged in redesign. Usually, it is not clinical care that patients complain about, it’s the administration and structure.”

Non-executive director

There seems to be little disagreement that patients should be involved in decisions in the NHS and that a shift in this direction would support decisions of value. Most of the people we spoke to felt their organisation was getting better at including the patient perspective, but that more could be done to make this better. We were told of specific examples where patient input had influenced decisions, yet there was an acceptance that this was often not explicitly communicated back. This was particularly the case when it came to patient feedback and complaints, which we were told was a powerful tool for supporting a decision.

“Ultimately this is about going back to basics – just asking the simple questions – most patient complaints are about communication.”

Head of nursing

Lessons from the published literature

There is a strong logic for involving patients and citizens in decisions relating to finance and quality. However the evidence base on how this should and does work remains thin. The logic of involving the public relates to their legitimate role in how public resources are spent and therefore has particular salience in relation to allocative decisions – for example priority setting, commissioning and disinvestment

The logic of involving patients derives from their status as the intended beneficiaries of health care services and their expertise in relation to understanding quality. There is therefore a particularly strong case for involving patients in decisions relating to organisations and services (i.e. more technical decisions) and any subsequent evaluation of these. The wider literature on public engagement suggests that it can be achieved but needs to be well-resourced and conceived, and should avoid charges of tokenism. The wider literature on

³⁷ An example of extensive engagement can be found in the North West London “Shaping a healthier future” consultation in which 17,022 responses were received following 200+ consultation events

patient involvement suggests that significant professional, cultural and organisational impediments need to be removed before meaningful engagement can be achieved

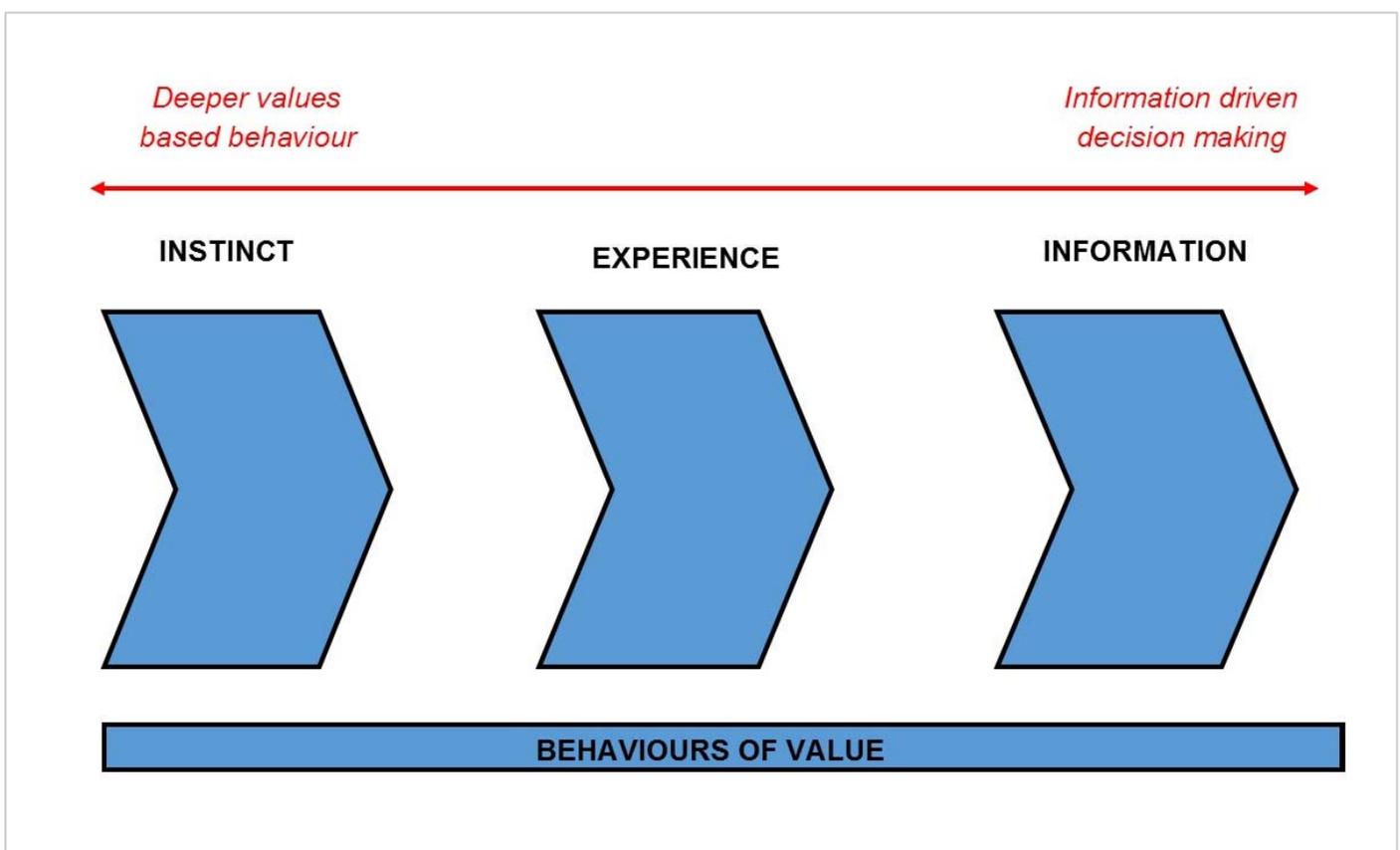
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9 THE RIGHT BEHAVIOURS

Relationships of value focus on how decisions can and should be shared by different people so as to relieve pressure and combine skills and experiences in the decision-making process. These relationships will partly define how people behave. Yet, there is still a need to explore individual behaviours to understand the impact that these have on decision-making, and indeed on forming those relationships.

Behaviours concern the way in which people act or conduct themselves in response to a particular situation. In this study, we have explored numerous decisions made in the NHS regularly and a crucial aspect in understanding what affects these is to understand the way people behave in making them. Specifically, we are looking at the processes, often internal, that decision-makers go through in order to select a course of action. Three main aspects in particular stand out as those that often govern decision-makers: instinct, experience and information – as highlighted in the diagram below.

Behaviours of value



Our study looks at behaviours in more detail to explain how it impacts on making decisions of value. It describes two evident directions of travel for NHS organisations that will now be outlined in more detail along with the main challenges to realising a greater shift.

These two directions of travel are towards:

- **Deeper values-based behaviour**, and
- **More information-driven decision-making**

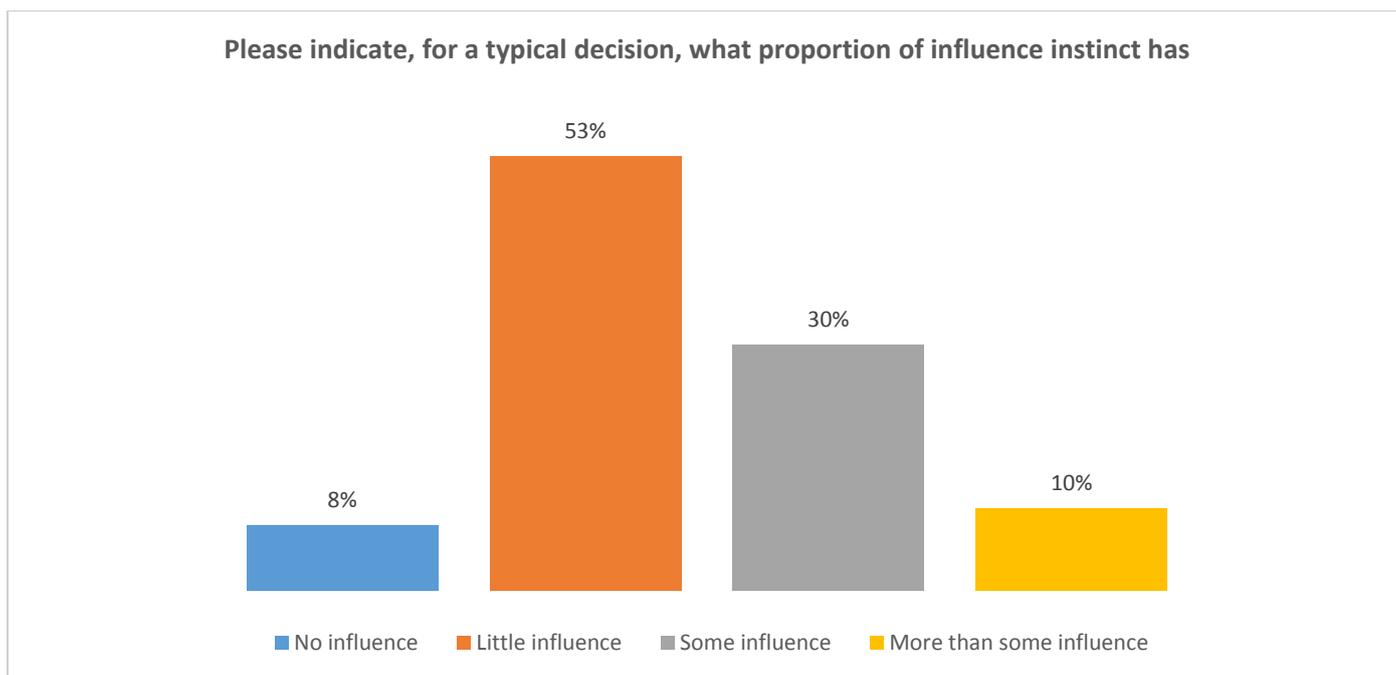
9.1 DEEPER VALUES-BASED BEHAVIOUR

“The everyday rush makes it hard to share and embed the organisation’s values. I believe that most people share the same values, but sometimes it feels like people don’t have a vocation any more, they have a job. People need the space to think about values. Lower bands are not engaged in values because they simply do not have the time or space. If you don’t have access to time, you can’t think about values.”

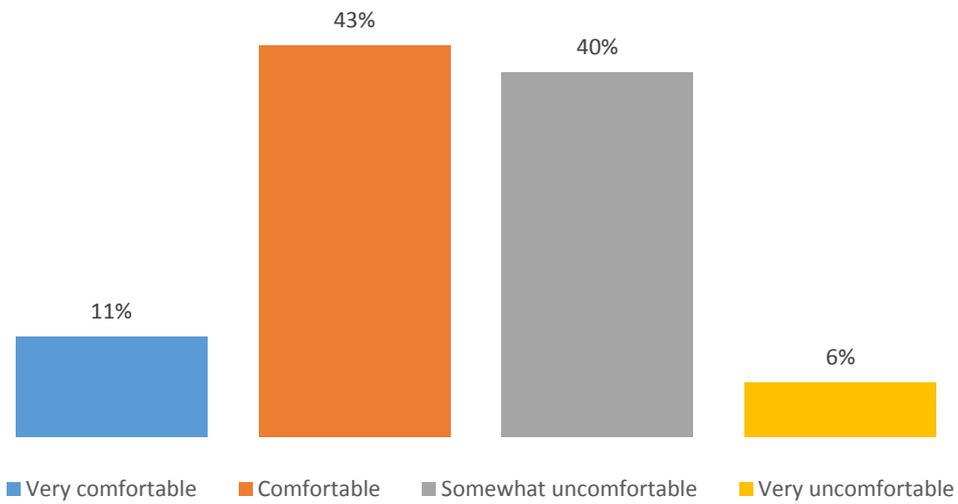
Medical director

A fundamental part of any norm are the values that guide how people behave. All the organisations we spoke to have taken time to define their organisational values to make clear how people are expected to behave. These values seem really important to the way an organisation, and its staff, behave because they establish the tone for what constitutes acceptable behaviour, forcing exceptions to stick out.

When consider the importance of values, it is interesting to note the extent to which decisions are driven on the instincts of decision-makers in the NHS. Our national survey suggests that only a few decisions in the NHS are made based on instinct, yet where people do use it they sometimes feel uncomfortable with how reliable it is. In the survey, 60 per cent of respondents indicated instinct had little or no influence on their decision-making and when they were required to use their instinct 46 per cent felt somewhat or very uncomfortable in its reliability.



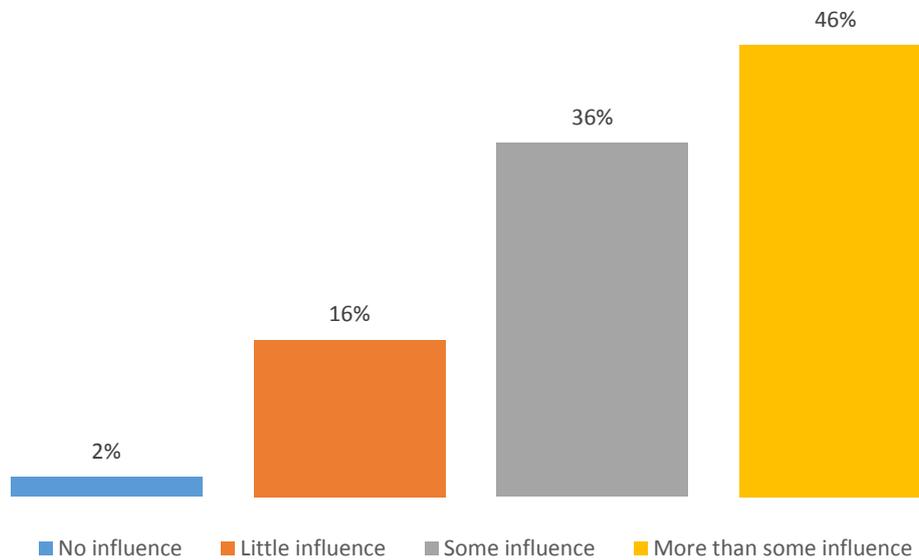
How comfortable do you usually feel with the reliability of using instinct in decision-making?

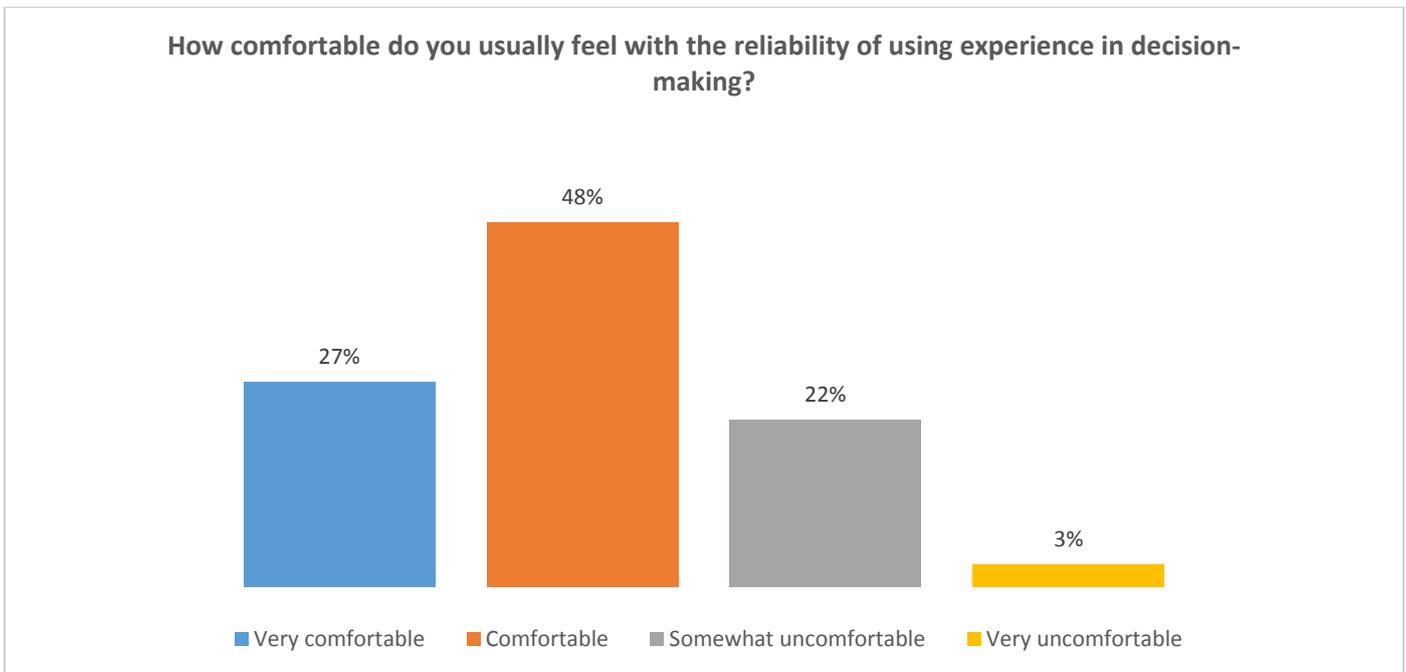


Sources: *Decisions of Value* survey

Nonetheless, some of the people we interviewed told us they did sometimes rely on a “gut feeling” on what the right decision might be. One reason why they might feel slightly uncomfortable with making decisions based on instinct could be the fact it is often used in the absence of experience. The national survey shows how far people use experience to make many decisions and the extent to which this is seen as a reliable way to behave.

Please indicate, for a typical decision, what proportion of influence experience has





Sources: Decisions of Value survey

Many people seem to find comfort in having values defined across an organisations. On first glance, many of the values defined by different organisations appear broadly similar and relatively straightforward. Some reinforce the importance of putting patients and staff at the core of everything the organisation does, most commit to being respectful, caring and innovative. Nonetheless, the values that have been established, usually with staff and the public, are essential features for any organisation and there is no doubting that having values articulated in a clear and accessible way is a must in the NHS.

“Our values are being developed by staff, but the message gets easily lost. The next step is the difficult bit – embedding the values in the way we work.”

HR business partner

Many of the people we spoke to suggested that the process for establishing the values in their organisation was really important for bringing about a culture and identity which staff can be proud to work for. Some indicated that the values created were already upheld in the way they work, but that the process of defining them reinforced this behaviour as the norm. We were told of some teams taking them further to establish a stronger set within their environment of how they expect each other to behave.

Communication is important so that staff are fully aware of the values established and how they are being delivered. A key factor in how values are received is the mind-set of people receiving them. We did hear cynicism from some of the people we spoke to about values and scepticism that the values established really were being upheld. There is also a concern that values can often be demoted at times of crisis. Certainly, the test for any set of values is how they are supported every day and whether people are held to account for behaviour against those values. Like in developing relationships, this culture shift relies on trust and takes time to develop.

“Values slip when expectations are too high and resentment soon sets in.”

Nursing team leader

The real challenge seems to be how to maintain momentum in the values once they are established. Some organisations are embedding their values within the recruitment process, so as to ensure the right values are upheld from the start.³⁸ Other organisations are also exploring how to refresh their values to ensure they remain relevant, without appearing to undermine those already established.

Lessons from the published literature

There is a considerable literature on the role of values in clinical decision-making but far less on decisions in systems and organisations. Studies have highlighted the gap between the ethical principles of cost-effectiveness analysis (e.g. as encapsulated in the Quality Adjusted Life Year) and the social values of wider communities and societies. The importance of allocative decisions being informed by wider social values has therefore been emphasised. The non-health literature on public service motivation has some application to tier three decisions. For example this literature would suggest that altruistic professional and personal values are likely to be important in decision-making, alongside other considerations

Some further insights might be gained from the non-health literature drawing on personality theories and the discipline of psychology. Literature relating to decision-making under pressure suggests that stress affects memory, executive functioning and decision-making with decision-makers reverting to more emotional feedback in order to make decisions, even when factual, objective information is still available, and that individuals do not systematically consider all relevant alternatives when under stress.

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³⁸ These moves are supported by a Values Based Recruitment (VBR) project led by NHS Employers and Health Education England

9.2 MORE INFORMATION-DRIVEN DECISION-MAKING

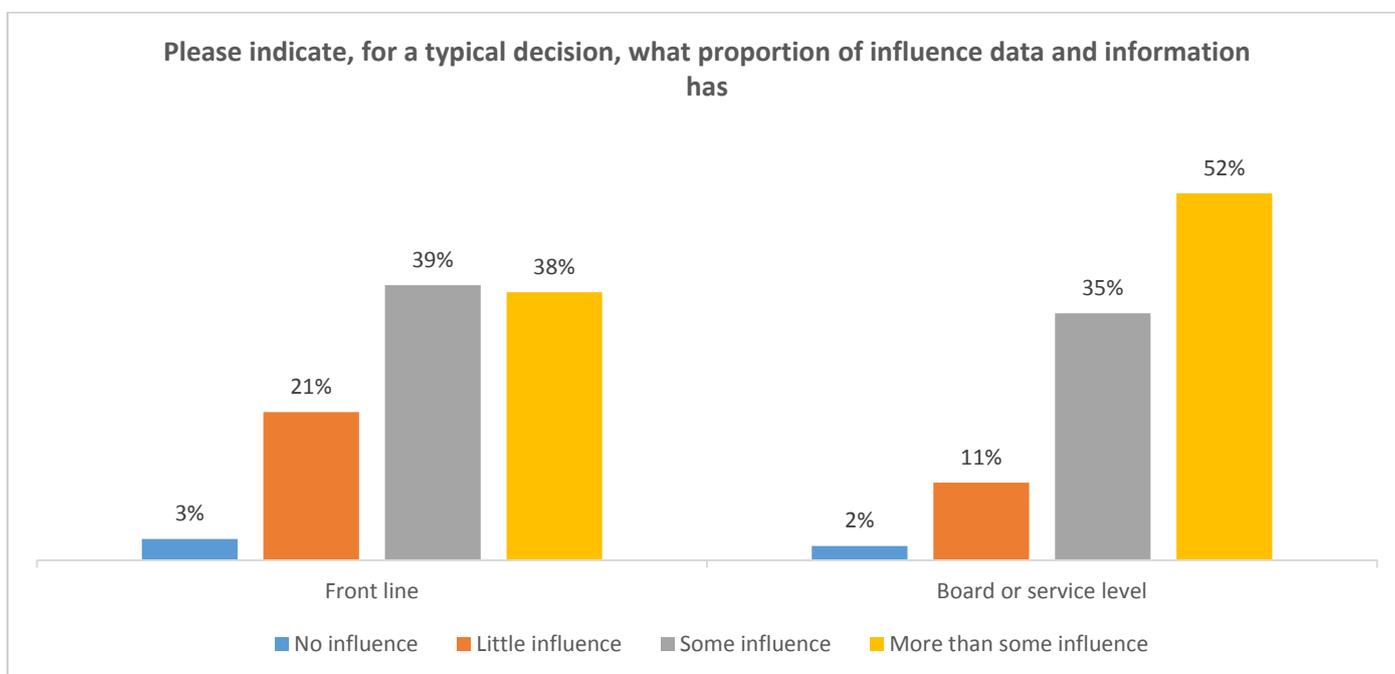
“Data is essential but it needs to be triangulated with instinct and experience. For example, data might show you that a ward has the correct staff to patient ratio, but it will not show the acuity of the patients involved – judgments often depend on what you have seen before.”

Head of nursing medicine

Data and information plays a significant role in making decisions of value. All decisions will be based in some part on information, although where there is less information factors such as instinct and experience will likely come to the fore. We heard that data and information was playing a bigger role in decision-making now at all levels. Our national survey indicates that more than half of people at a board level see data and information having more than some influence over their decision-making. This contrasts slightly with people on the front line, although 38 per cent still feel data and information has more than some influence.

“Sharing comparative data from different wards stimulates the question – what is being done differently?”

Chief executive officer

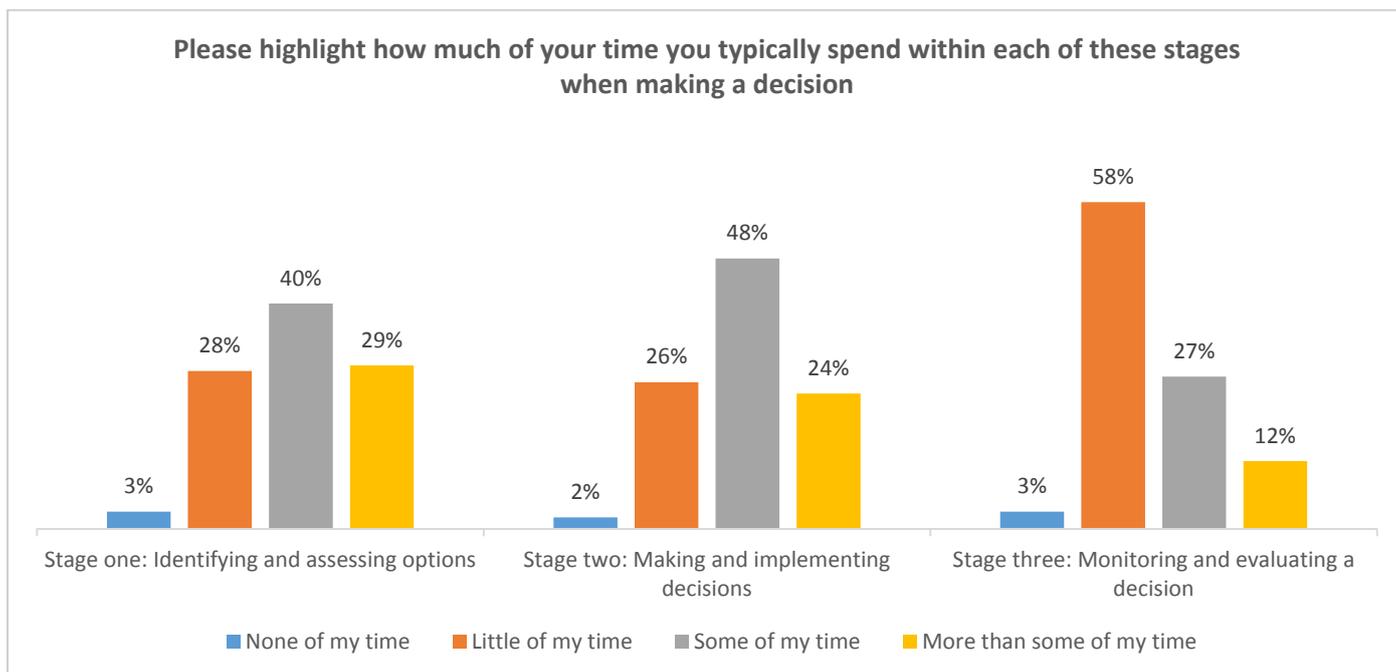


Source: Decisions of Value survey

However, the people we spoke to were sure that information had a bigger role to play. In particular, many people thought that not enough time was being spent using information to evaluate decisions after they are made to learn lessons and adapt if necessary. In our survey, 61 per cent of people indicated that they spent little or no time assessing and evaluating a decision. This compares to 28 per cent when making and implementing decisions and 31 per cent when identifying and assessing options. Many people told us that the decision-making process would be less problematic if you could rely on a robust evaluation to monitor the impact and make adjustments where needed.

“It is very hard to get the monitoring aspect of a decision right because a new crisis often intrudes at this stage. You end up going from one crisis to the next – it can make you feel very reactive”

Assistant medical director

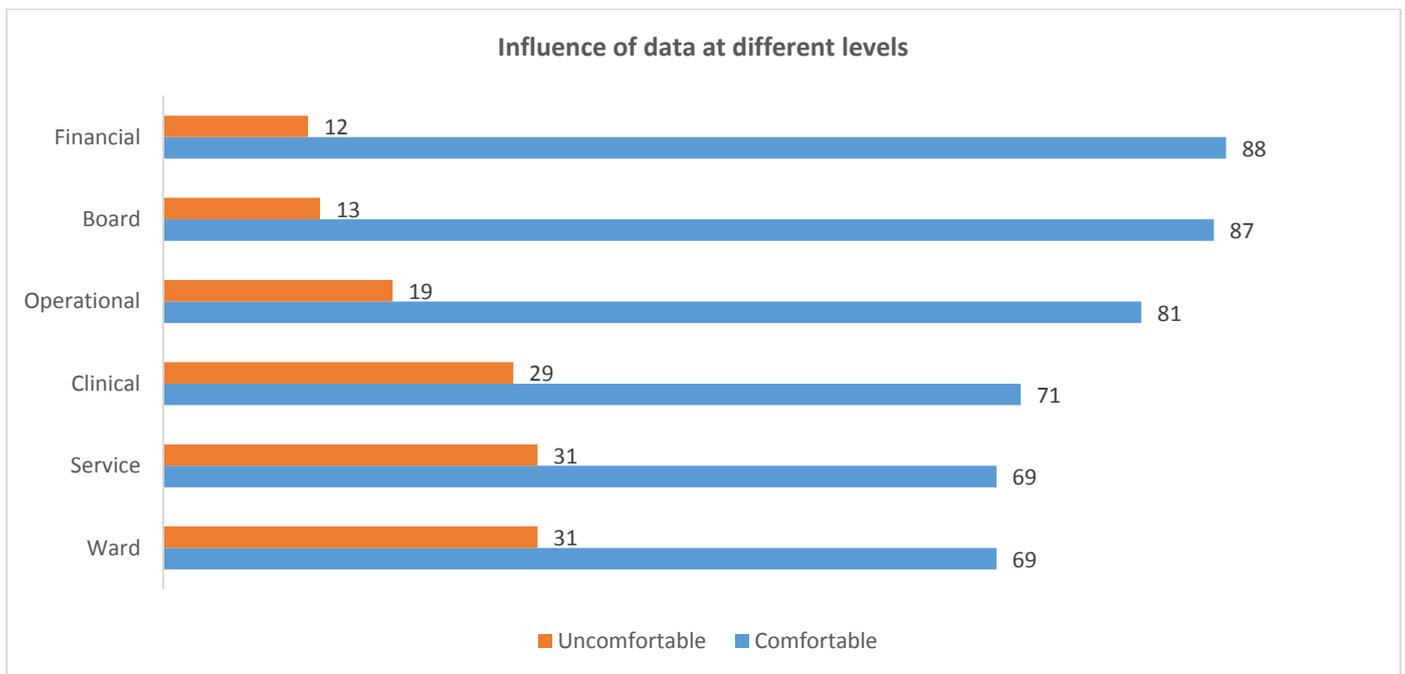


Source: Decisions of Value survey

A challenge presented to us with regards to the use of data and information was the extent to which staff were comfortable using it to make decisions of value. Clinicians are certainly adept at using data when it comes to their clinical duties, but with organisation decisions they appear to see it as less reliable. Overall, most staff are comfortable with the reliability of using data and information in decision-making, yet staff at the ward and service level, as well as clinical staff overall, are less so. It is also important to recognise where a desire for information might be inhibiting people to make decisions. We were told of delays in making decisions because the “right” information wasn’t available and that in some instances a better decision could be one made promptly and instinctively. What was important for most people was understanding the point at which information becomes intelligence.

“In an idea world, I would want to spend one day a week working with business intelligence to inform my strategic thinking - this simply doesn't happen.”

Clinical director



Source: Decisions of Value survey

Mind-set appears to be a big challenge for improving the use of data and information. *Challenging Bureaucracy*, a study by the NHS Confederation looked at the collection and use of data in the NHS. It showed that clinical staff largely understood the value of the data they collected and its relevance to patient care, but felt more could be done to increase the value of what is already collected.³⁹ Some of the people we spoke to felt an instinctive distrust for the data and information being used, either because they thought it inaccurate or suspected it was being used against them.

Data has a natural tendency to be detached from specific contexts and many people told us of times where they had been presented with data they simply did not recognise from their own experience on the ground. There were also a number of examples given to us of people who did not feel empowered to use the data and information available to them because they were not aware of why it was being collected. Medical Royal Colleges believe that a fundamental shift from separate management data collections, to extractions from standards-based and patient focused electronic health records will improve data accuracy and clinical buy-in thus driving better decision-making – not to mention improve the quality of care.

“In our team, we have set a day aside to do audits and the results are presented to the team with an explanation for why certain indicators may be in the red. For example, might be because of malfunctioning instrumentation and we can turn a negative into a positive – ‘well done for doing what you could with bad instrumentation’.”

Ward manager

An apprehension that data and information could be against them was a common concern from clinical staff. This was not necessarily an accusation against their organisation, but rather an example of the impact of external factors. A good example can be found in the use of data and information provided by the Friends and Family Test in acute

³⁹ NHS Confederation (2013) – *Challenging bureaucracy* - the review include interviews with 79 clinical members of staff and 89 managerial and administrative staff

services. Many people we spoke to felt this could be a powerful tool to empower staff to understand how patients experienced the services they are providing and allow them to reflect and measure improvements. In the public domain however this information has been widely used in the media to shame particular hospital wards, thereby reducing the likelihood that staff will embrace it.⁴⁰

Lessons from the published literature

There is a growing literature on the role played by evidence and information on allocative decisions in health and social care. These generally indicate that information vies for primacy with other drivers and agendas. The role of information in organisational (technical) decision-making is less well understood despite substantial investment in health care informatics. Such evidence as exists suggests that improved communication between functions within organisations – including finance, informatics and service delivery – promises to improve overall performance.

There are grounds for believing that decision-making is enhanced where investment in option appraisal, decision modelling, and other forms of information and analysis is greatest. However this should be offset against opportunity cost of investing resources in this area. A good example of this is formal cost-effectiveness analysis which has been applied with some success to allocative decision-making at tier two but which remains something of an expensive luxury at sub-tiers.

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⁴⁰ “NHS shame: list of wards patients did not recommend” in *Daily Telegraph* (30/07/13)

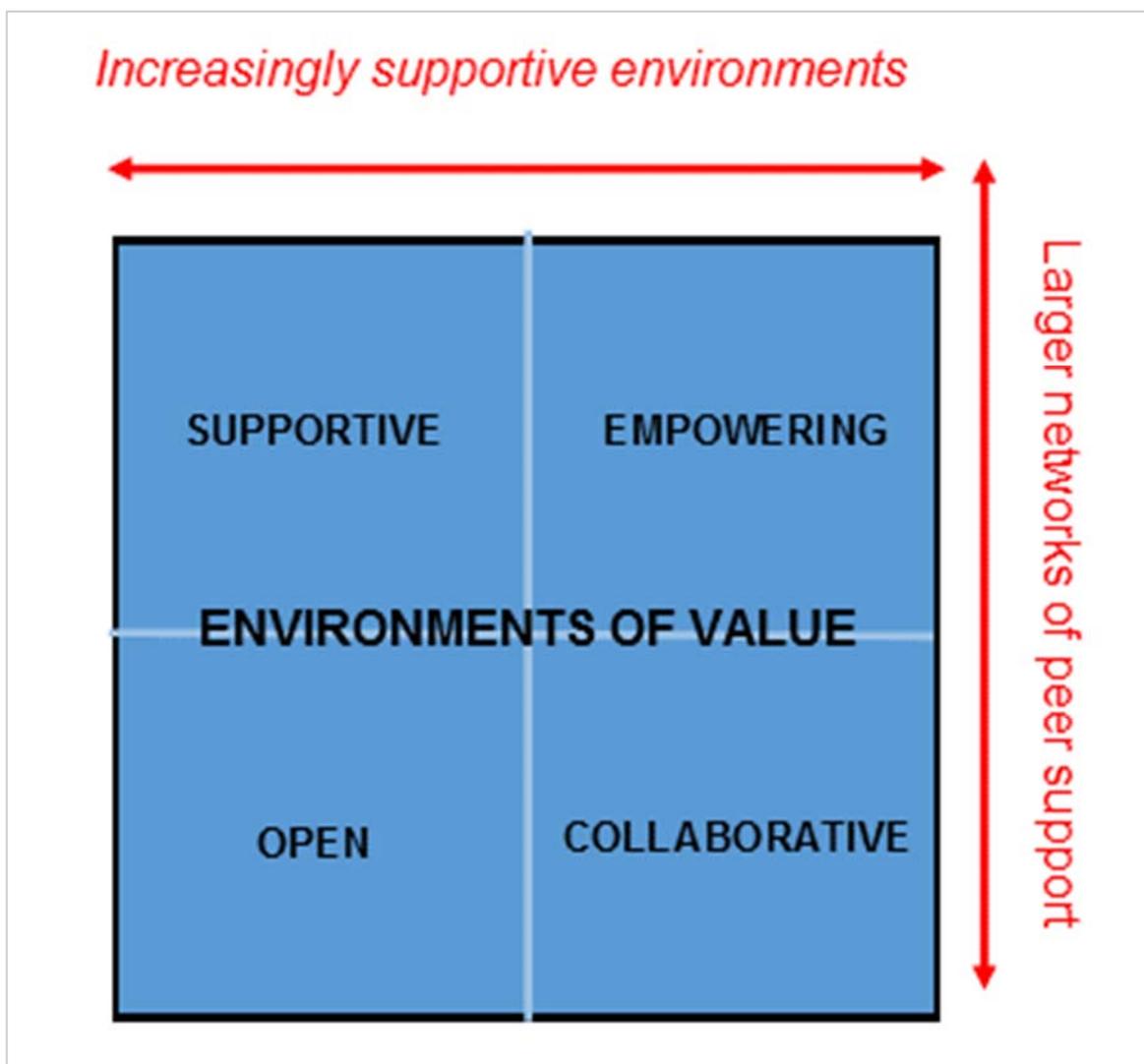
10 THE RIGHT ENVIRONMENTS

Bounded rationality implies that decision-makers are limited in their ability to make 'rational' decisions by a number of factors, not least the environments within which they operate.⁴¹ As a result, decisions tend to reflect an optimal choice on the part of the decision-maker *given the constraints applied*. To understand the decisions made in health care, we will need to look at the environments those decisions are being made and consider their impact.

Environments concern the surroundings or conditions in which a person lives or operates. In this study, it has become increasingly obvious that the health care environment is seen as unique among decision-making settings and there is an essential need to understand it. Specifically, it is important to understand whether the lack of any kind of optimal environment to make decisions renders it harder for health care to balance quality and finance and if this will get more difficult in the future.

The primary aim should be for any environment to empower people as far as possible within the decision-making process, while also being as open, supportive and collaborative as possible – as highlighted in figure seventeen below.

Environments of value



⁴¹ Simon, Herbert (1978) - *Rational decision-making in business organisations*

Our study looks at environments in more detail to explain how they impact on making decisions of value. It describes two evident directions of travel for NHS organisations that will now be outlined in more detail along with the main challenges to realising a greater shift.

These two directions of travel are towards:

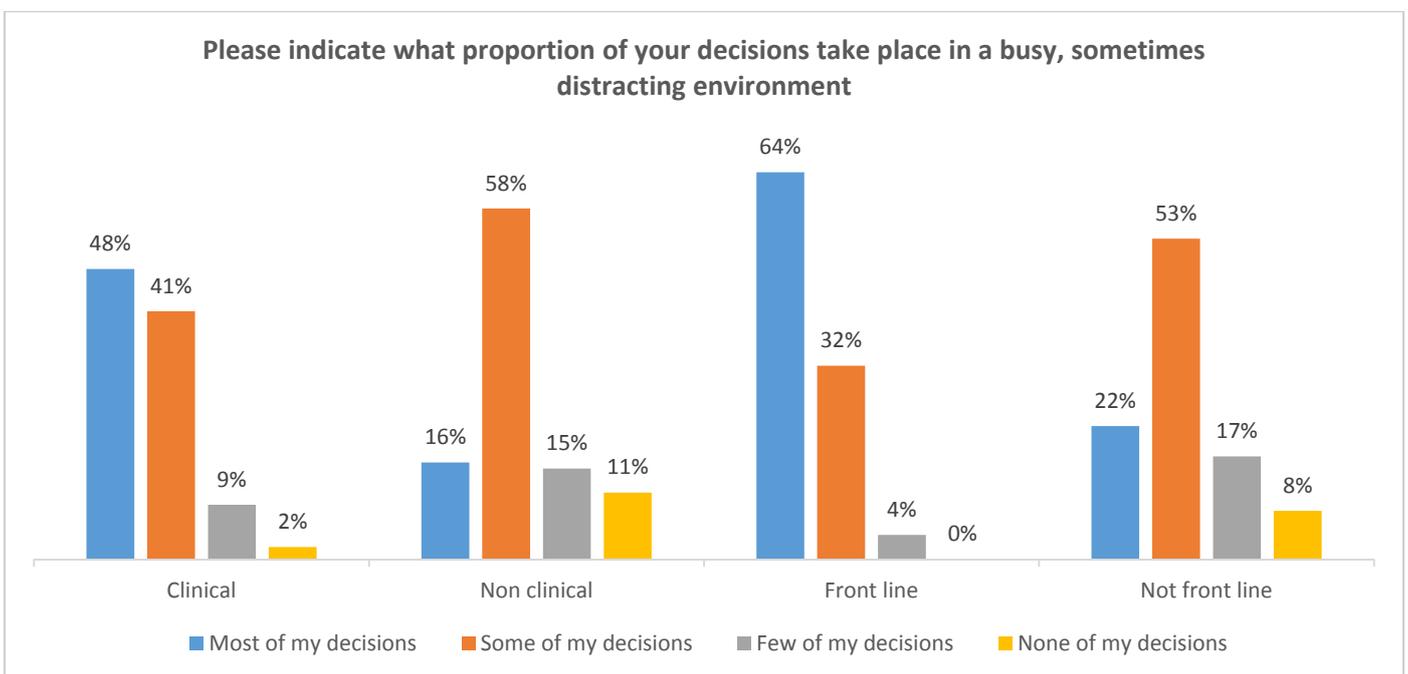
- **Increasingly supportive environments**
- **Larger networks of peer support**

10.1 INCREASINGLY SUPPORTIVE ENVIRONMENTS

“Front line staff are too willing to go the extra mile – you cannot forget there is a patient at the other end. But, this can lead to fatigue. 60 hour weeks are just not sustainable and will inevitably impact on value.”

Nursing team leader

When we began to explore environment we expected to hear about how challenging health care is to work in. Many of these assumptions were confirmed and our study highlights perceptions that are important to acknowledge. Almost half of clinical staff say that most of their decisions are made in a busy, sometimes distracting environment - this compares to 16 per cent of non-clinical staff. Furthermore, 64 per cent of front line staff believe their environment is busy in contrast to 22 per cent at service or board level. Our discussions highlight that people do feel you can get used to the sometimes intense nature of health care, but it often takes time and a particular mind-set.



Source: Decisions of Value survey

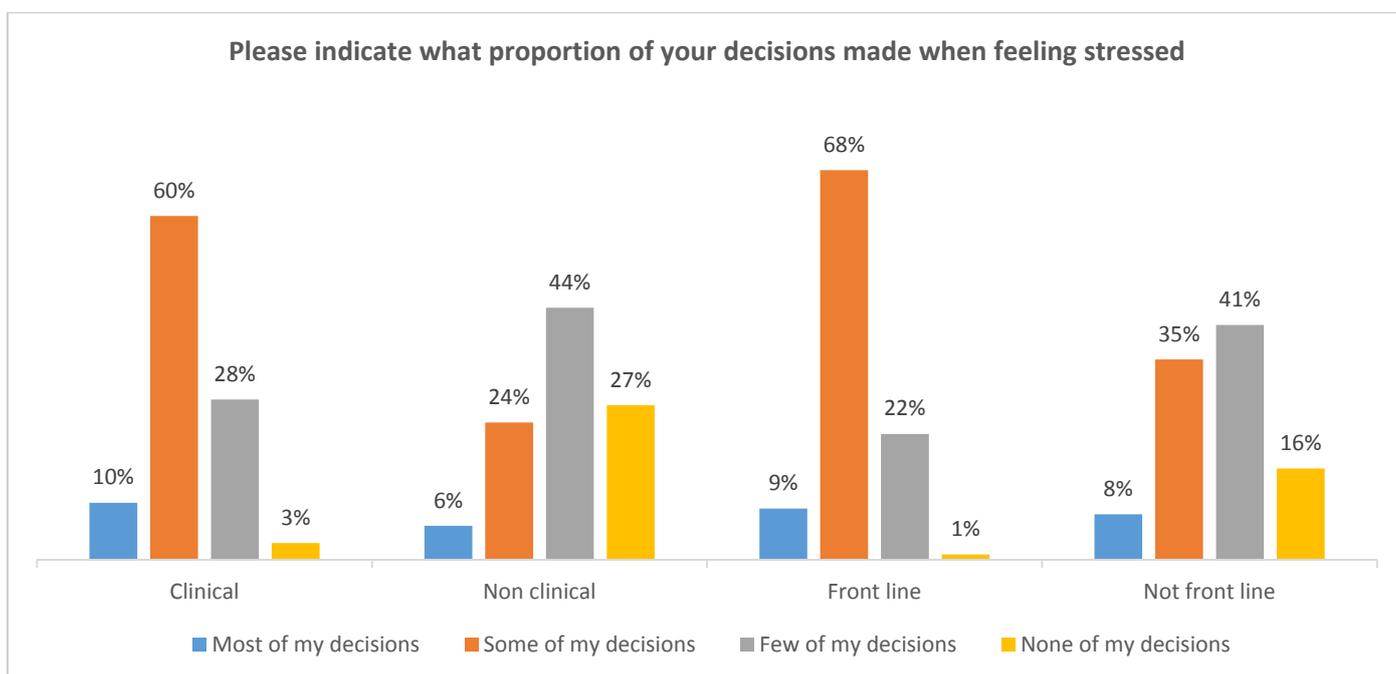
It is important to recognise that while we discussed environments with people in the confines of contributing to organisation decisions, rather than clinical decisions, many felt the lines between these two were often blurred. Clinical managers in particular told us they often had little time to contribute to organisation decisions and so these duties were often conducted in between clinical and other duties. Some even told us they usually took this type of work home or else worked longer hours. These discretionary efforts were not unfamiliar to most people and were often recognised within teams. Some people refused to bring their work home with them, but this often meant their time in work was more difficult as a result. Our study supports the findings from the most recent NHS staff survey, which shows that 71 per cent of staff work extra hours.⁴²

⁴² NHS Staff Survey 2013 – see <http://www.nhsstaffsurveys.com/>

“We can only ask people to do so much before they leave. As a manager, I don’t feel I can do much to relieve the pressure. I can only reassure them we are all in it together and that it will eventually get better.”

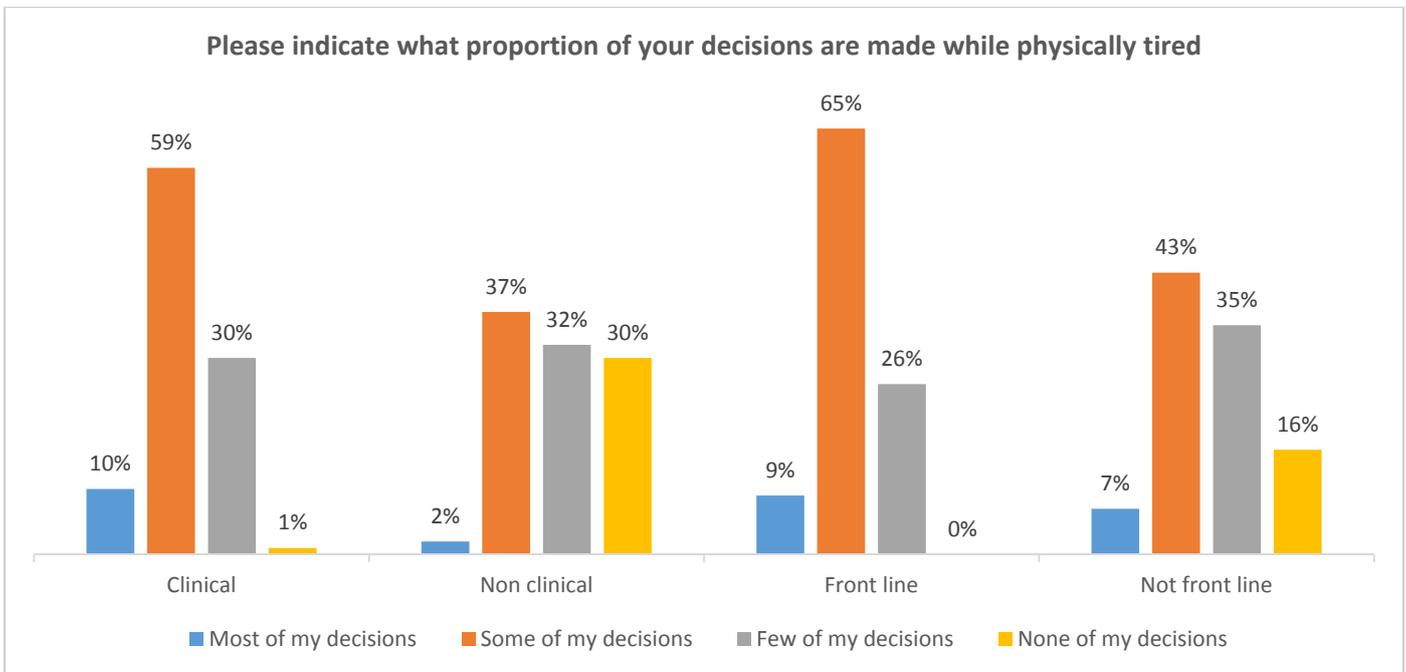
Service lead

The sense we got from the interviews was that most people accepted that health care will always be a challenging environment to work in and that they had generally recognised it as part of their vocation since they came into the NHS. Yet many of the people we spoke to believed it was starting to get worse and they were concerned about how bad it might get. This seems to be reflected in the number of people feeling stressed when making decisions. The survey shows a large majority of both clinical and front line staff noting that some or most of their decisions are made when feeling stressed. The most recent NHS staff survey indicates that 38 per cent have suffered from work-related stress in the last 12 months.



Source: Decisions of Value survey

It stands to reason that stress is not conducive to good decision-making and so it is not unreasonable to suggest that this environments can impact on decision-makers ability to balance quality and finance. The consequence for this can also be shown in the responses we received with regards to decisions being made while feeling both physically and mentally tired. The survey again shows a large number of clinical and front line staff making decisions while physically tired, but also shows an impact on other staff as well – shown in figure twenty.



Source: Decisions of Value survey

The picture this paints is a bleak one. The study shows many people feeling tired, stressed and distracted when making decisions. This is at a time when we are looking for people, particularly clinical staff, to be more engaged in decision-making to deliver value. People told us candidly how this environment was leading them to make bad decisions or to withdraw from some decisions altogether. It also makes it harder for them to develop and maintain the types of relationships and behaviours expected of them as part of the culture shift in the NHS.

Senior leaders and their organisations seem to understand these pressures and are looking at ways to support staff health and well-being. A recent survey of finance directors by the King’s Fund highlighted their main cause for concern in their organisation’s performance being staff morale.⁴³ Work is underway to look at how staff health and well-being could be improved in many organisations, although this has often focused on it as a responsibility of the employer, for example to reduce sickness absences, rather than in their interest as part of a strategy to improve decision-making.⁴⁴

“We need to create a positive experience feedback loop – ‘your idea is really interesting’ – so they are more likely to come back with more. Cannot have a negative experience feedback loop – “that’s a terrible idea” – because they won’t engage anymore.”

Assistant medical director

Senior leaders we spoke to felt that improving service delivery, so there was an appropriate model of care for the patients coming through the door, would naturally improve the environment in the NHS though they doubted this was likely to happen rapidly. There was a sense that greater empowerment and identify would improve the mind-set of staff and help them to feel more engaged and comfortable with their environment. Certainly, some of the people we spoke to felt more stressed in situations where they felt they were being ignored. As such, it is hard sometimes to see

⁴³ King’s Fund (2014) – *Quarterly Monitoring Report*. This report include the views of 74 trust finance directors and 47 CCG responses.

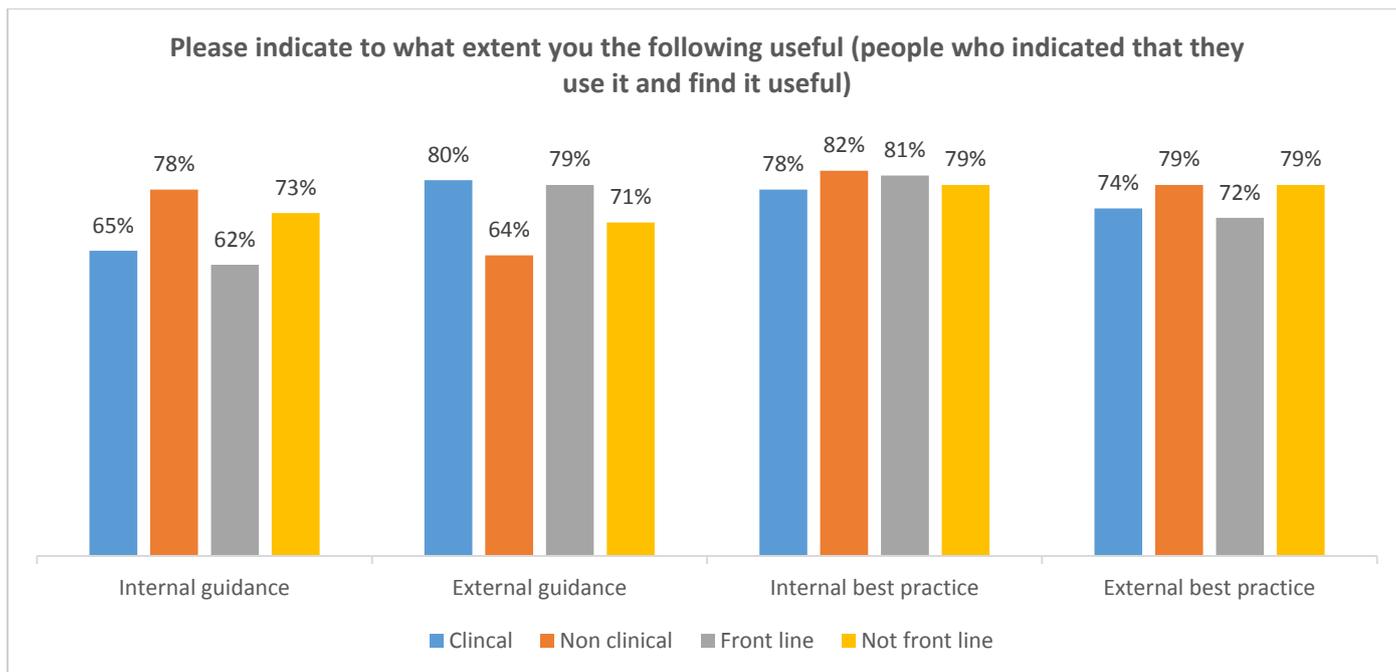
⁴⁴ See the Health, Work and Wellbeing initiative led across government and looks to improve the general health and wellbeing of the working-age population

what needs to come first between empowering staff or improving environments; both must progress to have maximum effect.

“We need more positivity. Nobody hears about the thank yous – we need to publicise and publish the positive.”

Head of nursing

When we asked specifically about what support decisions makers used and how useful they found it, there were positive responses about some of tools people used. Guidance, both within an organisation and from national bodies, was used by most people and they generally found it useful. Of particular use was accessing best practice from within their organisation or across the NHS.



Source: Decisions of Value survey

Lessons from the published literature

A range of contextual factors can influence decisions relating to quality and finance in health care. This is illustrated in the literature through studies of, for example: the effects of reimbursement mechanisms on technology adoption; system characteristics and case managers' resource allocation decisions; culture and quality improvement; organisational characteristics and hospital capacity management decisions. Research indicates that the composition of senior management and the relationship of this to the units of delivery can be important for decision-making. Various prescriptions (e.g. Service Line Management, Clinical Microsystems improvement) have been put forward to optimise these relationships.

The greater range of regulatory factors may induce raised levels of risk aversion in health care decision-making. There is also a body of literature relating to 'dynamic decision-making' – defined as having four characteristics. These are as follows: A series of decisions is needed; the decisions are not independent; the state of 'the world' changes during the decision process; the decisions are made in real-time. In these circumstances, the decision-maker cannot control when, or how often, they have to make decisions.

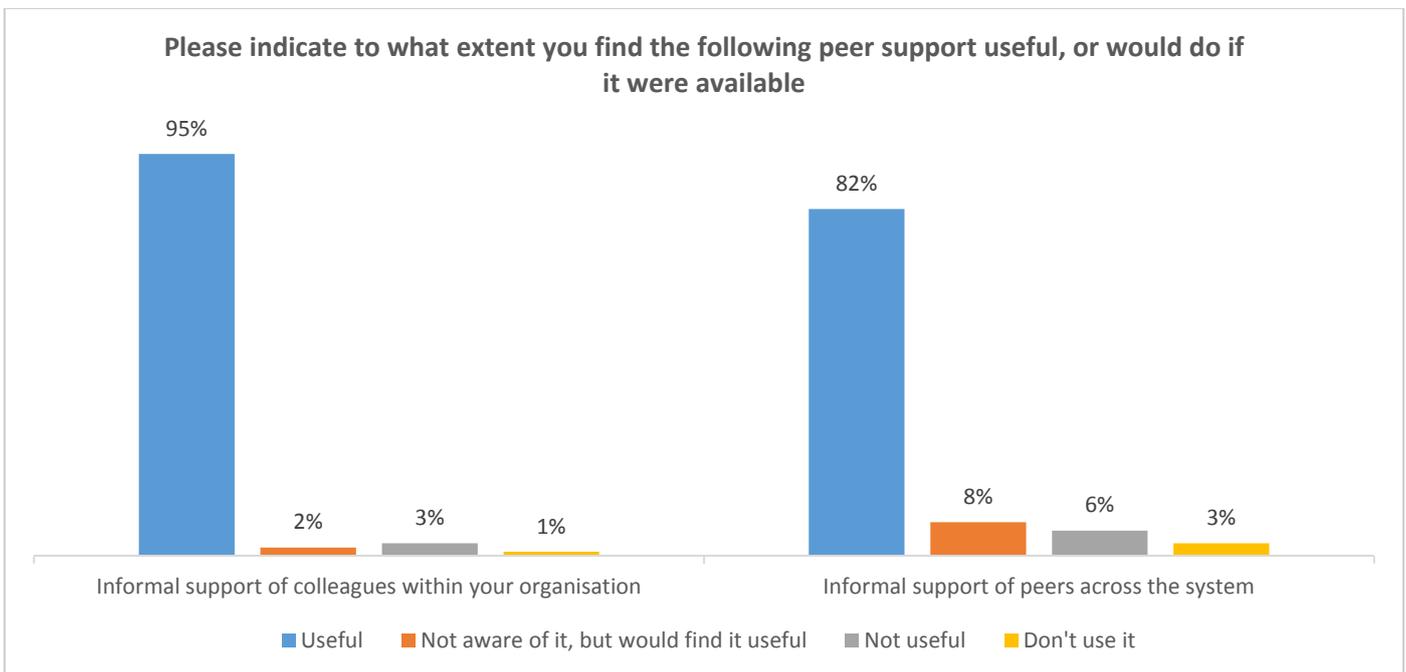
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10.2 LARGER NETWORKS OF PEER SUPPORT

“Clinicians are very good at networking – how can we tap into that?”

Director of acute services

The NHS has a strong tradition of peer-to-peer support and it is clear from our study that many people find this to be a valuable resource when making decisions. Peer support is generally understood to be a mutual exchange and interaction between like-minded colleagues, which is based on respect and understanding, and survey evidence shows it is a leading source of support. Figure twenty two shows that 95 per cent of people, across most levels and backgrounds, access informal support from colleagues within their organisation and find it useful. It also shows that 82 per cent that find peer support across the system useful and a further 8 per cent would find it useful if it were available.



Source: Decisions of Value survey

The survey results highlight the extent to which peer support is a crucial part of decision-making and although this is reflected across all levels, it was clear from the staff we spoke to that it was more firmly established within the clinical field. Clinicians told us they had strong links with peers often established during their training and were usually with peers outside their own organisation. The nature of these relationships were mainly clinical and focused around a particular specialty or service.

“The support I receive from my peers is really useful, but it is not aimed specifically at supporting me in my managerial roles.”

Clinical director

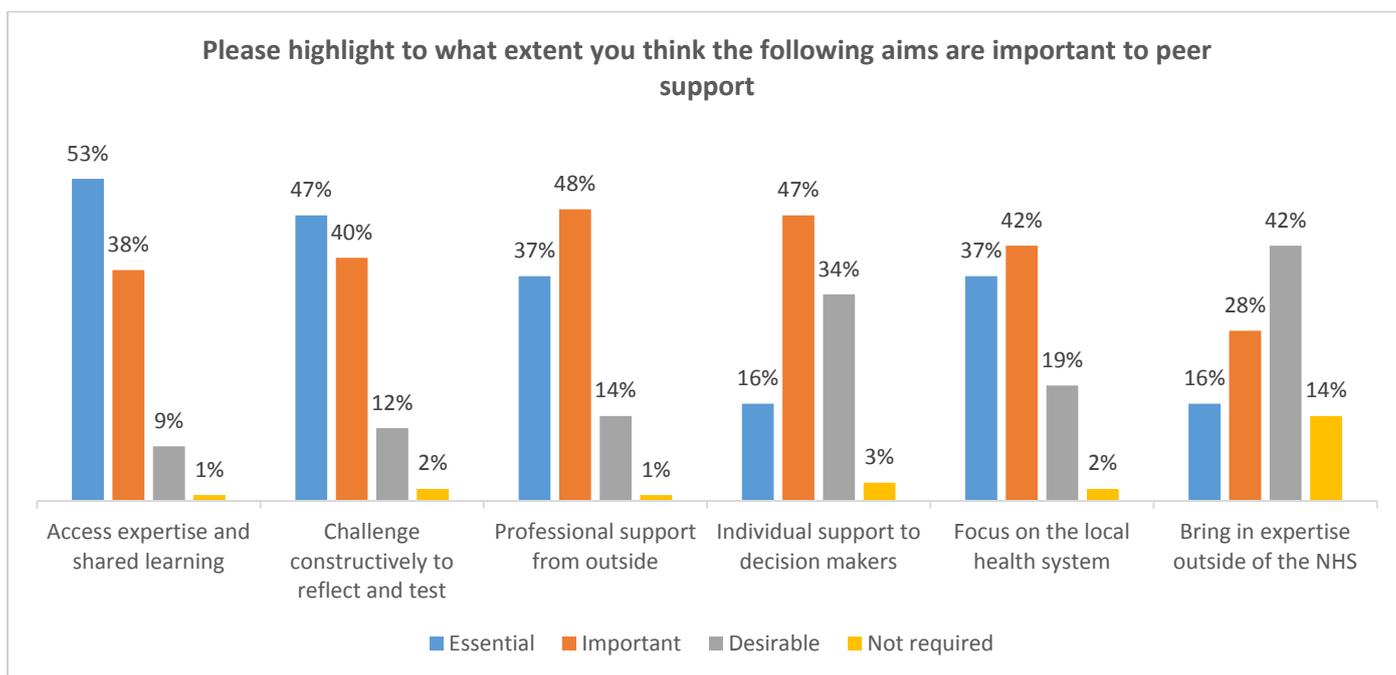
Given the significance of experience in making decisions it makes sense to encourage peer networks that allow decision-makers to access the experience and expertise of other people. Figure twenty-three shows that 91 per cent

of the people in the national survey thought this should be an essential or important aim of peer support. Many people we spoke to also thought it should go further and challenge people constructively and allow them to reflect and test how they make decisions. The national survey shows 87 per cent of people thinking this was essential or important in peer support.

This tendency for challenging peer support reflects the conclusions of Prof Don Berwick for embracing an ethic of shared learning, and more specifically the recommendations he made for making use of peer review outside of formal networks to facilitate this learning. This was also echoed by Prof Sir Bruce Keogh.

“On the front line, staff rely on a personal bank of knowledge, so it is not systematised or disseminated throughout the team.”

Chief executive officer

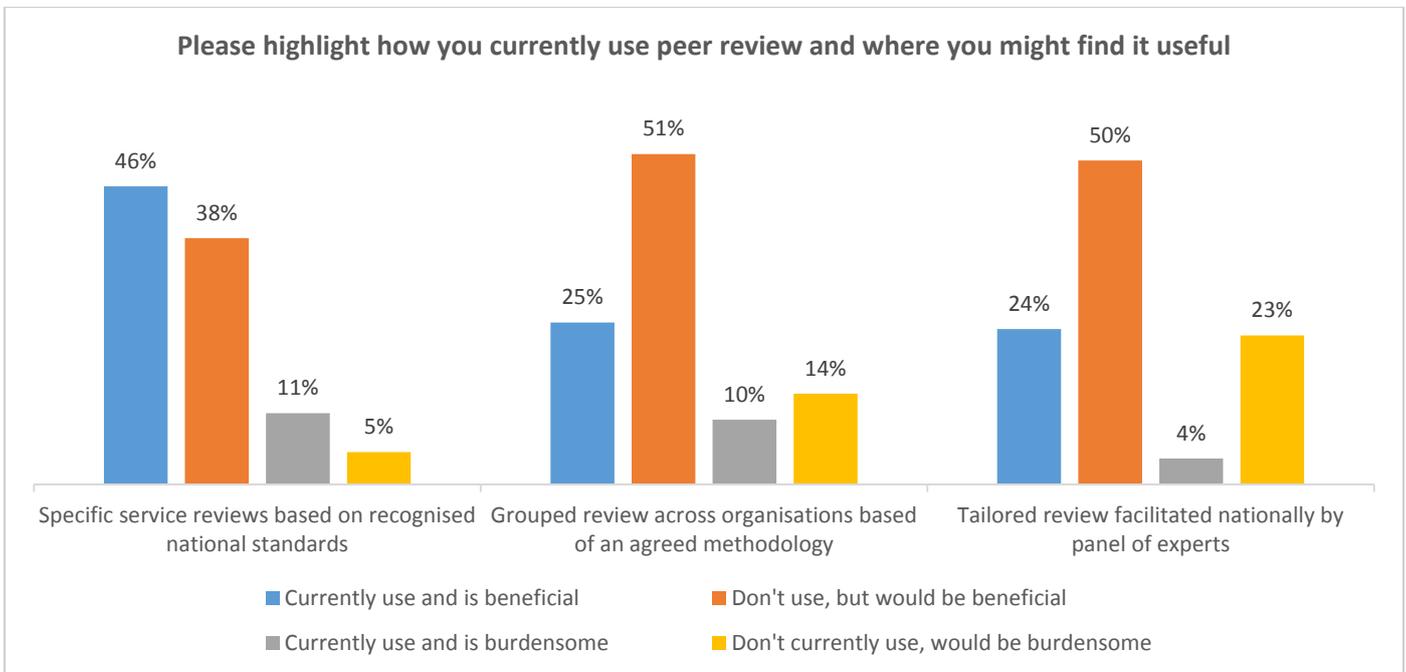


Source: Decisions of Value survey

When we explored peer review in more detail, again we found it more prominent as part of clinical practice. We also found it generally focused on quality or on finance, rather than looking at value across the two. Figure twenty-four highlights that 46 per cent of the people who responded used service-specific reviews, based on recognised standards, while a further 38 per cent don't currently use this but would find it beneficial if they did. Fewer people were aware of familiar with reviews facilitated by a regional group of organisations or nationally, yet many indicated they would find this beneficial.

“Have a sliding scale for peer support is essential. Maybe you want review and maybe you want a chat, maybe you want a team and maybe you want an individual”

Director of acute services



Source: Decisions of Value survey

The relationship between burden and benefit of such reviews is crucial. While there is a desire to expand peer support networks, there is also a hesitance about establishing anything that adds to the demands that formal requirements pose. Peer support offers an essential tool for self-regulation and allows the NHS to make use of the experience and expertise existing within it – but it will need to complement formal regulatory structures rather than add an additional layer.

Lessons from the published literature

Much of the literature on networks in health care focusses on either clinical networks or networks of innovation and improvement. By contrast little is formally known about how the combined imperatives of cost and quality can be best supported through peer support and networking

The broader literature suggests that new ways of working require more open networks - for example spanning previously divergent functions and professional roles. However the literature also suggests that such 'cosmopolitan' networks are harder to create and sustain than traditional professional networks.

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these two types of people together and facilitate a mutual exchange of ideas and experience. Clearly, those looking to learn will gain much from this interaction but so too will those with something to teach. They will have the opportunity to highlight the positive in what they do and will engage them in considering what they do that works, as well as further lessons they could consider to improve.

Through this project, we have built up a strong database of people at all levels of the NHS who are engaged in this work area and interested in being part of it as it develops. We would be keen to exploit this opportunity and turn our findings, of what support the NHS would find useful and what that support should be focused on, into deliverable support.

We are also keen to thank those organisations and staff that have been involved, in particular those involved in the local engagement research.