Thesis submitted to Swansea University in fulfilment of the requirements for the Degree of:

DOCTORATE OF BUSINESS ADMINISTRATION

TO WHAT EXTENT DOES PROFESSIONAL VALUE AND ENGAGEMENT PLAY A ROLE IN THE SUSTAINABLE DELIVERY OF VALUE BASED HEALTHCARE?

Marc Aneurin Morgan Penny MBA

STUDENT NUMBER: [redacted]

SWANSEA UNIVERSITY

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Abstract

This research critically examines the role of professional value and engagement in sustaining Value Based Healthcare in publicly funded healthcare organisations. Originally conceptualised in the United States of America to enhance healthcare efficiency and effectiveness, Value Based Healthcare is gaining global traction. However, its implementation in publicly funded systems like the NHS presents challenges, particularly in organisational change, professional engagement and culture.

Using a socio-technical systems perspective, this study recognises healthcare as a complex system requiring alignment between social and technical components. It explores how professionals perceive value in Value Based Healthcare initiatives and the factors influencing their engagement. A mixed-methods approach, combining qualitative interviews and quantitative survey data, provides a comprehensive understanding of professional value within Value Based Healthcare frameworks.

Key findings reveal that successful Value Based Healthcare implementation depends on core themes underpinning professional value: Engagement, Individual Consequence, Shared Aims, Ownership and Skills Development. Addressing change management challenges — such as resistance, cultural adaptation and organisational readiness — is essential for sustainability. The study highlights the direct and ensuring professionals also derive value. It proposes adding 'Professional Value' as a core domain within Value Based Healthcare, alongside existing Personal, Societal, Allocative and Technical values.

This research contributes to academic discourse and healthcare management by integrating professional value into Value Based Healthcare sustainability strategies. The findings offer valuable insights for policymakers, healthcare leaders and practitioners seeking to enhance Value Based Healthcare's long-term effectiveness. Ultimately, it advances understanding of how professional engagement is a critical enabler in realising Value Based Healthcare's full potential, ensuring better patient outcomes and system-wide improvements.

Declarations & Statements

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed: [redacted] Date: 10/02/2025

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Where correction services have been used, the extent and nature of the correction is clearly marked in a footnote(s). Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

Signed: [redacted] Date: 10/02/2025

STATEMENT 2

I hereby give consent for (a) for the thesis, if accepted for a research degree, to be made available for electronic sharing and for inter-library loan (subject to the law of copyright) and (b) for the title and summary to be made available to outside organisations.

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STATEMENT 3

The University's ethical procedures have been followed along with those of the NHS and, where appropriate, that ethical approval has been granted.

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Acknowledgments

Embarking on a Doctorate of Business Administration (DBA) at Swansea University while working full-time at Cwm Taf Morgannwg University Health Board has been a journey marked by both challenges and rewards. Undertaking the DBA part-time over several years has required me to carefully balance the demands of my work, study and personal life. The complexities of this undertaking have been further compounded by the logistics of maintaining a long-distance relationship between South Wales where I live and work and Bangor in North Wales where my partner resides.

As I reflect on my journey, I am filled with gratitude for the many people that have supported me along the way and wish to acknowledge the following people.

Firstly, my partner David who has been a continuing source of motivation, encouragement and support and helped me remain focused and lifted me up when my spirits have fallen through the ups and downs or the research. His ability to give me the confidence to continue and counter my imposter syndrome has made the completion of this research possible, and I am eternally grateful.

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Glossary & Commonly Used Abbreviations

ADKAR	Awareness, Desire, Knowledge, Ability and Reinforcement
AJG	Academic Journal Guide
BMC	BioMed Central
CAOC	Cynicism About Organizational Change
CROM	Clinical Reported Outcome Measure
CTMUHB	Cwm Taf Morgannwg University Health Board
DBA	Doctor of Business Administration
EC	European Commission
GDP	Gross Domestic Product
HPH	High Performance Healthcare
IHI	National Health Insurance
MBA	Master of Business Administration
NHS	National Health Service
OECD	Organisation for Economic Co-operation and Development
PDCA / PDSA	Plan Do Check Act / Plan Do Study Act
PREM	Patient Reported Experience Measure
PROM	Patient Reported Outcome Measures
PV	Professional Value
SJR	SCImago Journal Rank
SNIP	Source Normalized Impact per Paper
STS	Socio-Technical Systems
TofC	Theory of Change
TQM	Total Quality Management
UHB	University Health Board
UK	United Kingdom
US	United States
USA	United States of America
VBHC	Value Based Healthcare
WG	Welsh Government
WSQ	Whole System Quality

CHAPTER 1 - INTRODUCTION AND BACKGROUND TO THE RESEARCH

1. Introduction

Every day, it seems, the British health and care system is the target of negative reporting. The National Health System (NHS) is associated with being *'free at the point of need'* but equally is seen to be too costly to constantly justify the allocation of taxpayer revenues to a system that has perceived worsening performance and increasing costs. In contrast, the U.S. system of health (a private sector funding model) is perceived as *'best practice'* management and is regarded as an efficient systems benchmark. Many methods, of the U.S. model and its perceived superiority, have been imported (some of these were actually historical imports themselves from other sectors such as the automotive industry in Japan and the lean movement which turned into the Virginia Mason Production System – a U.S. healthcare provider that has embraced leaner working practices (Kaplan & Patterson, 2008) to other countries and the U.K. in particular. The U.S. system is however benchmarked as very expensive to operate and has undergone recent changes that has challenged the dominance of the lean healthcare model (Papanicolas et al., 2018). More recently, a new model has emerged in the US, which is termed as Value Based Healthcare (VBHC) (Porter & Teisberg, 2004). The U.S. lean model focused on process efficiencies as a means of reducing costs whereas the new VBHC model promotes highly efficient and effective healthcare. VBHC is the product of Professor Michael Porter and Professor Elizabeth Teisberg (2004). Porter himself is associated with higher performance in the manufacturing sector with his historic publications promoting a systems approach to supply chains, improved value adding and a systems approach to manufacturing and service sectors. At one level, VBHC could represent a switch in language from costs (and system decline) to value creation and opportunities for enhanced patient flow (at the lowest costs) and increased revenues from providing value for healthcare organisations by focusing on outcomes rather than just the service process or clinical intervention. Such a new model is both rationally attractive to corporations and it is gaining significant interest in economies beyond America.

The VBHC approach, despite its popularity in the U.S., offers few benchmarks of exemplary performance and remains aspirational for care provision without any demonstrated utility of the approach in a publicly funded system such as in the U.K. Service providers, operating complex organisations, which embrace the principles of improved 'value for money' from VBHC do so without any example of best practice that can be emulated. The current U.K. complicated service settings means organisations must experiment to test service improvement and its impact on value (Snowden & Boone, 2007). At the heart of this research gap lies some fundamentally important questions including what is value? (a definitional gap) and how can it be improved to result in more efficient and

effective care (a practice gap). It is this fundamental immaturity of the VBHC subject and potential new approach to health and care delivery that has fascinated the researcher and fuelled his desire to research this subject.

1.2 The Motivation of the Researcher

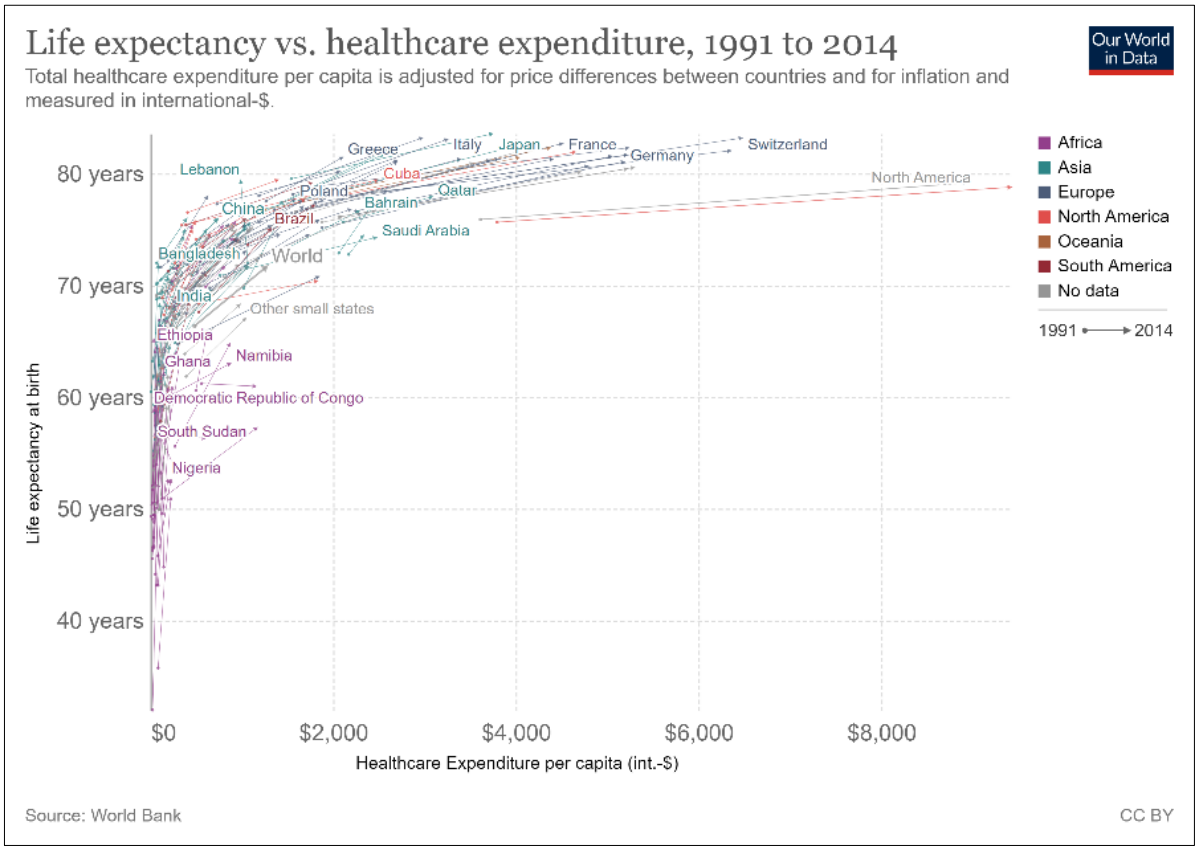
The desire to pursue a Doctorate of Business Administration (DBA) has been a long-standing ambition of the researcher following the positive experience of his Master of Business Administration (MBA) research at Cardiff University in the mid-2000s. To study, at the DBA level, offered an ability to further develop and apply service sector learning to the context of heath and care systems where the researcher is employed as a senior manager and leader. The importation of the potentially dominant VBHC model and its translation into a public system and British cultural context is both exciting but equally unproven. This research aims to explore how VBHC can be effectively implemented to improve patient outcomes while ensuring economic efficiency and societal benefit, especially during times when financial constraints and service demand are putting immense pressure on healthcare systems across the world. The researcher is employed in Wales, U.K. and can see the theoretical potential of VBHC and also the potential for organisations to embrace new models to counter the dysfunctions of costly and decreasing healthcare performance.

The researcher, a senior leader at a large Welsh combined primary and secondary care provider with significant complexity (complex geography and patient demographics) witnesses how difficult it is to manage services, to innovate and to manage healthcare within budgets. He is highly experienced in operational excellence, business transformation and innovation methods having spent over 25 years leading change and transformation across public and not for profit organisations. The researcher is driven by a passion to improve public practice and leverage staff skills and experience to add value for patients and service users. The researcher actively supports health and care charities and those most vulnerable in society where volunteers want to add value and do so with even smaller budgets. These struggles catalysed the interest of the researcher to conduct theory building research into value and its conceptualisation and exploitation to deliver more for less. Based on this the author will declare, from the outset, that their natural preference is, and always has been, a pragmatic one and that the focus of this research concerns the practical implications for the organisation for which they work (as well as wider healthcare services). That being the case it is likely that the researcher will assume a pragmatic position to their research strategy, which will be explored further in chapter 3.

1.1. The Research

According to the initial systems designer of the modern National Health Service (NHS) in the U.K., *"No society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means"* (Aneurin Bevan, July 1948).

It can be argued that a measure of the social construct called 'society' is its ability and willingness to care for those who need it (Brown, 2017; Morris, 2023). Over the past couple of hundred years, investment and provision of care, for those in society 'with need', has increased. This period has been termed the 'age of enlightenment' and the development of 'scientific theory' and practice (Porter, 1999). In parallel, global life expectancy has more than doubled and child mortality has decreased but inequalities still exist (Dattani et al., 2023). Increasing healthcare expenditures have fuelled service improvements and life expectancy however data shows diminishing returns on investment where more investment has reduced impact on life expectancy (Figure 1). Shockingly, the Organisation for Economic Co-operation and Development (OECD) estimates that one-fifth of all health spending could be channelled to better use by identifying and removing inefficiencies in healthcare delivery (2021). In the United States of America alone some $1 trillion USD could be saved (OECD, 2017).



[1]*Figure 1 - Link Between Healthcare Expenditure and Life Expectancy (Source: Roser et.al., 2013)*

[1] Roser, M., Ortiz-Ospina, E., & Ritchie, H. (2013). Life Expectancy. https://ourworldindata.org/life-expectancy

However, most governments continue to increase annual healthcare spending. The U.K. healthcare spend by the U.K. Government has increased each year, and since 2009/2010 increased by over 35.9% spend (*NHS expenditure programme budgets: April 2019 to March 2020*, 2021). Globally, healthcare spending by most countries is expected to outstrip GDP by mid-2030 (*Health spending set to outpace GDP growth to 2030*, 2019) unless major transformations are introduced that enhance value, reduce costs and can absorb the complexities of an elderly and comorbid society.

Key Trends for Change and Uncertainty

- A growing global population
    - In 2019 the global population was estimated to be 7.7 billion, United Nations estimate that by 2030 the population will have grown by 10% to 8.5 billion and almost 10 billion by 2050 (*World Population Prospects 2019: Highlights*, 2019).
    - Falling proportions of working-age people 25-64 compared to those over age 65 putting further pressure on health and social care systems (*World Population Prospects 2019: Highlights*, 2019).

- A growing societal expectation on healthcare (Lateef, 2011), (Ordu et al., 2021)
    - A change in people's expectation on their health outcomes and quality of life
    - Experience of service they receive at the point of care and ongoing care
    - Choice in care and a patient centric service

- The impacts of COVID-19 pandemic on healthcare systems
    - Increase in patients presenting with higher acuteness of disease due to delays
    - The resilience of people working within the healthcare system and their capacity to deliver change whilst also dealing with other system pressures
    - Diagnostic and treatment backlogs - around 1 in 5 of the Welsh population is on an NHS waiting list, and around 37 per cent of people waiting to start treatment have been waiting over 9 months (*Impact of the waiting times backlog on people in Wales who are waiting for diagnosis or treatment*, 2021)

- A drive to a population healthcare focus and value of outcomes
    - Cwm Taf Morgannwg University Health Board based in South Wales has recently launched a strategy to focus the organisation into a population health organisation (Nnoaham, 2021)

○ The World Economic Forum has launched 'The Global Innovation Hub for Value in Healthcare' selecting 4 countries to accelerate the pace of Value Based transformation in health systems around the world with Wales being the centre exploring 'A whole system approach to value-based healthcare for Wales'. • Financial position in which Healthcare systems are having to operate ○ Global recession 2009/2010 and subsequent austerity in UK and other nations ○ Growing health spend - (*Health spending set to outpace GDP growth to 2030*, 2019) Global uncertainty affecting purchasing power such as increase in energy prices, unrest in Eastern Europe

Table 1 - Changes in the Operating Environment (OE) for Health and Care Providers (Source: The Researcher - Marc Penny 2025)

These trends beg the question *'How long can countries continue to invest more and more in healthcare provision whilst not seeing the expected gains in life expectancy which has been a traditional measure of effectiveness?'*

Beyond the narrow focus of a single lens of life expectancy, quality-of-life changes and health outcomes, which may be delivered through healthcare intervention and treatments, must be considered. To understand the impacts of healthcare interventions on individual and population outcomes requires the view that effective healthcare provision, not as binary 'survive or die' from intervention nor from simple life expectancy measures but necessitates understanding the value that any intervention provides across a number of measures.

The contemporary VBHC model can trace its origins to the 20th Century in the U.S.A. and private healthcare provision, with Porter and Teisberg introducing it as a concept in 2004. VBHC, proposed as a modern antidote and clear vision of a future improved state of health & care provision (Porter and Teisberg, 2004). The Porter and Teisberg paper (2004), '*Redefining Competition in Health Care'* and a later 2006 publication, '*Redefining Health Care: Creating Value-Based Competition on Results'* initially formalised VBHC principles and the model (Porter & Teisberg, 2004; Porter & Teisberg, 2006) with these publications widely regarded as the seminal texts on VBHC . The papers represent an architectural and transformational shift in health care policy and a switch in focus to understanding and system design for outcome value (not just cost minimisation of each process stage). VBHC, for

complex organisations of multiple stakeholders, proposes that value to the patient is greater than just individual patient value.

The concept and development of VBHC can be traced to other historic health improvement initiatives and principles which themselves represent models that have supported organisational viability in slower and less complex operating environments and can be regarded as an evolution of thinking and extension of earlier strategies and theories that support patient-centric service flows (lean hospitals model (Graban, 2011)), the improvement of services (Whole System Quality in Healthcare (WSQ) model (Sampath et al., 2021)) and calls from the patient safety movement for more effective care and resilient service provision (Safety II model (Hollnagel et al., 2015)). The re-prioritisation of VBHC-derived value as an outcome for system design (rather than implied or a driver for process-level change) creates a new opportunity for value to be released for a multitude of stakeholders including clinical staff.

This thesis draws on, and seeks to inform, the Welsh Governments "*A Healthier Wales: our Plan for Health and Social Care"* (2019) vision[2] for the Cwm Taf Morgannwg University Health Board area (employer of the researcher) and the wider NHS. It is hoped this work will ultimately benefit academic knowledge and professional practice by testing the utility of the VBHC approach as a viable means of delivering optimised care (*A Healthier Wales: our Plan for Health and Social Care*, 2019). Importing VBHC to Wales represents a translation from a private health and care model to a public one and a change in cultural setting where VBHC is recognised as an approach, but presently poorly grounded in practice. The research explores the linkage between the success of VBHC deployment and the cultural element of change, professional value and human behaviours to develop new theory and applied practice in this vital and critical area of management and population care.

This research provides a contribution to the contemporary understanding of VBHC from a Social-Technical Systems (STS) theoretical lens to determine the value and utility of the approach for service delivery in the U.K.

[2] *The document sets out the Welsh Governments vision to transform health and social care services in Wales, focusing on integrated, person-centered care. It emphasises prevention, early intervention and seamless collaboration between health and social care providers. The plan aims to shift from reactive care to a proactive, sustainable model that promotes well-being and reduces inequalities.*

1.2. Research Context

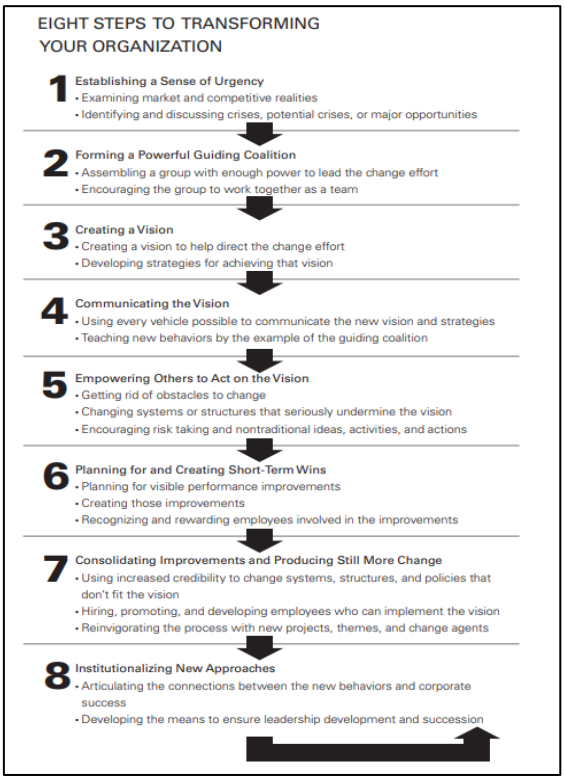
VBHC, its adoption and deployment represents a collection of activities and projects to enhance value, however the question remains – is VBHC a viable new model with transformative powers and, if so, will it transition from an essential model to an applied and sustained/embedded set of actual practices. In the context of a national Welsh 'drive' towards VBHC has resulted in committed organisational resources, mandated by the Welsh Government, so that each Welsh health and care provider has staff who are dedicated to promoting VBHC. The questions remains, is VBHC a process, a culture, a group of projects or a radical departure in health and care delivery that will involve changes to the working practices of hundreds of thousands of staff?

Existing published works on VBHC application presents little evidence from a discourse perspective or critical evaluation, for instance, the study "Redefining Value: a discourse analysis on value-based health care" (2020) identifies four distinct discourses — Patient Empowerment, Governance, Professionalism and Competition — each with unique perceptions of VBHC's purpose, underscoring the ambiguity and varied interpretations (Steinmann et al., 2020). These issues result from difficulties with the newness of the approach and measurement horizons for true evaluation of VBHC projects and a reliance on a number of small scale case studies (van Elten et al., 2023). Research and academic discussion does highlight relational dependency of key 'actors' or 'organisations' and the need to carefully exploit these dependencies (releasing synergies) that enhance value and enable VBHC success (Steinmann et al., 2020) and engagement of such actors and policy makers to set the direction and boundaries of appropriate VBHC application (Smith et al., 2022). These discussions remain largely abstract and often fail to engage professionals and professional bodies in the U.K. NHS context. As such, VBHC is an immature and vague subject and area of professional practice where many questions exist concerning the effective deployment of VBHC principles.

One under-researched area is implicit model(s) of change management and the culturally appropriate methods that assist organisational transitions that result in sustained, embedded and viable VBHC application/outcome results. The imposition of U.S.A. private sector VBHC on U.K./Welsh publicly funded organisations that cannot increase sales or profits from VBHC but must reconcile tighter budgets is a significant cultural difference. Change management and innovations have both received major criticism in the academic literature in the NHS context. The main reason for such ambiguity is the sheer number of stakeholders that must engage willingly to enact changes in processes or engage in a change that is transformational in roles and responsibilities (such as Medics, Nurses, Allied Health Professionals, Healthcare Scientists, Administrative staff etc).

The study of change management stems from the autocratic large-scale organisations of the early 20th century and a managerial prerogative based on the bureaucratic structures and scientific "one best way" of management. Since this time, increasing complexity of the operating environment have eroded the use of bureaucratic structures that inhibit fast decision making. The development of health and care organisations largely followed this militaristic and mass production management systems thinking and it was not until the late 1980s that global health systems started to become aware of and experiment with Total Quality Management (TQM) see McLaughlin & Kaluzny, (1990) and the 'customer' concept as a focus and purpose for the healthcare provider. The 1990s with increased environmental uncertainty and changeability resulted in a new concern that was exemplified by Connor in his book 'Managing at the Speed of Change' (1993) which promoted organisational knowledge of what to change and importantly how to enact change successfully. The publication also identified areas of corporate resistance and cultural conflicts which could only be overcome by creating a 'burning-platform' for change that would unite disparate stakeholders and commonly focus them on timely interventions to restore system viability (Conner, 1993).

The increased environmental turbulence of that era created the need to develop adaptive and dynamic organisational capabilities for periodic and continuous improvement cycles so organisations could become agile and responsive to their changeable operating environments. The imperative to change, and change quickly, is reflected in the work of Kotter and his formulaic approach to managing change (a model which still dominates the process and way in which organisations in health care settings frame change). Kotter (Kotter, 1996), a professor of Harvard Business School, further developed the principles of Change Management devising the 8 failure modes or 8 step process for leading change Figure 2.



[3]Figure 2 - Kotter 8-Step Process for Leading Change (Source: Kotter, 2007, p4)

Kotter proposed organisational executives and leaders should "create a sense of urgency" and a challenge that threatens but unites a collective response from all employees. He then advocated building a coalition, strategic vision, building an army of workers, removing barriers, identifying and exploiting quick wins, accelerating change and sustaining modes for such rapid change of the time. Kotter also provided a practical tool kit and guide to help understand organisational challenges to change and ways of addressing them (Kotter, 1996). Connors & Smith (2011) later argued that changing the organisational cultural and beliefs was needed to drive change successfully and not a process which prioritised fear to catalyse such a response (Connors & Smith, 2011).

Facilitating and fostering positive change is a huge pragmatic challenge for large-scale organisations such as UK health and care providers and many other authors have highlighted Leadership, Vision, Communication, Education and Data aspects that underpin successful change (*The Five Elements of Optimal Care Delivery: Organizational Readiness*, November 30, 2018). The modern change approach, in general, is presented in the academic literatures as holistic, proactive and reactive, inclusive and a systems approach which is agile in nature. Any VBHC model would therefore have to fit within this environment and increased pace of change that is experienced by health and care organisations.

[3] Kotter, J. P. (2007). Leading change: Why transformation efforts fail. In Museum management and marketing (pp. 20-29). Routledge.

The emergence of VBHC, over the last 2 decades and its principles, have largely been developed and extended through academic discourse and empirical case study research of "real-life" application. However, these studies have focused mainly on the management of services and not the elements of 'people change', 'cultural change' and 'human factors' that mainstream research promote as critically important to enacting VBHC. A pragmatic account of change has also not been accompanied with theoretical developments and progression of such VBHC understanding and little evidence is presented from a Socio-Technical System Theory (STS) perspective of people, processes and the technology used to support VBHC (Trist & Bamforth, 1951b). STS theory, which will be explored as a theoretical lens of this study in the next chapter, posits the relationship between social and technical aspects of organisations can only be optimised to deliver value if the social system (people, roles and culture) and the technical system (tools, processes and technology) are aligned and mutually-supportive (Trist, 1978). All healthcare systems are forms of STS (e.g. diagnosis, assistive care delivery or supporting information exchanges that enable patients to move through the care service and professional engagement at each stage). In this manner, the researcher frames VBHC as a socio-technical system.

Pragmatically, and in the absence of underpinning research, the Welsh Government has promoted value improvement in the form of Prudent Healthcare (*Prudent Healthcare: Securing Health and Well-being for Future Generations*, 2016) and the frugal use of resources for co-produced services where professionals and patients share power and work together as partners to deliver valuable health outcomes (*Prudent Healthcare: Securing Health and Well-being for Future Generations*, 2016). However, the prudent approach does not fully explain the toolkit and interpersonal skills needed to exploit value from the NHS 'Professional'. A summary of Prudent Healthcare principles can be found in Table 2.

PRINCIPLE	DESCRIPTION
Do no harm	Prioritise actions that avoid unnecessary or potentially harmful interventions.
Care for those with the greatest health need first	Focus resources on individuals who need them most, promoting equity in healthcare access.
Only do what is needed	Avoid unnecessary tests, treatments, and interventions; ensure that each action adds value.
Enable patients to play an active role	Empower patients to take part in decision-making and manage their own health where possible.
Reduce variation	Standardise best practices across services to ensure consistent and effective care.
Promote evidence-based interventions	Use interventions and treatments backed by strong evidence, avoiding those with limited or no benefit.
Increase resource efficiency	Ensure healthcare resources are used effectively, minimising waste and optimising outcomes.

Table 2 - Prudent Healthcare Principles (Source: Bevan Commission 2015)

The prudent principles provide a national "essential logic" and essence for improvement, but these principles are generic and directional whereas the U.S.A. system of VBHC's definition has a broader definition of value as an essential logic but neither articulates methods to change and improve decisions to enhance professional care practice, whereas Toussaint (2010) provides real-world examples for implementing lean in healthcare. These works bridge the gap between lean methodologies and VBHC by highlighting actionable methods that professionals can use to improve care delivery and achieve measurable outcomes (Toussaint & Gerard, 2010). Outside of the U.S.A., VBHC has shown embryonic forms of application. In Sweden VBHC was applied to a case study and 3 main themes emerged from interviews with professionals involved (2016). These themes included effective resource allocation, anchoring of change to create engagement and a dedicated leadership structure (Nilsson et al., 2017a). The study found participants lacked knowledge and understanding of VBHC at the beginning of its deployment and, despite increasing staff knowledge, it was difficult to maintain the engagement of staff. This research highlighted the determining factor of 'people' engagement in VBHC change (Nilsson et al., 2017c) but the study merely presented the three themes and its impact on success and started to identify a knowledge gap. Mjåset et al., (2020) focusing on a comparative study of the USA, Norway, Netherlands and England, found significant risks and problems with an autocratic "top down" implementation of VBHC and called for greater government involvement and direction to enable professionals to enhance value especially when using ~~with using~~ a common national IT systems to deliver patient data, as data system variety and inter-system incompatibilities limited progress amongst staff and inhibited the establishment of a VBHC improvement culture. These studies show the embryonic state of VBHC and how national cultures may lead to issues of the U.S.A. system morphing to suit and fit local operating and system conditions. Wales is such a new context with its laissez faire operating model, funding mechanisms and Welsh culture - as such it is a fitting context within which to explore VBHC and its adaptation or failure to adapt and embed.

A review of successful VBHC experiments at Aneurin Bevan University Health Board (2018) in South Wales declared the main components of VBHC success as clear outcomes, reduced costs and effective informatics underpinned by enabling factors of a common professional language and culture (*Value Based Healthcare: Learning from practice*, 2018). The study involved working with patients, carers and clinical teams to build a local value culture in Wales and offered an insight that Wales would be a fertile and suitable operating environment to explore VBHC. A year later, in 2019, the European Commission (EC) officially recognised VBHC and issued a document which defined it as *'Value-Based*

healthcare is a comprehensive concept built on four value pillars: appropriate care to achieve patients' personal goals (personal value), achievement of best possible outcomes with available resources (technical value), equitable resource distribution across all patient groups (allocative value) and contribution of healthcare to social participation and connectedness (societal value)' (*Expert Panel on effective ways of investing in Health (EXPH) Defining value in "Value-Based healthcare*", 2019 Pg 5). However, the EC failed to discuss the cultural changes necessary to embed sustainable VBHC principles and, equally, within the report there was no mention of the importance of the professional in generating value through enhanced service delivery or how these professionals could support and sustain VBHC principles in practice.

The importance of a unifying language, culture and behaviour mirroring the Aneurin Bevan University Health Board findings was derived from the research of the Centre for Evidence-Based Medicine in Oxford, England (Hurst et al., 2019). This study identified the key challenges to implementing a sustainable VBHC programme as the need for large-scale reforms through system-wide behaviour change to increase value in the NHS. Such scaled change was also deemed to include individual clinical behaviour change (professional level) and culture change of professionals and organisations (Hurst et al., 2019). At the same time, the Welsh Governments "Healthier Wales – Prudent based Healthcare" report was published which articulated a vision for Wales and its people through investing in improving the quality of services (*A Healthier Wales: our Plan for Health and Social Care*, 2019). It was proposed that the improvement would be achieved through strengthening talent and leadership and developing high quality clinical information. These commonly recurring elements to the success of VBHC were intriguing to the researcher and led him to think further on the development of measures (using feedback from people, patients and staff) so that VBHC could be embedded to support the Welsh Government and NHS organisations needs and visions. The measures, which provide feedback on "what matters most" to people would ensure that improvement activity is outcome driven.

Further Welsh Government policy documents also explicitly recognise the power of VBHC. The "Putting Value at the Centre of Health and Care in Wales A Three Year Action Plan DRAFT 2019-2022" identified 6 goals to implementing VBHC in Wales. It expanded the cultural elements that may be required to embed VBHC sustainably by identifying Communication, Education and Engagement (*Putting Value at the Centre of Health and Care in Wales A Three Year Action Plan 2019-2022* ~~2019~~). However, the implementation of these perceived goals of VBHC introduction and sustainability received no further elaboration.

The VBHC "change talk" of nations is very similar but empirical research addressing the success of change within health and care settings has found that maintaining organisational change is difficult and influenced by cultural human aspects of work as much as VBHC projects. Narine & Persuad (2003) found organisational "readiness for change" and the participation of people within the system in the change effort was critical for positive service change (Narine & Persuad, 2003). Bridges and Bridges (2017) argue that sustainable change results from system transformation and by developing the people working in services and not frightening them with Kotter's 'sense of crisis' (Bridges & Bridges, 2017).

Other research highlights the problems of focussing on improvement principles and tools in isolation (Radnor et al., 2011) or practical inhibitors (Bateman & Rich, 2003) without an essential underpinning logic. Such criticisms have been common of previous models of healthcare service improvement including the lean methodology and its ignorance of 'people engagement issues' despite a belief in respect for all staff (Hines et al., 2004).

As such, there are many change models available for organisational staff to use or mandate but the VBHC implementation process seems impeded by a lack of human factors integration. Searl, Borgi and Chemali (2010) also noted these softer issues were prevalent in their Health Research and Policy paper which called for a human-centred healthcare system, with success of the system and any change dependent on understanding and acting upon the human thought processes, exhibited behaviours and promoting healthcare system optimisation for patients and the professionals working in the system within which acceptable cultural behaviours were practiced (Searl et al., 2010). The researchers went no further and instead concluded that further research into this area was an imperative.

In summary, current VBHC research emphasises high-level principles, theoretical frameworks and organisational strategies yet it largely omits a critical review of sustainable change: the healthcare professionals and workers role in these transformations and how value is perceived by these stakeholders. Previous studies of VBHC deployment have focussed on systems and policies, resources and cost-efficiency without sufficiently addressing the perspectives and involvement of healthcare staff (Mjåset et al., 2020; Nilsson et al., 2017c) and academic gap poses a serious problem concerning the poor recognition that professionals are agents of a sustainable VBHC service, the interpretation of its values and learning from VBHC outcomes in the short and long term.

Thus, research has overlooked the professional's "lived experiences and feedback" even though they are cited as the regulator of adaptability and responsiveness to deliver services that meet the operating conditions of the organisation. Studies of the "Prudent Healthcare" framework in Wales (*Prudent Healthcare: Securing Health and Well-being for Future Generations*, 2016) promotes greater patient-centredness and value-focused care but fails to incorporate insights from the NHS workforce. Additionally, VBHC is unlikely to succeed if theoretical change models such as Kotter's Change Management framework provide top-down policies or imposed demands and simplistic continuous improvement will fail to be transformative as it improves task level activities within a service. Meaningful progress for VBHC studies must therefore account for the human-centred challenges encountered by professionals on the ground of the potential transformation of health systems using a VBHC approach. These however may never be realised or may, despite their logic, enjoy only temporary success as embedding of the values and practices are not achieved in practice (Hurst et al., 2019).

The current stage of academic knowledge would suggest that future research should actively engage healthcare workers and professionals exploring their roles, challenges and contributions to delivering VBHC using an inclusive approach to discourse and the cultural alignment necessary for enduring practice change (Searl et al., 2010).

1.3. Broader Context and Underlying System Dynamics

Such dynamics mean that VBHC implementation is neither a static nor incremental model but a processual approach that must adapt itself to fit the operating environment within which it is embedded. Of most importance therefore is the study of how value can be extracted from staff who themselves are in short supply and overloaded with current service demands, but the same staff must be engaged to ensure the success of a VBHC initiative (and its sustainability as an organisational change programme).

Bringing together the elements of VBHC, change management and learning from previous health care improvement initiatives, this research starts to develop an overlap of research focus which may influence the success or failure or the aims and ambitions of VBHC within the wider context of professional value and socio-technical systems (summarised in Figure 3).

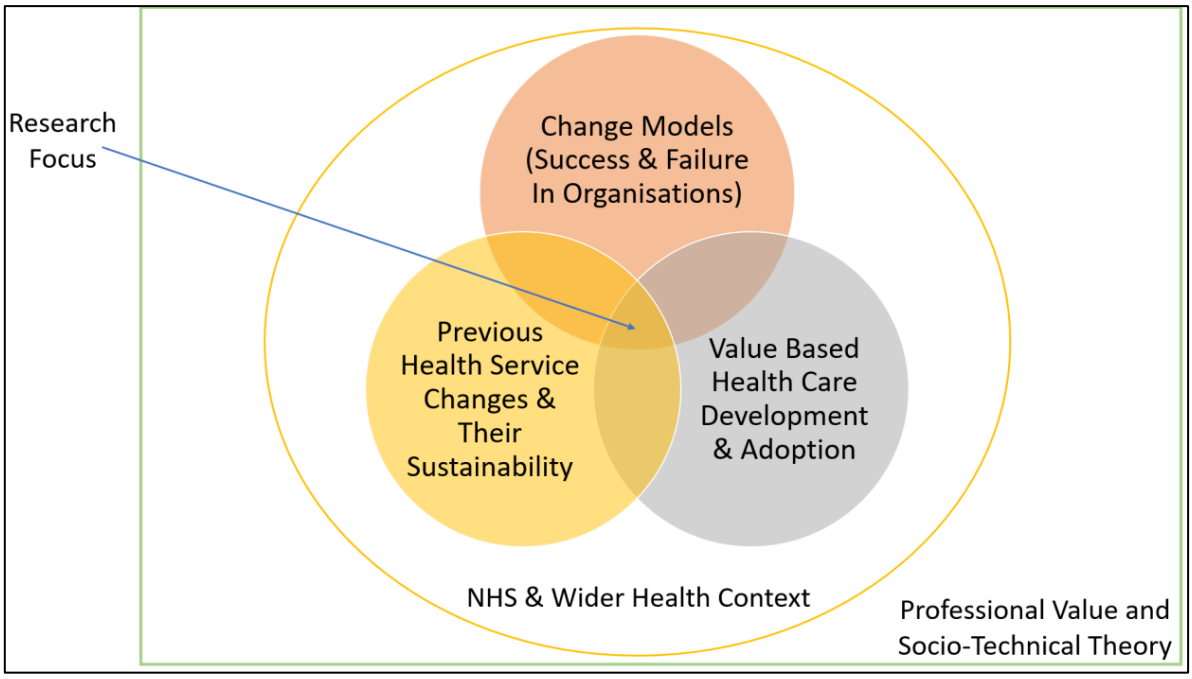


Figure 3 - Research Sphere of Influence (Source: The Researcher - Marc Penny 2025)

As a delimitation to the scope of this study, this research does not focus on evaluating if VBHC itself is able to deliver its aims and objectives or is the right intervention for healthcare systems in any particular country. Instead this research focuses on the scope of the cultural and professional requirements to implement VBHC in healthcare systems of the U.K. and Australia (where VBHC is being implemented).

The current state of VBHC discourse and its explicit ignorance of the role of healthcare professionals creates a key knowledge gap. While VBHC aims to increase efficiency and value for patients, society and taxpayers, little attention is given to professionals' involvement in its implementation. Challenges such as poor staff engagement, time constraints and the failure to integrate VBHC into professionals' core duties persist (Brown & Brown, 2013a; Gray, 2004). Such discretionary effort (where professionals exceed their contractual roles but conduct activities that support their work roles) is another underexplored issue. Both innovation and improvement are activities that require additional discretionary effort by staff that are often beyond their official job descriptions and duties. To engage professionals in discretionary efforts effectively requires staff ‘volunteering’ rather than an employment contract expectation. The only mandated activities that require discretionary effort in the sector concerns the number of hours and credits for Continuing Professional Development (CPD) each year. Mandated time spent in improvement activities has never been reported in the academic or professional management literatures and therefore remains discretionary effort for the individual and collective professionals. Due to work pressures, demand for services and the complexities of

current patients and services, the perspective of the healthcare workers (especially executives who design systems and senior clinicians who provide the knowledge to solve patient problems) is key. The motivation of these workers to engage and invest their tacit or explicit knowledge to implement VBHC and improve value, their productivity and learning from VBHC experiments (Nilsson et al., 2017c) is seen as key. The alignment of rewards and incentives with VBHC goals is an attractor to professional knowledge workers in private healthcare settings (Porter, 2008, 2009) but it also remains under-researched and a gap. Such a financial motivation is absent from the U.K. public sector where profits are not made nor redistributed to staff. Such a gap calls for deeper exploration particularly what the term 'value' means for professional workers in the context of VBHC.

This research, it will be argued in the literature review chapter, will by its design span health systems to conclude the U.K. and international contexts (with specific focus on Welsh NHS organisations) in order to build understanding in the cultural and professional elements needed (if any) to successfully deliver sustained improvements in VBHC outcomes. The Welsh context is important to this study because, as a nation, it is a microcosm of NHS type systems around the world with the same technologies, professionals and intent. VBHC is also a key tenet within the Welsh Governments *"A Healthier Wales"* (2019) vision, so the national champion for change is the Government and their expectations of success and sustainable delivery of care pervade the system, its language and organisational policies of providers. VBHC will therefore be key to achieving the overall vision for Wales which is stated as "… *that everyone in Wales should have longer and happier lives…..Services and support will deliver the same high quality of care…..Services will be designed around the individual and around groups of people, based on their unique needs and what matters to them, as well as quality and safety outcomes*...' (*A Healthier Wales: our Plan for Health and Social Care*, 2019 Pg 4). As such, this research has national interest and impact.

This research draws from a distinct set of literatures including, Health Care Management, Organisational Change and Socio-Technical Systems Theory. The field of VBHC and its application is an immature field of study emerging and developed in the early to mid-2000's and most literature and research has focused on the principles, methodology and "essential" thinking needed to deliver its objectives. However, there is little research on VBHC sustainable deployment within existing structures, cultures and ways of working in the health system. This study is therefore timely and relevant as a means of theory building and the closure of a subject and contextual gap. To assist the reader, the researcher will now declare and make explicit his research objectives and the question he seeks to answer.

1.4. Research Question and Objectives

The guiding research question of this study has emerged from a literature review of the subject of improving health services. The research theme and overarching question is stated as:

To what extent does professional value and engagement play a role in the sustainable delivery of Value Based Healthcare?

To effectively answer this question, two sub-questions were developed to explore the key dimensions of professional value and engagement:

- How do professionals derive value from being involved in and delivering Value Based Healthcare?
- What features of 'Professional' value offer greatest benefits to professionals engaged in Value Based Healthcare?

The combination of these questions, it is argued, offers the greater potential contribution to knowledge to the study of VBHC models in the public sector context whilst also making a pragmatic contribution to the practice of VBHC by healthcare professionals and NHS staff in Wales.

1.5. Proposed Contributions

The research helps inform the successful delivery of the Welsh Governments *"A Healthier Wales"* vision both within Cwm Taf Morgannwg University Health Board (researcher employer) area and the wider Wales NHS/other care contexts. In this systematic study, the researcher will determine how VBHC is being applied, adapted and emulated in Wales and other contexts.

The research therefore contributes to the contemporary academic understanding of sustainable VBHC implementation and the impact of adopting such a model of service design and delivery. The study contributes to the modern understanding of the success of a culture change and enhanced professional 'value' within NHS organisations. Specifically, this research provides insights into:

- The further development and addition of new dimensions of VBHC implementation and professional value to the current body of knowledge.
- The research will inform the outcome of the delivery of "A Healthier Wales" vision; specifically, VBHC, patient outcomes and population health improvements.

- Lead to potentially greater benefits sustained over a longer period of time for the population's health and wellbeing.

The research contributes to an academic and applied knowledge by:

- Extending the body of knowledge and theory for the design of VBHC and actions needed in its actual application within an organisation and wider health system.
- Extending and bridging the current body of knowledge and application of Socio-Technical Theory into VBHC.
- Confirming the applicability of existing change theories and models into the sphere of VBHC.
- Developing a conceptual framework for professional value related to VBHC.
- Offering implications and proposals for groups of individuals and organisations in terms of ensuring the longevity and success of VBHC when applied in their contexts.

1.6. End of Chapter Conclusions and Thesis Structure

This chapter establishes the foundational context of the research by exploring the current challenges faced by healthcare systems globally, with a particular focus on the UK and Wales. It frames the concept of VBHC as a response to the growing demand for efficient and effective health outcomes during financial constraints and societal pressures and expectations. The introduction of VBHC highlights a shift from traditional pure cost-based models to one prioritising measurable value, which more recently has encompassed patient outcomes, societal benefits and economic efficiency. The chapter underscores the research gap in understanding the cultural, professional and human dynamics essential for the successful and sustainable implementation of VBHC in a public healthcare context.

Drawing on the complex interplay of systems, people and processes, this chapter emphasises the role of healthcare professionals working within the system as drivers of change within VBHC frameworks. It identifies the need for deeper exploration of how professional value, engagement and discretionary effort contribute to embedding VBHC principles in practice. It positions the Welsh context, with its unique socio-political environment and "A Healthier Wales" strategy, as an ideal setting for examining the adaptation and sustainability of VBHC models in publicly funded healthcare systems.

Bridging both the theoretical and practical, this thesis is structured to guide the reader through a systematic exploration of these challenges. It is structured around 6 chapters with the next chapter focusing on the literature review based on the authors sphere of influence discussed previously (Figure 3). This review will cover the elements identified to define the gap and understand the current level of research and understanding of VBHC in healthcare systems across the world. This chapter will also set out to define in the context of this research 'professional value' to aid the development of a conceptual framework and evaluation of the authors research questions. The literature review and the qualitative analysis from this will inform the 2nd part of chapter 2 which focuses on the development of the conceptual framework and how the author will intend to validate the framework and answer the research questions using experts and quantitative data.

Chapter 3 sets out the authors philosophical position and research strategy along with the methodology the author intends to use. This chapter will help frame how the author intends to answer the research question whilst ensuring quality and identifying any potential limitations in the methodology used.

Data which will be gathered as set out from chapter 2 and 3 will be presented in chapter 4 'results and findings' with analysis and discussions in chapter 5 where evaluation of the findings in relation to the authors research questions will be considered. This chapter will review the identified research gap in relation to the findings and authors research questions as well as how the findings relate to socio-technical system theory and wider change theory models.

Finally, chapter 6 will draw the research to a close by providing an overall conclusion to the research, the authors conceptual framework and how the research has contributed academically to theory and also real-life practice. The author will ensure as part of this chapter limitations of the research are identified as well as potential further areas of research.

The next chapter will present the systematic literature review which is designed to provide answers to how "professional value" is defined and to explore the current understanding of VBHC in healthcare systems globally (and its place in the historical development of healthcare services). The chapter will craft the authors draft conceptual framework and then provide the theoretical lenses, through which,

this study will be reviewed and the bodies of theoretical literature to which this study will make a contribution to academic knowledge.

CHAPTER 2 - LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2. Introduction to the Literature Review

The previous chapter established the background and research intent of this study of implemented VBHC. This chapter provides a comprehensive review of the relevant academic literature which influences this subject area and is a critical exploration of existing research and its weaknesses. These deficiencies will be used to identify the research gap which the researcher seeks to resolve. This chapter will also present a review of the theoretical lenses and theories (such as socio-technical theory) which will be used to frame and view the findings of the research.

To assist the reader, the focal literature review and the main body of the chapter will explore three key spheres (of specialist literature) of influence:

- Change Success and Failure in Organisations – reviewing literature on change management and theory with an emphasis on what drives or hinders successful change particularly within complex systems and organisations.
- Previous Changes in Healthcare and their Sustainability – examining past healthcare reforms, their outcomes and the factors that influenced whether the changes were sustained over time.
- Value-Based Healthcare Genealogy and Elements of Success – tracing the historical development of VBHC, its theoretical foundations and the factors that contribute to successful implementation.

Additionally, the author will define the key concept and dimensions of 'Professional Value' within the context of VBHC to create a conceptual framework which will be operationalised in the research strategy and methodologies presented and defended in chapter 3.

This chapter presents a thematic analysis (drawing from the conceptual framework) to present insights from the extant literature and to highlight trends, gaps, and areas for further exploration. Throughout the review the author will adopt a critical approach ensuring that the analysis questions the robustness and applicability of previous research. This examination will ensure that the foundation for the subsequent research and chapters is both well-informed and academically sound.

The framework will then be contextualised within the background theoretical literatures.

2.1. Research Spheres and Literature Review Strategy

2.1.1. Research Spheres of Influence

To identify and articulate the research gap and position this research within the established published academic literatures, Figure 4 was developed to depict the main bodies of knowledge from which this study draws.

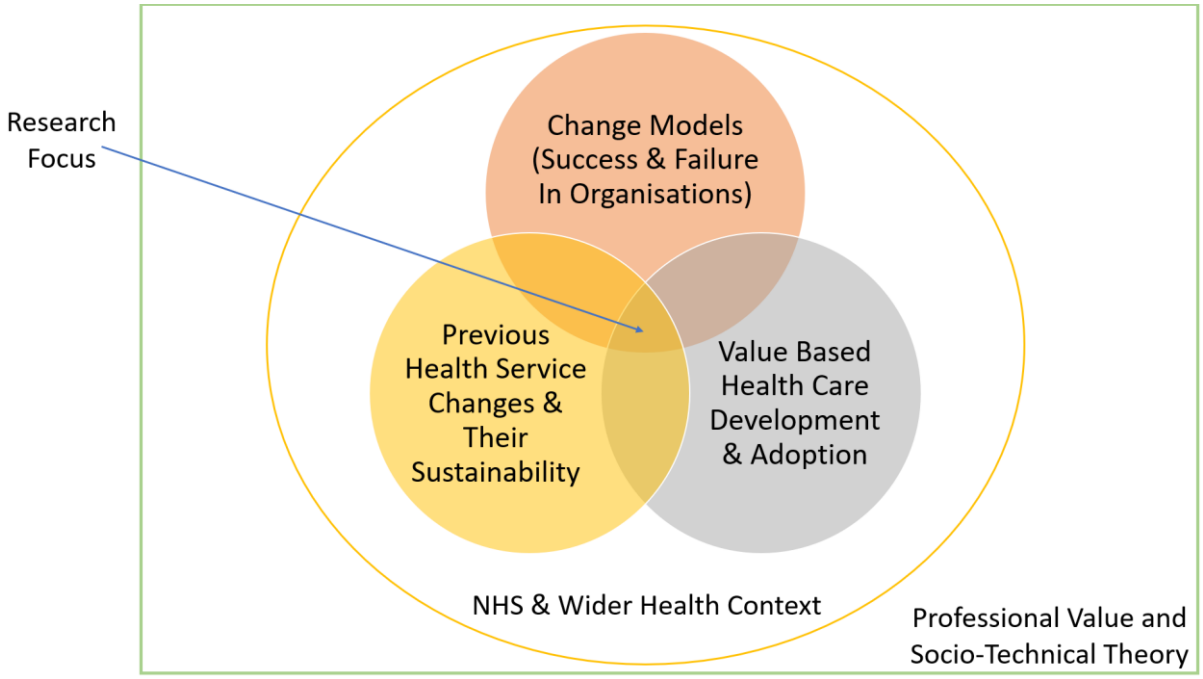


Figure 4 - Research Sphere of Influence (Source: The Researcher - Marc Penny 2025)

The research spheres of influence include:

Change Success and Failure in Organisations

- Including existing change models and existing evaluations.
- A review of previous change delivery in non-health organisations and lessons for success and failure.
- Sustainability of change in non-health organisations.

Previous Health Changes & Their Sustainability

- Review of previous change and improvements in health organisations, their effectiveness and lessons learnt.
- Review of the role of culture within health organisations and its impact on change success or failure.

Value Based Healthcare

- An exploration of its genealogy.
- Lessons from its deployment.
- A review of VBHC sustainability in delivering benefits.

These combined spheres represent critical bodies of literature and based on the authors review of the extant literature, have not been holistically reviewed together, the intersection of the spheres, represents the unique position of the researcher. The 3 spheres sit within the wider context of 'professional value' and within a national context/culture in which Health Care is practiced (Figure 4). The research question and sub-questions (chapter 1) are derived from this focal literature review and from within the overlapping intersection of the 3 research spheres. Drawing together these often separately examined domains, the researcher highlights a novel and underexplored intersection. This integrative approach not only establishes a clear and justified research gap but also positions the study uniquely within the academic landscape.

The Venn diagram goes beyond theoretical alignment, it anchors the research in real-world, practical relevance by mapping academic insight to the lived context of healthcare delivery, professional values and national cultural influences. The originality of this approach lies in the synthesis of existing frameworks from diverse fields into a cohesive and practice-informed lens, from which the research questions and sub-questions are logically derived. This offers potential for fresh actionable insights in improving sustainable healthcare change.

2.1.2. Strategy for Literature Review

(Hart, 2001) defines a literature review as the '*selection of available documents on the topic, which contain information, ideas, data and evidence written from a particular standpoint to fulfil certain aims or express certain views on the nature of the topic and how it is to be investigated, and the effective evaluation of these documents in relation to the research being proposed*'. The researcher's strategy for the conduct of a critical literature review involved a critical literature review undertaken with a combination of an integrative reviews and a historical review to provide a genealogy to VBHC (to identify its development, weaknesses and gaps).

The researcher drew and reviewed publications that can be classified into the following forms as a means of quality assurance that both academic and professional literatures were used to inform the conceptual framework (Saunders et al., 2019):

- Secondary Literature:

  - Peered Review Academic Journals (including international journals with high citation scores from healthcare literatures and management journals that rated at national and international impact grades as per the ABS journal rankings),
  - Non-Peered Reviewed Academic Journals,
  - Professional Body Journals, and,
  - Books published by reputable international publishing houses.
- Grey / Primary Literature:
  - Government Reports,
  - Industry Reports and management consulting reports,
  - Public Sector Institution Reports,
  - Think Tank Reports, and,
  - Healthcare organisation web pages.

Due to the emergent nature of the research topic, especially within the VBHC context where there is limited academically rigorous literature available, the majority of publications use case methods or social studies of a single organisation to report findings. These publications lack depth, rigour and analysis and thus no established and calibrated validated scales or questionnaires could be employed or migrated to this new VBHC context. The lack of available published materials (and varying academic quality levels) meant the literature review was designed to include "grey" literature to supplement established and seminal publications concerning improving healthcare services. A number of parameters were defined by the researcher to target the search (Bell & Waters, 2018). Table 3 presents the parameters of the literature review.

SEARCH CRITERIA	RESEARCH PARAMETERS
Language of Publication	Predominantly English however the author will not exclude any relevant materials found in other languages subject to there being a highly likely hood of significant impact on the research. Where any material is found in another language care will need to be given to ensure accurate translation
Subject Area	Dependent on the spheres of influence described. Within 'Previous Health Changes & Their Sustainability' and 'Value Based Health care' the subject area will firmly be within health context, however for reviewing wider 'Change Success and Failure in Organisations' and 'Socio-Technical Theory' the subject area will be left open to ensure as wide a range of learning as possible can be explored
Geographical Area	Although the author has a specific interested in Wales and the wider UK for the application of the research the geographical parameter for searching and learning will be global

SEARCH CRITERIA	RESEARCH PARAMETERS
Publication Period & Literature Type	Due to the limited nature of Value based healthcare research the author will not confine search parameters to a particular date nor literature type. Care will be given on the age and quality of any literature however will not be constrained by these parameters

Table 3 - Search Criteria and Parameters (Source: The Researcher - Marc Penny 2025)

The primary search engines and repositories selected for the literature review were hosted by the Swansea University 'iFind' library service. iFind is an academic content search engine and was supplemented by 'Google Scholar' to ensure the widest range of publications were included. These engines search numerous databases and directly access journal publisher repositories including:

- ProQuest,
- EBSCOhost Business Source,
- ABI/INFORM Collection,
- British Nursing Index,
- Healthcare Administration database,
- BMJ Open Access Journals and British Medical Journal Collection, and,
- Nursing & Allied Health Database.

Seminal works, collected during the review were entered into the Litmaps app (an app which actively searches reference lists and generates a graphic that demonstrates extent of citations associated with the publication). This acted as a quality assurance procedure to prevent omission of major articles from the final literature database from which this study draws.

The primary "search terms" used to select relevant articles, were created using a Boolean Logic and search terms was constructed by combinations of search words (Figure 5).

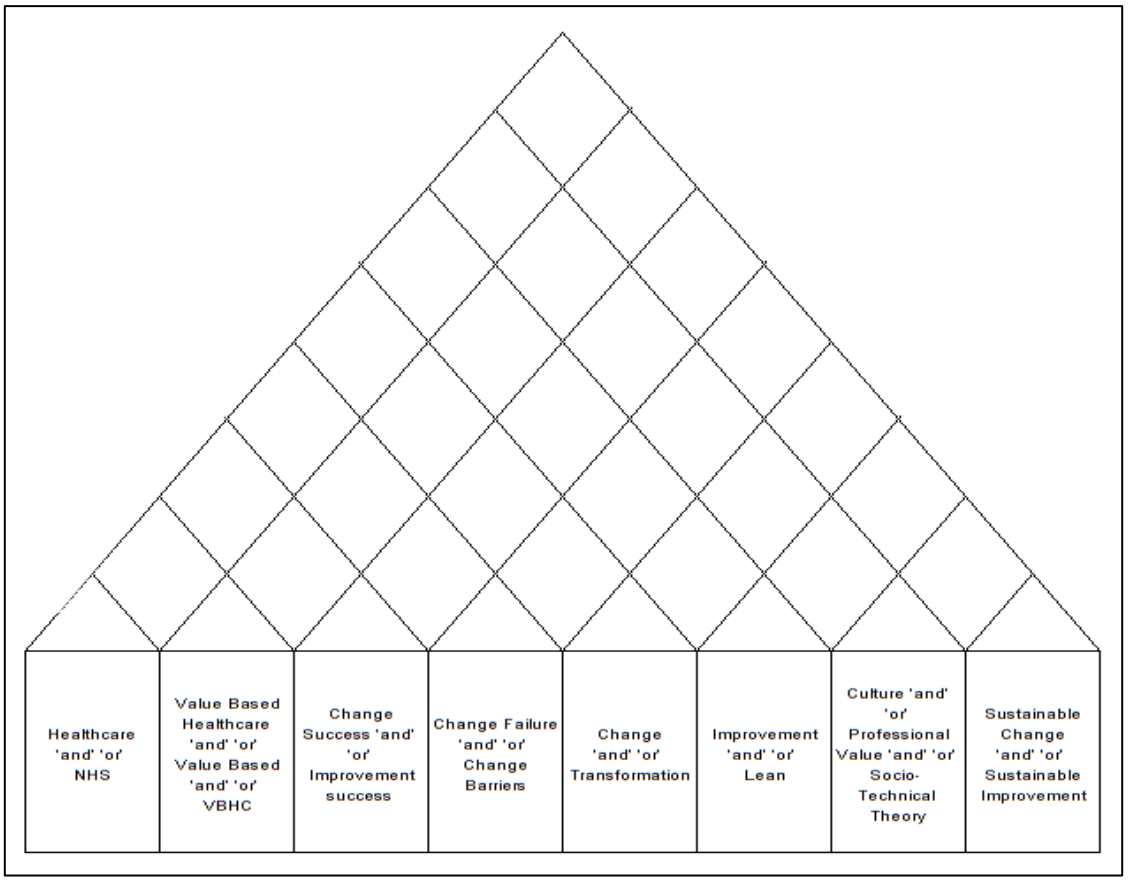


Figure 5 - Literature Review Search Terms (Source: The Researcher - Marc Penny 2025)

The researcher created a compiled journal list in a spreadsheet which included the abstract, methods, findings, weaknesses and gaps identified by the author(s). A full list of journals included in the literature review will be gathered and assessed which showed the number of articles from each journal and its associated 2021 SJR score, 2021 SNIP score and where included its 2021 AJG rating which provided additional assurance concerning citation quality and impact of that study. Having provided the logic and process of the literature review, the next section of this chapter will refine the subjects (contained with each of the three spheres identified in chapter 1).

2.2. Defining Services and Their Characteristics

A service operation is defined as an intangible activity (or benefit offered) to meet the needs of people typically involving a transaction in which no physical goods are transferred. Thus, services are distinguished by their intangibility, variability and inseparability from their demand (Lovelock & Wirtz, 2004). Services play a key role in modern global economies and include sectors like healthcare, education, finance and hospitality where they are often designed to enhance customer experiences and meet specific needs (Kotler et al., 2019).

The Table 4 below presents the key dimensions of a service to assist the reader understanding.

COMPONENT	DEFINITION	CITATION
Intangibility	Services cannot be physically touched or stored, making them fundamentally different from goods.	(Lovelock & Wirtz, 2004) (Zeithaml et al., 1985)
Variability	Because services depend on the people providing them, there can be variations in quality across different providers or even the same provider at different times.	(Lovelock & Wirtz, 2004)
Inseparability	Services are typically produced and consumed simultaneously, meaning they often require direct interaction between the provider and the consumer.	(Parasuraman et al., 1988)
Service Design and Delivery	Service design includes planning the processes, infrastructure, and resources necessary to provide the service.	(Bitner et al., 1990)
Customer Involvement	Many services, particularly in healthcare and education, involve active participation from the consumer.	(Gronroos, 2007)

Table 4 - Key Components of a Service (Source: The Researcher - Marc Penny 2025)

Workers and professionals (socio dimension of work) are key to delivering services often interacting directly with customers or "service users" to provide solutions to their needs. Effective training and professional development are essential for all service staff so service standards can be managed especially in complex settings where there is high variety of needs and low repeatable volume of work (Bitner et al., 1990). In healthcare for example, professionals provide both technical expertise and compassionate care which are essential to delivering positive health outcomes (Berry & Bendapudi, 2007) whereas call centres for banks may simply repeat an engineered task (with no staff discretion) every time the phone rings with a customer call .

A 'healthcare service' is the organised provision of medical care to individuals (often called patients) and encompasses a range of activities aimed at maintaining or improving health within a population. Such services include prevention, diagnosis, treatment and rehabilitation offered to patients by professionals in a range of settings (hospitals, clinics and community). The structure and funding of healthcare services can vary significantly across countries and is influenced by social, economic and political elements (*The World Health Report 2010. Health Systems Financing: the Path to Universal Coverage*, 2010).

2.2.1. Healthcare Models

Healthcare systems worldwide generally follow one of four models: the Beveridge Model, the Bismarck Model, the National Health Insurance (NHI) Model and the Out-of-Pocket Model. Each has distinct historical roots and operational structures.

- The Beveridge Model

Named after Sir William Beveridge this model was designed to provide universal healthcare funded by general taxation minimising patient costs at the point of service (Great & Beveridge, 1942). Developed in the UK post-World War II the model established the National Health Service (NHS) in 1948. Healthcare is a public good provided by the government which also employs most healthcare providers (Klein, 2013). Countries with this model like the UK and Spain typically focus on accessibility and equity in healthcare (*The World Health Report 2010. Health Systems Financing: the Path to Universal Coverage*, 2010). This remains the dominant UK model of care provision and funding.

- The Bismarck Model

Originating in 19th-century Germany under Chancellor Otto von Bismarck, this model relies on employer and employee contributions to social health insurance funds (Busse et al., 2017). These funds are highly regulated and non-profit ensuring access to care for all insured individuals. The system operates with private healthcare providers but under government oversight to control costs (Saltman & Busse, 2002). Countries such as Germany and France use this model which maintains a blend of private and public healthcare elements (*The World Health Report 2010. Health Systems Financing: the Path to Universal Coverage*, 2010).

- The National Health Insurance (NHI) Model

The NHI model combines elements of the Beveridge and Bismarck systems. It is publicly funded through taxes but relies on private healthcare providers. This model as seen in Canada provides universal coverage through a single-payer system reducing administrative complexity and negotiating power with providers. While patients have free choice of providers the system limits access to specific services to control costs (*The World Health Report 2010. Health Systems Financing: the Path to Universal Coverage*, 2010).

- The Out-of-Pocket Model

The Out-of-Pocket model is not systematically funded by insurance or government. Individuals pay for healthcare services directly often resulting in inequitable access and financial burden on patients (*The World Health Report 2010. Health Systems Financing: the Path to Universal Coverage*, 2010). This

model is prevalent in countries without established public health insurance or where healthcare spending is highly individualised such as South-East Asia.

A summary of the different types of healthcare models is shown in Table 5.

FEATURE	BEVERIDGE MODEL	BISMARCK MODEL	NATIONAL HEALTH INSURANCE	OUT-OF-POCKET MODEL
Funding Source	General taxation	Payroll contributions	Tax-funded (single-payer)	Direct payments by individuals
Provider Ownership	Primarily government	Private, non-profit funds	Private providers, publicly funded	Private providers
Coverage	Universal	Universal for the insured	Universal	Limited to those who can afford it
Access to Care	Free or low-cost	Low-cost for insured	Low-cost, universal	Direct payments; often inequitable
Provider type	Publicly-owned NHS or regional provider	Private, contracted providers	Private providers operating within a publicly funded system	Private providers
Provider motivation	Value for money from allotted budget	Efficient service delivery within reimbursement limits	Providing universal care with cost efficiency	Profit-driven

Table 5 - Healthcare System Models Summary (Source: The Researcher - Marc Penny 2025)

Healthcare funding models shape the structure, accessibility and efficiency of care delivery, directly influencing performance in healthcare systems. Models like Beveridge and National Health Insurance prioritise universal access through public funding, fostering equity, parity and streamlined delivery. The Bismarck Model seeks to balances public oversight and value for money with private provision, driving efficiency and innovation. In contrast, Out-of-Pocket systems highlight the risks of inequity and fragmented care where funding is unsystematic and based on ability to pay. Achieving high performance requires aligning funding mechanisms with service delivery models that emphasise equity, efficiency and quality.

2.3. Features of an NHS Service

In the United Kingdom the NHS operates as the primary healthcare provision based on a national health insurance healthcare model. This model and the NHS, offers services that are free at the point of use and accessible to all. The NHS and the professionals working in it operates within a complex and ever-changing landscape, shaped by demographic changes, financial pressures and continually rising patient expectations. Its structure includes various organisations responsible for commissioning

and delivering healthcare services, with funding flowing through a network of governmental and local entities (Rowe, 2021). Governance structures across the 4 UK regions vary slightly but ultimately delivery is at a localised level. Leadership within the NHS increasingly reflects the principles of complex adaptive systems, emphasising adaptability and collective decision-making to navigate the system's complex challenges (Underwood, 2024).

Schmenner (1986) categorised services within the NHS into three main types based on his service process matrix categories (Schmenner, 1986).

2.3.1. Mass Services

These are high-volume, low-customisation services designed for efficiency and standardisation. Examples include vaccination programmes and health screenings. These services aim to maximise accessibility and throughput while maintaining a baseline level of quality (Johnston et al., 2012).

2.3.2. Service Shops

Service shops balance standardised processes with a degree of customisation. Outpatient departments, diagnostic imaging and routine surgical procedures are representative of this category. These services require a degree of patient interaction and diagnostic intervention, often involving multidisciplinary teams (Silvestro et al., 1992).

2.3.3. Professional Services

At the high end of customisation and complexity, professional services include specialised treatments such as oncology care, cardiothoracic surgery and mental health counselling. These services depend on the expertise and judgment of highly trained professionals and often involve complex decision-making processes tailored to individual patient needs (Schmenner & Swink, 1998). These services are often provided by specialist tertiary providers on a regional basis.

2.4. Dimensions of Service Quality

The quality of healthcare services in the NHS is multidimensional, reflecting both clinical outcomes and patient experiences. Key dimensions are summarised in the Table 6 below:

DIMENSION	DESCRIPTION	REFERENCES

Technical Quality	Clinical accuracy and the effectiveness of interventions, ensuring appropriate diagnoses and treatments.	(Donabedian, 1988) (Campbell et al., 2000)
Functional Quality	The way services are delivered, including the nature of interactions between patients and professionals and the overall experience of care.	(Grönroos, 1993) (Parasuraman et al., 1988)
Accessibility	The ease of obtaining healthcare services, considering geographic location, scheduling flexibility and waiting times.	(Gulliford et al., 2002)
Reliability	Consistency in service delivery, ensuring the same level of care quality across different interactions and providers (parity).	(Zeithaml et al., 1985) (Berry & Parasuraman, 2004)
Tangibility	Physical evidence of service quality, including cleanliness, infrastructure, equipment availability and staff presentation.	(Kotler et al., 2019) (Taylor, 1992)
Empathy	Demonstrating care and understanding of individual patient needs, fostering trust and emotional support.	(Berry & Parasuraman, 2004) (Ladhari, 2009)
Responsiveness	The readiness of healthcare providers to meet patient needs promptly, including managing emergencies and addressing concerns.	(Bitner et al., 1990) (Michel et al., 2008)

Table 6 - Dimensions of Service Quality (Source: The Researcher - Marc Penny 2025)

These dimensions offer a holistic perspective on quality and underscore the NHS's dual focus on clinical outcomes and patient-centred care and quality.

2.5. What Enables High Performance Health Care Service Provision and How it is Measured

High-performance healthcare (HPH) is attributed to effective leadership, organisational culture and evidence-based practices but the key role played by healthcare professionals is frequently underemphasised in the researchers opinion, where organisational culture and readiness for evidence-based practice are essential with the direct involvement and perceptions of healthcare professionals significantly influencing the successful implementation change (Cleary-Holdforth et al., 2022). Workers and professionals who are the direct deliverers of care play an essential role in translating organisational goals into actual patient outcomes and experiences. Staff also determine the:

- Safety of a service.
- The quality of a service.
- The timeliness of a service.
- The flexibility of a service. And ultimately,
- The costs of a service.

(Rich et al., 2006)

Staff interactions with patients (combined with their expertise and adaptability are key to delivering high care standards, especially in complex healthcare settings (Braithwaite et al., 2017; Mannion & Davies, 2018). A supportive work environment that focuses on staff engagement, phycological safety and well-being is essential to reduce staff absenteeism, burnout and high staff turnover that adds stress to the performance of services and their outcomes (Salyers et al., 2017; West et al., 2016). The extent to which staff feel valued, supported and aligned with their organisation's vision and goals also directly impacts the quality of care provided (Janes et al., 2021). Table 7 provides a summary of the key enablers of high-performance healthcare organisations and their impacts on performance.

ENABLER	DEFINITION	POSITIVE IMPACTS ON SERVICE PERFORMANCE	CITATION
Effective Leadership	Leadership that provides clear vision, direction and fosters collaboration and adaptability among professional staff.	Enhances service quality, motivates staff and aligns organisational goals with patient outcomes.	(Cleary-Holdforth et al., 2022)
Organisational Culture	Shared values, norms and practices that inform behaviours and attitudes within complex healthcare organisation.	Encourages readiness for evidence-based practices, enhances teamwork / multidisciplinary working and drives quality improvements.	(Cleary-Holdforth et al., 2022)
Evidence-Based Practices	Clinical and operational decisions based on the best available research evidence, combined with professional expertise and patient need.	Improves safety, quality and cost-efficiency of services.	(Rich et al., 2006)
Staff Engagement	The degree to which professionals feel emotionally and professionally invested in their roles and aligned with organisational goals and vision.	Increases staff retention, reduces burnout and enhances patient care quality and experience.	(West et al., 2016) (Salyers et al., 2017)
Psychological Safety	An environment where professionals feel safe to express ideas, take risks and report issues without fear of negative consequences.	Reduces absenteeism and turnover while fostering innovation and improved care delivery for patients.	(Salyers et al., 2017)
Supportive Work Environment	A workplace that prioritises staff well-being, development and values their contributions.	Sustains high-quality care delivery and staff satisfaction while mitigating stress-related impacts.	(Janes et al., 2021) (West et al., 2016)

ENABLER	DEFINITION	POSITIVE IMPACTS ON SERVICE PERFORMANCE	CITATION
Staff Competence and Expertise	The knowledge, skills and adaptability of healthcare professionals in delivering patient care.	Ensures high standards in safety, flexibility and timeliness of care delivery, improving overall patient outcomes.	(Braithwaite et al., 2017) (Mannion & Davies, 2018)
Patient-Centred Outcome Focus	Prioritising care delivery that addresses patient needs, experiences and values while balancing operational efficiency.	Improves patient satisfaction, safety and service timeliness while maintaining financial sustainability.	(Aiken et al., 2011) (Shaw et al., 2009)
Balanced Metrics	Incorporating staff well-being, engagement and resilience into performance measurement frameworks alongside patient outcomes and financial efficiency.	Avoids trade-offs that harm service quality and fosters a holistic approach to performance improvement.	(Seddon, 2008)

Table 7 - Enablers of High-Performance Healthcare Service (Source: The Researcher - Marc Penny 2025)

Despite the clear influence of healthcare professionals on patient outcomes current measurement frameworks often overlook metrics related to staff satisfaction, resilience, experience and engagement focusing instead on quantitative patient outcomes and financial efficiency. Such a focus causes dysfunctions when trade-offs occur (Seddon, 2008). High-performance healthcare requires a balanced and 'context specific' approach that emphasises patient-centred outcomes, operational efficiency and includes the perspectives and well-being of healthcare staff and professionals working within the system. Such conditions and workplaces foster an environment where staff thrive and sustainably deliver high-quality care (Aiken et al., 2011; Shaw et al., 2009). High performance healthcare services therefore depend on qualified and competent staff who are invested in and valued and who understand the value they provide to their (often vulnerable and distressed) patients and service users.

2.6. Change Success and Failure in Organisations

The 1st sphere of the literature (Figure 3 in chapter 1) relates to understanding what impedes and enables organisational and process improvement changes and the successful sustainability of learning-improvement organisational processes that enhance value from the staff. This section will review the literature by reviewing existing change models and theories.

Organisational Change Management is defined as an approach to guide organisations, teams and individuals through change in current working practices and the transformation of care to realise a desired “future” improved state. With growing pressures from technological, regulatory and market changes, organisational change management is seen by organisations as essential for adaptability, resilience and economic viability of service continuity (Burnes, 2004; Kotter, 1996). However, many traditional change models, including Lewin's "Unfreeze-Change-Refreeze" (Lewin, 1947) and Kotter’s eight-step process (Kotter, 1996), are criticised for being overly simplistic and outdated. These models fail to account for the complexity and dynamism of modern healthcare environments and systems, where conditions are highly variable, and one-size-fits-all approaches often fall short (Graban, 2011). As well as delivering technical change organisational change management, in the modern VBHC operating environment, must address the “human side” of change recognising that sustainable transformation depends heavily on employee acceptance and engagement (Armenakis & Bedeian, 1999; Lewin, 1947) with the meaningfulness of any proposed change or transformation. The need to invest in staff results from change and improvement being a discretionary effort above the contract of employment.

More contemporary models, such as TQM (Total Quality Management), Lean, Agile and others, attempt to address these gaps. Among these, Lean has gained significant traction in healthcare for its emphasis on improving quality, patient safety and employee satisfaction while eliminating waste (Graban, 2011). However, Lean too faces criticisms when applied without adaptation to healthcare's complex socio-technical systems. Critics argue that Lean implementations often prioritise efficiency at the expense of staff well-being and patient-centred care (Graban, 2011).

Few “classic” and dominant change models exist (such as Lewin’s "Unfreeze-Change-Refreeze" and Kotter’s eight-step process which explore the importance of preparing individuals for change, implementing change initiatives and embedding new behaviours within the organisation (Kotter, 1996; Lewin, 1947)). The emergence of VBHC reflects an evolving perspective that prioritises patient-centred outcomes and acknowledges the nuances of complex healthcare service settings. Unlike earlier models, VBHC incorporates the variability and interconnectedness of modern healthcare, advocating for tailored approaches that align with specific organisational contexts (Graban, 2011). Other change frameworks such as Prosci’s ADKAR model focuses on aligning individual behaviours with organisational goals through awareness, desire, knowledge, ability and reinforcement (Hiatt, 2006).

Despite these structured approaches studies indicate that most change initiatives fail to meet their goals, highlighting the complex nature of organisational change management and the need for strategies that account for organisational context and culture (Beer & Nohria, 2000), despite the growing use of continuous improvement models like Lean and Agile. This failure underscores the importance of adopting flexible and context-sensitive approaches, as there is no universal best way to implement change in healthcare settings. VBHC, with its nuanced understanding of healthcare settings, offers a more promising and sector specific pathway by avoiding the pitfalls of retrofitted manufacturing models (Graban, 2011). Research has shown that the success rates of change initiatives remain relatively low, with estimates suggesting that over 70% of organisational change efforts fail to meet their objectives (Beer & Nohria, 2000) despite the growing use of continuous improvement models. To become successful and to adapt to modern conditions of the NHS in Wales, VBHC models will need to be sympathetic to staff, enhance their value and contribution to service delivery and design, and enhance the rate of successful change/velocity of improvements

2.6.1. What is Change Failure and is it a Bad Outcome?

The term organisational change management “failure” refers to the inability of a change or transformation initiative to achieve its desired outcomes resulting in unmet objectives, wasted resources and often reduced employee morale and productivity (Kotter, 1996). Failure is frequently attributed to factors such as inadequate leadership, poor communication, lack of employee engagement, and resistance to change in the management literatures (Armenakis & Bedeian, 1999; Kotter, 1996) and in the healthcare literature (Beer & Nohria, 2000).

Project failure results in resource loss, compromised morale, or generates employee to future change in the form of overt and covert resistance (Armenakis & Bedeian, 1999; Kotter, 1996). However, an emerging perspective informed by a recent school of thought termed improvement science suggests that change "failures" can be valuable learning opportunities for organisations. Improvement science, which promotes evidence-based continuous improvement portrays unsuccessful outcomes as just iterative steps that generate insights for refining future interventions and changes rather than as pure failures. In effect, poor change outcomes result in new alternatives being tested and if they work then more of that form of investment of staff time is conducted (Langley et al., 2009). This learning-oriented view aligns with principles of a "just culture," where employer organisations and team leaders encourage organisations to treat mistakes as learning points rather than focusing solely on

punishment and blame which dis-enfranchises staff and associate change with negative experiences for those involved (Dekker, 2007).

Many organisations struggle to consistently adopt this approach of improvement science and default to autocratic 'top down' imposed processes of change where accountability measures are used that hold employees responsible rather than examining systemic causes of how empowerment can be used to spread change initiatives to more staff so a learning organisation is created (Senge, 1993). Research in Welsh healthcare reveals the consequences of a punitive approach, Andrew Cooper and Dr. Adrian Neal found, in the context of service improvement, safety incidents and service failures resulted in employee harm and that disciplinary actions for those involved with service mistakes created a culture of fear and contributed to employee stress which then limited opportunities for open staff discussion about the causes and symptoms of service errors (Cooper et al., 2024). Such management practice limits learning and prevents the organisation from addressing the root causes of repeated issues which will, overtime repeat.

Studies show that a culture focused on blame and accountability often undermines organisational resilience (Farrow, 2024) as employees become risk-averse fearing repercussions rather than seeking improvements. Beer and Nohria (2000) argue that this approach inhibits innovation and adaptability. Improvement-oriented organisations or "learning organisations" as described by Senge (1993) view setbacks as essential for growth and encourage an environment of psychological safety where employees can report issues without fear. This fosters resilience by transforming failures into opportunities for development and learning. These works show a polarisation of approaches from conventional policing and apportioning blame to poor worker behaviour to more enlightened modern approaches which accept service failures (Perrow, 1999) and promote learning (Edmondson, 1999).

Despite the theoretical benefits adopting a learning-focused approach to change, failure elimination and reduction remain challenging processes for many organisations. Organisations often revert to individual accountability due to pressures to manage risk quickly especially in complex organisations such as the NHS (By, 2005). The latter is especially true where regulated professionals must act in accordance with their licences. As such, improvement science, alongside models like ADKAR provides frameworks that balance learning with accountability and support learning from failures as structured opportunities for organisational growth and employee development (Cameron & Green, 2012; Hiatt, 2006). For organisations to learn from failures they must commit to building a culture where leaders

view failures not as setbacks but as lessons for enhancing future initiatives. These approaches are restorative though and modern service provision for high performance will also look for opportunities to improve even when failure has not occurred. While these approaches are restorative, modern service provision for high performance also seeks opportunities to improve proactively, even in the absence of failure. This proactive stance is exemplified by continuous improvement models such as the Plan-Do-Study-Act (PDSA) cycle, which encourages organisations to systematically test and implement changes, fostering an environment of ongoing enhancement (Langley et al., 2009). By embracing both restorative and proactive improvement strategies, organisations can cultivate a resilient and high-performing culture.

2.7. Service Recovery and Organisational Learning

2.7.1. Service Recovery

Service recovery involves addressing and rectifying failures in service delivery to restore patient trust and satisfaction. In healthcare, this can range from resolving complaints to managing adverse medical events and outcomes. Effective recovery strategies include transparency, active listening and implementing corrective measures promptly (Berry & Parasuraman, 2004). Research suggests that well-handled recovery efforts can result in heightened patient trust (Michel et al., 2008).

2.7.2. Organisational Learning

Organisational learning is vital for enhancing service quality and preventing recurring failures. In the NHS, this involves embedding feedback mechanisms, incident reporting systems and reflective practices into everyday operations (Edmondson, 2015; Senge, 1993) and within NHS Wales initiatives such as Speaking up Safely and Learning from events aim at continually improving from learning.

2.7.3. Application to Healthcare

The principles of service recovery and organisational learning are closely linked to socio-technical systems theory, which advocates optimising both human and technical aspects within organisations (Trist, 1978). In practice, this means fostering an organisational culture that values continuous improvement, shared learning and collaboration across teams and professionals working in the system. This approach not only enhances patient outcomes but also supports staff engagement and professional development.

2.8. Theory of Change and Change Models Review

Theory of Change

Change theory and organisational change management are key aspects of high performance and highly reliable enterprises and these models are critical to effectively introduce and sustain improvement in a range of settings and contingencies. The Theory of Change (TofC) was originally designed to evaluate social programmes (Weiss, 1995) and has been widely accepted and practiced in the health and care sectors. The theory of change posits that change occurs through a sequence of sequential and intermediate steps with clear and measurable outcomes. The approach helps to implement change by understanding where the change team is now and where they want to be. An important feature of the approach is "mapping out" and visualising the steps and route map of change for those involved.

Critics argue that TofC over-simplifies change and/or acts as just a guideline tool which is overly process focussed, lacking in cultural empathy and does not help to implement change as part of a wider programme of work. Vogel (2012) in his report for the UK Department for International Development (based on workshops and interviews with staff), argues that TofC is simplistic and does not account for other interacting factors in the operating environment (Vogel, 2012) which would include professionals working within the system and acting with their agency. This perspective is reinforced by De Silva et al. (2014) who argued that whilst TofC aims to clarify assumptions and depict causal linkages towards an improved state it lacks flexibility in highly variable contexts such as healthcare, where rapid adjustments to change activities are often required (De Silva et al., 2014). Some critics propose that the myopic emphasis on mapping outcomes and indicators leads to a bias towards quantifiable results and neglect of qualitative changes (to culture) that are equally valuable but harder to measure (Pascale et al., 2010).

Lewin 3-Step Model

Kurt Lewin's change theory was introduced in the 1950's. Lewin's 3 step model involves stages of unfreezing working practices, changing and refreezing these practices to standardise and sustain improvement (Lewin, 1951). The model, which is still cited by modern studies (Coulter, 2021; Cummings et al., 2016; Sorensen, 2023) argues change requires disrupting the current state (unfreezing), moving to a new state (the change) and then stabilising the new practices (refreezing) as an action learning cycle. Complex organisations such as NHS healthcare operate in dynamic and complex settings which necessitates continuous change. This setting poses challenges for 'refreezing' changed working practices. Some authors believe the method may not actually fit with the NHS

organisational context and the critical review of the 3-step model by Burnes in largely discredited it (Burnes, 2004). While the simplicity of Lewin's model provides a generic and foundational framework for understanding change, poor utility for complex, adaptive systems like healthcare remain (Snowden & Boone, 2007).

In defence of Lewin, his model commences with the organisational management level staff advising employees of the need for change and articulating the reasons/benefits for it. A critical literature review (2013) proposed what was lacking from Lewins conceptualisation was employee engagement and their involvement in the identification of change and the modern team approach to healthcare (Shirey, 2013). The researcher reflected that often the 3-step model omits human factors and delivers change "to" employees as opposed to delivering change "with" the employees (Cummings et al., 2016). In effect, Lewin's model reflects the time of its conception and prevailing management models of the 1950s where such autocracy existed and the management prerogative dominated all forms of change. The researcher reflected that, in settings where interdisciplinary collaboration is essential to provide complicated care services, healthcare professionals struggle to exploit Lewin's framework due to its linearity and lack of staff opportunities for continuous feedback.

McKinsey 7'S

In the 1980s Peters & Waterman developed what has become known as the McKinsey 7S model which aims to provide a more holistic approach to change by considering seven organisational elements (Peters, 1982). The two leading thinkers were employees of the consulting firm McKinsey and hence its name. The seven elements of the model, each starting with the letter 'S' include (Table 8):

ELEMENT	DEFINITION	APPLICATION IN A HEALTHCARE SYSTEM
Strategy	The organisation's long-term plan to achieve its goals and maintain competitiveness.	Developing strategies to improve patient outcomes, enhance care delivery, and reduce costs while aligning with healthcare policies and regulations. Often National or Regional level.
Structure	The organisation's hierarchy and the arrangement of roles and responsibilities.	Establishing an integrated structure with clear lines of communication across departments and functions (e.g. Government, Commissioners and Delivery teams, clinical and administrative) and within multidisciplinary teams.
Systems	The processes and workflows that support daily operations.	Using electronic health records, patient management systems and digital tools to collect patient outcomes and experience feedback (PROMS and PREMS).
Shared Values	The core values and culture that guide employee behaviour and organisational priorities.	Values like patient-centered care, ethical practices and teamwork to foster a culture of collaboration and empathy in care delivery.

Style	The leadership and management approach of the organisation.	Adopting transformational leadership to inspire innovation, support staff and ensure alignment with the objective of providing high-quality care.
Staff	The organisation's workforce, including their capabilities and composition.	Ensuring a diverse, multidisciplinary team of healthcare providers, administrators and support staff trained to deal with the complexities of modern healthcare.
Skills	The competencies and expertise within the organisation.	Developing specialised skills in medical technology, data analysis and patient communication to meet the demands of a rapidly evolving healthcare environment.

Table 8 - McKinsey 7S Elements, Definitions and Healthcare Applicability (Source: The Researcher - Marc Penny 2025)

Peters and Waterman argued that, to deliver successful change, organisational leaders and managers must understand the 7 interconnected factors. The model provides a more holistic and superior approach than Lewin's 3-step model and encourages organisations to consider both the hard (strategy, structure, systems) and soft elements (style, staff, shared values, skills) of change with the latter starting to encompass what we might term professional value to the employee. The model is cited in the healthcare organisational change management literatures.

A cross-sectional study published in 2022 by BMC Health Services Research tested the McKinsey 7S framework to evaluate organisational performance within public hospitals identified limitations of the model to sufficiently address the human element of change which included motivation, job satisfaction and personal development which may impact on long term sustainability of the change (Chmielewska et al., 2022). While the McKinsey 7S framework aims for a balanced organisational structure its limitations in accounting for individual motivations and job satisfaction may exclude healthcare professionals from key aspects of organisational change. In complex and high-stress environments like healthcare settings where professional autonomy and real-time adaptability are key, healthcare professionals may find the model overly prescriptive.

However, while the McKinsey 7S framework offers a comprehensive approach to aligning organisational elements, it is arguably better suited to broad structural change rather than the nuanced demands of process change. Process change, particularly in healthcare requires a granular focus on workflows, inter-professional collaboration and the integration of patient-centred care practices. The model's emphasis on strategic alignment and organisational structure may overlook the iterative and dynamic nature of process change, where adaptability and continuous feedback are essential (Kaplan et al., 2010). For example, the rigid categorisation of elements within the 7S model

may constrain the flexibility needed to respond to the evolving nature of patient needs and healthcare delivery methods. The model's limited emphasis on the 'soft' elements — such as staff and shared values, reduces its applicability to process-driven environments where human behaviour and interpersonal dynamics / relationships are key. Studies have highlighted that successful process change in healthcare often relies on bottom-up approaches that empower frontline staff and encourage participatory decision-making (Greenhalgh & Papoutsi, 2018). The McKinsey 7S model's top-down orientation may therefore inhibit these critical factors, making it less effective in addressing process-specific challenges that require localised innovation and contextual adaptability.

ADKAR (Awareness, Desire, Knowledge, Ability and Reinforcement)

Another dominant and popular model is the ADKAR change management model which was developed by Prosci (a change management organisation and form of consultancy). The model developed in the late 1990s and is renowned for its focus on the individual impacted by, and involved in, change. It is a process model much like Lewins and unlike the McKinsey approach. The acronym ADKAR stands for Awareness, Desire, Knowledge, Ability and Reinforcement, and the model articulates that each of the ADKAR elements should be considered and addressed for successful change (Hiatt, 2006) and its sustainability. One of ADKAR's strengths is its focus on personal transformation (something which is sometimes overlooked by other change models) as key to organisational change and transformation, making it more adaptable to individual needs and professionals working within an organisation. The ADKAR model acknowledges themes such as 'job satisfaction' and 'personal satisfaction', as it assumes that individuals must not only understand the need for change but also desire it and feel capable of enacting it.

There has been some criticism of the ADKAR model for being too individualistic, sometimes underestimating the systemic and structural barriers to change that can exist in large organisations (Hornstein, 2015) especially ones as complex as healthcare organisations. While ADKAR emphasises personal / professional alignment and engagement with change and transformation, it offers less guidance on developing a sense of belonging or career development opportunities as part of the change process which are also key aspects of individuals desire to change. ADKAR focus on personal desire and motivation may oversimplify change assuming that resistance is rooted primarily in individual reluctance rather than structural constraints (Whelan-Berry & Somerville, 2010). ADKAR's individual-cantered approach may overlook the collaborative, team-oriented nature of healthcare work and professionals. Healthcare environments often require interdisciplinary coordination and

ADKAR's focus on individual desire and motivation may not fully capture the influence of team dynamics, shared goals and the complex multi-disciplinary nature in these settings.

John Kotter's Eight-Step Model

In 1996, John Kotter introduced his eight-step model for change, a model which was quickly and widely adopted as a key framework in organisational change management. Kotter emphasises creating a sense of urgency often described as *'the burning platform'*, building a coalition, developing a clear vision and strategy, strong communication, empowerment of individuals and professionals, maintaining momentum through short-term wins; and to achieve sustained change continually consolidating and building into the organisations culture (Kotter, 1996).

While the eight-step model provides a structured approach to change it has been argued that it focuses too much on top-down change, relying on leadership to drive the process. This can cause a lack of engagement and involvement especially in complex organisations such as healthcare where 'individual engagement' and 'bottom-up' initiatives are seen as key for change delivery and sustainability. Critics argue that this can lead to resistance among employees, particularly in complex settings where adaptability and collaboration are crucial (Appelbaum et al., 2012). By (2005) contends that Kotter's model assumes an idealistic view of change with its emphasis on clear sequential steps that may not align with the realities of organisations (By, 2005) where change is often non-linear. Kotter's emphasis on short-term wins has been criticised for encouraging a short-sighted perspective that might overlook the importance of incremental sustainable adjustments (Al-Haddad & Kotnour, 2015). These critiques suggest that the model may be more suitable for straightforward one-time changes than for continuous or iterative change processes. Although Kotter discusses 'building a sense of urgency' and 'creating momentum' the model does not address in depth how to make individuals feel part of a broader movement or how change might align with their personal career goals and job satisfaction. The model tends to prioritise organisational needs over personal development potentially leading to disengagement if employees do not see how the change benefits them personally.

Summary of Dominant Models

Across the models the author has reviewed a recurring critique is their insufficient consideration of the complex and dynamic nature of complex healthcare settings, where interdisciplinary collaboration, professional agency and contextual change are key. For example, while models like Theory of Change and Kotter's Eight-Step Model focus on structured, sequential processes, they are

often criticised for oversimplifying change and neglecting cultural, systemic and individual variability and need. Similarly, Lewin's 3-Step Model and the McKinsey 7S framework, despite offering foundational and holistic perspectives are criticised for their rigidity and limited adaptability to real-time healthcare dynamics.

The researchers study into professional value and sustainable VBHC underscores the need for approaches that integrate both individual and collective motivations, align organisational goals with personal development and foster multidisciplinary-oriented flexible environments. Critiques of these models reveal a common weakness such as a top-down orientation that inadequately engages professionals on the frontline, who are crucial for embedding sustainable changes. This insight suggests that for successful VBHC deployment, models must evolve to include participatory decision-making, interdisciplinary collaboration and ongoing adaptability, ensuring alignment with the complex and nuanced realities of healthcare delivery.

2.8.1. Studies from Change Implementation in Other Organisations

The researcher's review of organisational change models highlights a number of factors that enable or hinder successful change and transformation delivery. Weiss's 'Theory of Change' highlights the importance of mapping out steps towards desired outcomes but has been criticised for its oversimplification and lack of consideration for systemic complexities (Vogel, 2012; Weiss, 1995). Lewin's '3-Step Model' of unfreezing, changing and refreezing (Lewin, 1951) is still widely applied but faces criticism for its rigidity, especially in complex organisation and environments such as healthcare, where continuous change may render the concept of "refreezing" obsolete (Burnes, 2004; Shirey, 2013). This model often overlooks employee engagement a factor emphasised in more recent literature (Cummings et al., 2016).

The PDSA (Plan-Do-Study-Act) and PDCA (Plan-Do-Check-Act) cycles, which stem from the Total Quality Management (TQM) movement, provide a structured iterative approach for implementing and refining change. The PDSA cycle, introduced by (Deming, 1982), focuses on iterative learning through small-scale tests of change before scaling interventions, ensuring evidence-based, data-driven decision-making. It aligns well with healthcare environments where piloting and refinement are critical. Its extension, the PDCA cycle, introduces a "check" phase to reinforce quality assurance and control during scaling. Despite their strengths, critics argue that these models often overemphasise

process over cultural transformation, which can limit their ability to address human factors such as motivation and resistance to change (Hornstein, 2015).

The 'McKinsey 7S' model provides a broader more holistic view of change and transformation, taking into account both "hard" and "soft" organisational elements (Peters, 1982) but has limitations in addressing individual motivations and long-term sustainability of change (Chmielewska et al., 2022). The 'ADKAR' model developed by Prosci shifts the focus to the individual, stressing the need for personal alignment with organisational change (Hiatt, 2006). The 'ADKAR' model has been criticised for ignoring structural barriers within organisations (Hornstein, 2015) especially ones as complex as the NHS. Kotter's 'Eight-step Model' provides a structured leadership-driven approach to change but it may not pay enough attention to employee involvement and engagement, particularly in large complex organisations where bottom-up initiatives are crucial (Kotter, 1996). Together these models demonstrate the need for balancing top-down leadership with employee engagement, addressing both systemic factors and individual needs for sustainable organisational change. Research has found that most change initiatives are reactive leading to a failure rate of up to 70% (Bamford & Forrester, 2003) because change isn't planned and not seen as something that needs to be resourced with the right skills (Anyieni & Gidion, 2016).

All the reviewed change models do not adequately explore issues of resistance to change and how to]deal with it and simply accept that all staff wish to change and improve. Similarly, the concept of 'Organisational Inertia' is ignored. Organisational inertia is the inability to engage staff with rudimentary forms of change, even when transformational change is needed or 'burning platforms' exist. This inertia occurs due to factors which include leadership and culture. Evidence-based change models like PDSA and PDCA can help address this inertia by providing data that validates the benefits of change, thereby reducing uncertainty and resistance. However, their success depends on integrating professional values and fostering a culture of continuous improvement. Authors have also cited past practices and experiences of poor change that make them less responsive and committed to new challenges or opportunities (Baum & Singh, 1994).

Learning from published accounts of organisations implementing change shows a clear linkage between people-centric change models and deployments and the effectiveness of the change itself (Smith et al., 2022).

- Key learnings:
    - Change models should account for both systemic factors and individual engagement to ensure sustainability.
    - Simplistic models like 'Theory of Change' may overlook organisational complexity and human factors.
    - The rigidity of Lewin's '3-Step Model' may not suit environments experiencing continuous change.
    - Holistic approaches like the 'McKinsey 7S' highlight both hard and soft elements but may neglect individual motivation and satisfaction.
    - Personal alignment and individual transformation as emphasised by 'ADKAR' model are critical but must be balanced with addressing organisational-level barriers.
    - Leadership-driven models like Kotter's may risk disengagement if they do not sufficiently involve employees in the change process.

The preceding models are the most popularly cited models in general management settings and such a dominance extends to the framing and methods of healthcare. The most cited model was found to be the TQM-derived Plan-Do-Study-Act (PDSA) cycle (Deming, 1982) and the NHS Change Model developed in 2012. PDSA, or the Deming/Shewart cycle was used in quality improvement initiatives and forms a learning journey of incremental change making it particularly valuable in testing and refining interventions before large-scale adoption (the scaling of such PDSA is via the PDCA cycle). Table 9 provides definitions of the different elements of the PDSA and PDCA cycles.

ELEMENT	PDSA DEFINITION	PDCA DEFINITION
Plan	Identify the problem or opportunity, set objectives and develop a plan for change or improvement.	Identify the problem or opportunity, establish objectives and create a detailed plan for implementation.
Do	Implement the plan on a small scale to test its effectiveness.	Execute the plan on a small scale or specific area to observe results.
Study	Analyse data and outcomes from the test to determine the success and identify lessons learned.	(Replaced by "Check")
Check	(Replaced by "Study")	Compare actual results to the expected outcomes and identify any areas requiring adjustment.
Act	Apply lessons learned from the test to refine the plan and scale up successful changes.	Incorporate necessary adjustments into the plan and standardise improvements before repeating the cycle.

Table 9 - PDSA and PDCA Definition (Source: The Researcher - Marc Penny 2025)

The NHS Change Model (Figure 6) combines elements from various change theories and emphasises alignment of culture, leadership and patient engagement to drive successful change across NHS settings (*The Change Model Guide*, 2018; Ogrinc et al., 2021).

Figure 6 - NHS Change Model (Source: The Change Model Guide, 2018)

The NHS Change Model is a framework designed to facilitate effective and sustainable change within the National Health Service. It includes eight interconnected components that work synergistically to support change initiatives across the system (Table 10).

COMPONENT	DESCRIPTION
Our Shared Purpose	Establishing a collective vision and shared goals to unify stakeholders and guide change efforts.
Spread and Adoption	Promoting the dissemination and integration of successful innovations across the healthcare system.

Improvement Tools	Utilising methodologies and tools to support continuous improvement and enhance outcomes.
Project and Performance Management	Applying structured approaches to oversee initiatives, track progress and ensure accountability.
Measurement	Implementing metrics to evaluate outcomes, inform decisions and demonstrate the impact of changes.
System Drivers	Aligning policies, incentives and regulations to create an environment that supports desired changes.
Motivate and Mobilise	Engaging and inspiring individuals and teams to participate actively in the change process.
Leadership by All	Encouraging leadership at every level to foster a culture of collective responsibility and empowerment.

Table 10 - NHS Change Model Components (Source: The Change Model Guide, 2018)

While the NHS Change Model offers a structured and comprehensive approach to managing change, it has received critiques for certain limitations. One concern is its overemphasis on procedural elements, which may overshadow the cultural and human factors critical to successful change (Hornstein, 2015). This can result in insufficient attention to staff motivation, engagement and the challenges posed by resistance to change. The model's structured nature can limit its flexibility, making it less adaptable to the diverse and dynamic contexts within the NHS. The complexity of healthcare settings often demands context-specific approaches, and a one-size-fits-all framework may not address localised needs effectively (Greenhalgh et al., 2004).

Another issue lies in the model's limited validation, as there is a lack of robust evidence demonstrating its effectiveness across various settings. This raises questions about its universal applicability and highlights the need for further research and evaluation (By, 2005). The absence of a definitive model for change management within healthcare reflects the broader challenge in this field, as no single framework has emerged as universally effective. The variability and context-dependence of change processes underscore the immaturity of this subject area, indicating the necessity for ongoing refinement and adaptation to meet the unique demands of healthcare organisations (Ferlie & Shortell, 2001).

2.8.2. Change Success and Failure in Organisations Literature Review Summary

The author has reviewed the key change management theories. Change failure is an outcome that is typically portrayed of interventions in healthcare settings and some have suggested that up to 70% of

all change programmes fail (Beer & Nohria, 2000). Failure occurs when an initiative does not meet its objectives leading to resource loss, reduced morale and productivity declines. The cited sources of failure include poor leadership, ineffective communication and employee disengagement (Armenakis & Bedeian, 1999; Kotter, 1996). The modern framing of failure, resulting from the PDCA experimental learning process is depicting it as nothing more than an unsuccessful outcome of an experiment which prompts a new cycle and a different focus for change. Experimental PDCA success leads to continued PDSA cycles that follow more of the same focus of intervention. The improvement science approach views such failures as learning opportunities suggesting they can inform better future initiatives (Langley et al., 2009). However these authors provide no practical assistance as to when to determine an unsuccessful outcome and how repeated poor outcomes do not result in a feeling of futility and resistance. Adopting the experimental approach is challenging as many organisations under pressure, manage risks by defaulting to accountability measures that apportion blame to individuals for poor performance instead of addressing systemic issues. Blame fosters a culture of "fear" and this has been detected in NHS Wales, where punitive responses to mistakes hinder open discussion and resilience (Cooper et al., 2024). Learning-oriented organisations by contrast encourage psychological safety and see failure as essential for innovation and adaptability and as an approach aligns more effectively with frameworks like ADKAR to balance learning and accountability for continuous improvement (Beer & Nohria, 2000; Hiatt, 2006; Senge, 1993).

The researcher summarised the conceptual dimensions of change in complex settings such as healthcare in Table 11 below.

LESSON TITLE	LESSON SUMMARY	LESSON IMPACT LEVEL		
		INDIVIDUAL	TEAM	ORGANISATIONAL
Individual Feeling Part of a Movement	Many change models particularly leadership-driven ones such as Kotter's Eight-step Model often overlook the importance of making employees feel like they are part of a collective movement. While Kotter's model emphasises building urgency and maintaining momentum it can fall short in creating a sense of belonging. The ADKAR model with its focus on personal transformation takes a more individual approach but can still miss out on fostering a collective sense of purpose. For organisational change to be successful individuals need to feel engaged part of a broader movement and that their input is valued in the transformation process.	YES	YES	YES

LESSON TITLE	LESSON SUMMARY	LESSON IMPACT LEVEL		
		INDIVIDUAL	TEAM	ORGANISATIONAL
Career Progression Opportunities / Development	Career development opportunities are frequently under-addressed in popular change models. The ADKAR model acknowledges personal transformation which includes job satisfaction but offers limited guidance on how change can align with career progression. Kotter's Eight-step Model tends to prioritise organisational needs over personal career development potentially leading to disengagement if employees do not see personal growth opportunities. For long-term sustainability of change models must address how individuals can develop their careers as part of the transformation process.	YES		
Working Environment Conditions / Improvements	The McKinsey 7S model is known for its holistic approach addressing both hard elements like structure and strategy as well as soft elements like staff and shared values. The model encourages organisations to consider improvements in working conditions as part of their strategy for change. However, it is limited in not fully addressing individual motivations or the human elements that can improve the working environment such as job satisfaction and personal fulfilment. Change models must consider how altering organisational systems and processes can positively affect the working environment.	YES	YES	YES
Job Satisfaction	Job satisfaction is often a crucial but overlooked element in change models. ADKAR places significant emphasis on job satisfaction by acknowledging that individuals must understand and desire the change. ADKAR does not fully explore how changes can enhance long-term job satisfaction by aligning with personal goals and aspirations. The McKinsey 7S model while addressing organisational factors fails to deeply engage with the individual's sense of job fulfilment which is key to maintaining the momentum of change. Building on Maslow's hierarchy it can be argued that an individual gains job satisfaction from being able to realise their full potential and having the ability to undertake personal development (Ștefan et al., 2020).	YES	YES	

LESSON TITLE	LESSON SUMMARY	LESSON IMPACT LEVEL		
		INDIVIDUAL	TEAM	ORGANISATIONAL
Personal Satisfaction	Personal satisfaction is integral to the success of organisational change and is a key strength of the ADKAR model which focuses on the individual's awareness, desire and ability to change. It recognises that personal satisfaction including understanding and embracing the change is essential for transformation to sustain. Models like Lewin's 3-Step Model which focus more on organisational processes may miss these key personal elements which can lead to resistance and hinder long-term sustainability of change.	YES		
Integral to The Individual's Role	For change to be sustainable it must feel integral to the individual's role within the organisation. The ADKAR model by addressing personal transformation highlights this integration but other models like Kotter's Eight-step Model and Lewin's 3-Step Model risk minimising the individual's connection to their role. Potentially focusing too heavily on top-down leadership or organisational processes these models may fail to show employees how the changes are directly relevant to their roles, leading to disengagement and resistance to the transformation.	YES	YES	YES

Table 11 - Change Success and Failure in Organisations Summary (Source: The Researcher - Marc Penny 2025)

The concepts do not exist in a vacuum but have relation characteristics which are explored in Figure 7.

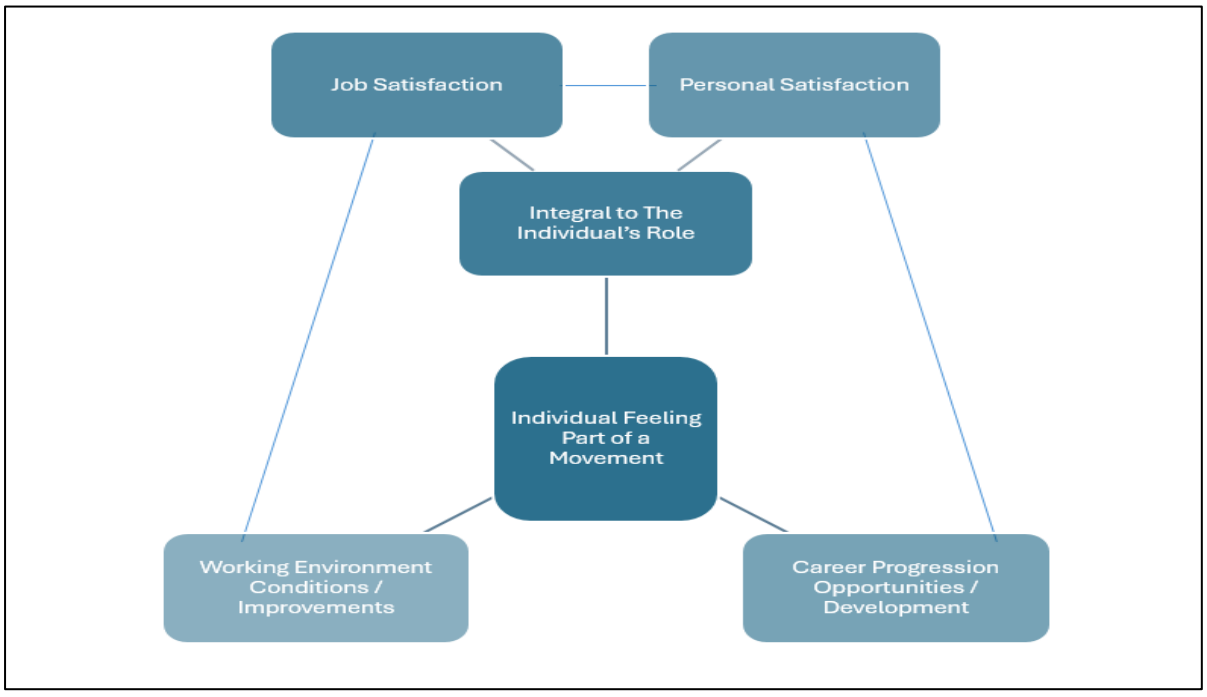


Figure 7 - Change Success and Failure in Organisations Diagram (Source: The Researcher - Marc Penny 2025)

The issues outlined highlight significant challenges that detract from the value of professional roles in organisational settings such as Healthcare. When systemic failures are misattributed to individuals, it creates a culture of blame and fear that suppresses innovation and undermines trust. This environment not only impacts on morale but also hinders professionals from fully engaging with their roles, seeing value in their contributions or aligning their work with personal and professional aspirations. Change models that overlook these dynamics risk fostering disengagement and resistance, ultimately impacting on sustainable change and transformation. For change initiatives to succeed, it is vital to create supportive environments that value learning, address systemic barriers and integrate individual development with organisational goals

2.9. Previous Changes in Healthcare and Their Sustainability

When reviewing the extant literature to understand what impedes/ enables change success and sustainability previous studies are contained in the 2nd sphere of influence which relates how staff view modern approaches including VBHC.

2.9.1. What Can be Learned from Past Healthcare Change Experiences

The researcher considered what lessons can be learnt from previous changes implemented locally or national initiates mandated across the UK NHS and wider healthcare systems. The chapter has presented the failure and unsustainability outcome of change as a typical view of numerous academic studies and a recurring theme. Failure to implement change in a systematic organisation-wide manner and only to implement change programmes (such as Lean healthcare) as a set of projects and tools can lead to the failure to deliver the desired benefits also (Burgess & Radnor, 2013).

“Loss of control” is a recurring theme that the literature identifies as a contributory to change failure (Shaikh, 2020). When healthcare professionals feel that they have lost control over decisions affecting their daily work, they often disengage from the change process as they feel isolated and under-valued (Janamian et al., 2022). Iles and Sutherland argue that the exclusion of staff from decision-making fosters resistance (Iles & Sutherland, 2001) to restore their value and pride. Studies also show that top-down approaches (with disregard for professional staff input) undermine engagement and commitment to change so maintaining control over the change process is essential for staff to remain invested in the healthcare setting (Narine & Persaud, 2003; Scott et al., 2003). The recurring theme

implies a need for "bottom up" and incremental "nudges" and interventions is needed in the healthcare context (Parekh, 2022). The extant literature also presents the rigid organisational hierarchies of management and excessive bureaucratic governance as increasing the professionals' feeling of powerlessness lost control which again prompts resistance and disengagement with service-organisational change (Mosadeghrad, 2013).

Table 12 provides a summary analysis of the literature reviewed for previous health service changes and their sustainability with 58 articles being reviewed of which 35 were excluded as they did not contain research or insights on barriers to sustainable change nor aspects of personal or professional engagement in sustainable change delivery. 23 articles remained which the author has reviewed as previously discussed in this section and their findings and conclusions mapped against the articles emerging themes. It should be noted that a number of the articles reviewed were literature or systematic review articles, these papers reviewed additional journals totalling 372 (although there is likely to be duplication within the papers reviewed as part of individual studies).

Source	Source / Research Type	Loss of control	Lack of vision, context and certainty	Not enough time / resources	Poor or unclear expectations	Lack of direct engagement with the	Unclear Benefits / aims	Not involved in decision making on the change	Poor leadership	Poor Communications / Top-down	Lack of training or skills	Not understanding terminology / Not using	Not being allowed to make mistakes and	No visible Leadership	Lack of recognition or reward
Organisational change. A review for health care managers, professionals and researchers. (Iles & Sutherland, 2001)	Multi-method approach. Desk research on change theories followed by literature search for empirical research of effectiveness of change models in healthcare 1990 - 1999	Yes	Yes	Yes	Yes										
Where Do Models for Change Management, Improvement and Implementation Meet? A Systematic Review of the Applications of Change Management Models in Healthcare. (Harrison et al., 2021)	Systematic review following Preferred Reporting Items for Systematic Reviews (PRISMA). Published healthcare change literature 1/1/09 - 31/8/20. 38 papers included in review			Yes		Yes	Yes	Yes	Yes	Yes					
Implementing change: the perspective of NHS change agents. (Massey & Williams, 2006)	Single case study review with 4 individual semi-structured interviews and direct observations		Yes	Yes							Yes	Yes			
Achieving and sustaining profound institutional change in healthcare: case study using neo-institutional theory. (Macfarlane et al., 2013)	Secondary analysis of data using mixed methods longitudinal case study review from an 8-year period and primary data form statistics, interviews and questionnaires (50 semi structured and 48 structured interviews).		Yes									Yes			
An evaluation of Lean and Six Sigma methodologies in the national health service. (Antony et al., 2021)	Literature review and primary research with 110 participants with people		Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes				

Source	Source / Research Type	Loss of control	Lack of vision, context and certainty	Not enough time / resources	Poor or unclear expectations	Lack of direct engagement with the	Unclear Benefits / aims	Not involved in decision making on the change	Poor leadership	Poor Communications / Top-down	Lack of training or skills	Not understanding terminology / Not using	Not being allowed to make mistakes and	No visible Leadership	Lack of recognition or reward
	using Lean and or Six Sigma in Healthcare														
Why hospital improvement efforts fail: a view from the front line. (Longenecker & Longenecker, 2014)	Focus groups research with 167 frontline leaders from 4 American hospitals			Yes	Yes	Yes	Yes		Yes	Yes					
Understanding the sustainability of health programs and organisational change. (Senge et al., 2007)	Journal paper		Yes				Yes			Yes	Yes				
A case study of change management effectiveness within the NHS. (Bamford & Daniel, 2005)	Case study methodology of the Health Protection Agency UK		Yes	Yes		Yes	Yes	Yes							
Gaining and maintaining commitment to large-scale change in healthcare organizations. (Narine & Persaud, 2003)	Journal paper (48 papers)	Yes	Yes		Yes	Yes	Yes	Yes		Yes	Yes				
Implementing culture change in health care: theory and practice. (Scott et al., 2003)	Literature review covering theoretical contributions and published studies (46 papers)	Yes						Yes	Yes						
'Designing Better Health Care in the South': A case study of unsuccessful transformational change in public sector health service reform. (Hurley et al., 2004)	Case study methodology from Australian project 'Designing Better Health Care in the South'		Yes			Yes	Yes		Yes	Yes					
Creating complex health improvement programs as mindful organizations: from theory to action. (Issel & Narasimha, 2007)	Single organisational research												Yes		
Implementing Lean in Health Care: Making the link between the approach, readiness and sustainability. (Radnor, 2011)	Multi-method review across 2 hospitals and 1 mental health trust with evaluation of data and evaluation		Yes	Yes		Yes			Yes	Yes	Yes				
Exploring barriers in lean implementation. (Rane et al., 2014)	Literature survey of peer reviewed journals (153 papers)		Yes	Yes		Yes			Yes	Yes	Yes			Yes	
Leadership and transformational change in healthcare organisations: a qualitative analysis of the Northeast Transformation System. (Erskine et al., 2013)	Individual research project	Yes	Yes						Yes	Yes				Yes	
Obstacles to TQM success in health care systems. (Mosadeghrad, 2013)	Literature review	Yes		Yes			Yes	Yes	Yes	Yes	Yes				Yes
Readiness factors for lean implementation in healthcare settings – a literature review. (Al-Balushi et al., 2014)	Literature review		Yes				Yes			Yes	Yes				Yes
Sustaining organizational culture change in health systems. (Willis et al., 2016)	Literature review		Yes			Yes		Yes	Yes	Yes		Yes			
The Productive Ward: releasing Time to Care - what we can learn from the literature for implementation. (White et al., 2014)	Taxonomic mapping of literature		Yes	Yes	Yes	Yes				Yes	Yes	Yes	Yes	Yes	
Lean healthcare from a change management perspective. (van Rossum et al., 2016)	Literature review		Yes						Yes		Yes	Yes			
TQM implementation for the healthcare sector: The relevance of leadership and possible causes of lack of leadership. (Chiarini & Vagnoni, 2017)	Literature review		Yes						Yes		Yes	Yes			
Development culture and TQM in Turkish healthcare: importance of employee empowerment and top management leadership. (Gözükara et al., 2018)	Structural equation modelling with 150 respondents from healthcare	Yes							Yes				Yes		
The implementation of total quality management in the NHS: how to avoid failure.	Multiple case study		Yes			Yes			Yes	Yes	Yes		Yes		Yes

Source	Source / Research Type	Loss of control	Lack of vision, context and certainty	Not enough time / resources	Poor or unclear expectations	Lack of direct engagement with the	Unclear Benefits / aims	Not involved in decision making on the change	Poor leadership	Poor Communications / Top-down	Lack of training or skills	Not understanding terminology / Not using	Not being allowed to make mistakes and	No visible Leadership	Lack of recognition or reward
(Nwabueze & Kanji, 1997)															

Table 12 - Previous Health Service Changes Theme Mapping (Source: The Researcher - Marc Penny 2025)

In addition to the review articles in Table 12 the author has undertaken further review of individual papers and identified further key themes which follows.

The lack of overall vision, context and certainty in healthcare reforms and an everchanging political landscape often leads to failure or change or change in direction reducing sustainability of improvements made. Clear and well-communicated vision is vital to ensure staff understand the direction of change (Iles & Sutherland, 2001) and ensuring that purpose and goals that healthcare professionals are expected to support and deliver do not constantly change. When the broader context of organisational transformation or change not communicated effectively (Massey & Williams, 2006) staff are left feeling disconnected and disengaged from the change and the organisation with organisational change requiring alignment and consideration of existing organisational structure and history (Macfarlane et al., 2013). Without understanding the context, changes may seem arbitrary leading to uncertainty and concern amongst professionals.

Leading on from vision, context and certainty is the aspect of having clear expectation of what is expected of people within an organisation and that of professionals in what they have to deliver. A lack of vision, context and certainty can lead to this lack of clear expectations and contribute to change failure. This lack of clear expectation can lead to confusion for professionals and inconsistent implementation of change and transformation and a misalignment between expectations and what is actually delivered (Iles & Sutherland, 2001; Longenecker & Longenecker, 2014). It can be argued that that clear communication of goals and deliverables is crucial for securing and maintaining commitment to change (Elving, 2005; Narine & Persaud, 2003).

Similarly unclear benefits or aims of change initiatives also contribute to failure. The literature identifies that when staff do not see the tangible benefits of change or how the change makes things better, they are less likely to invest in its success (Antony et al., 2021; Harrison et al., 2021). Clear

articulation of both short-term and long-term benefits (Swerissen, 2007) is essential for maintaining staff motivation throughout the change process and sustaining changes.

Lack of time along with some of the other themes explored can lead to a lack of direct engagement with change from workers and professionals which can be a key issue when it comes to change delivery and sustainability. Successful change is contingent upon the active participation of all staff (Harrison et al., 2021) being engaged and involved in the change. This links to ensuring don't feel a loss of control or that change is being 'done' to them. When healthcare professionals are not involved in planning or decision-making they are less likely to commit to change (Bamford & Daniel, 2005) and can be argued that without direct engagement with people within the organisation, there will be a disconnect between organisational goals and workers' realities day to day, making it difficult to achieve sustained change.

Another factor that the author has explored through the literature is the theme of people or professionals not having enough time or resources (Holterman et al., 2022) to undertake the change or deliver it in the long term. Healthcare organisations often face financial and operational pressures (evidenced in the UK NHS healthcare system) making it difficult to allocate adequate time and resources for change initiatives, with expectation that change, and its delivery can and should be delivered within existing resources and time constraints. Without sufficient time for planning and adaptation change efforts may be rushed and incomplete (Harrison et al., 2021; Iles & Sutherland, 2001) and resource and time constraints hinder the actual delivery of change, with the daily demands on healthcare professionals leaving little time for engaging with new change initiatives or additional activities (Longenecker & Longenecker, 2014).

Not having enough time can impact staff not being involved in decision-making and is closely linked to loss of control and engagement. Exclusion from decision-making leads to resistance (Bamford & Daniel, 2005) as staff feel that changes are being imposed upon them (Harrison et al., 2021) and they don't have an affiliation for or to the change. In contrast when staff are involved in the process, they are more likely to take ownership of the outcomes, thereby increasing the likelihood of sustainability (Narine & Persaud, 2003; Scott et al., 2003).

Through the literature review another key theme emerges relating to leadership. Poor leadership is frequently cited as a cause or contributory factor of change failure and lack of sustainability. Ineffective leadership often results in a lack of direction and vision (Harrison et al., 2021) which was explored earlier with Erskine et al. suggest that 'transformational leadership' is necessary for driving and sustaining change in the long term especially in complex organisations such as healthcare (Erskine et al., 2013). Furthermore, Nwabueze argues that leadership needs to include elements such as being charismatic and being able to sell a vision to employees (Nwabueze, 2011). Leaders who fail to engage with staff or provide adequate support create environments where change efforts fail and sustainability of change is put at risk (Longenecker & Longenecker, 2014). It can be argued that leadership must be inclusive and empower staff (Rich et al., 2023) for change to be successful (Mosadeghrad, 2013) also resulting in improved productivity and job satisfaction (Kirkman & Rosen, 1999). Connected with poor leadership is poor or top-down communication, which exacerbates the disconnect between leadership and staff during change initiatives. When communication is poor or top down and doesn't allow for questions and engagement staff may feel alienated leading to resistance to change and disengagement (Harrison et al., 2021). Inclusive and transparent communication (Narine & Persaud, 2003) is essential for gaining and maintaining staff commitment. Another aspect of leadership failure is the lack of visible leadership (Gupta & Moriates, 2017) where leaders are remote from the people in the organisation and not engaged with them on a day to day basis, this lack of visibility may contribute to disengagement of professionals working within an organisation and uncertainty about the direction of change (Erskine et al., 2013). Visible leadership is argued to be essential for maintaining momentum and ensuring that staff remain engaged throughout the change process and when leaders are not actively involved, staff question the legitimacy and importance of the change (Rane et al., 2014) and relevance to them and their roles.

Massey and Williams found that many NHS change agents lacked the skills required to manage complex change initiatives effectively (Massey & Williams, 2006). The lack of training or skills necessary to implement and sustain changes may directly contributing to change failure and transformation or the ability of professionals to sustain the change. Without proper training in necessary to support the change or strategy an organisation is seeking to enact staff are unlikely to adopt these approaches consistently through lack of understand and ability leading to poor outcomes (Antony et al., 2021). Similarly, not understanding terminology or having a shared language can create confusion and resistance to change particularly in interdisciplinary settings such as healthcare where many teams and departments (internally and externally) have to have the ability to work together. The literature shows that healthcare professionals often struggle to understand the language used in

change and that organisation fail to invest enough time and effort in enabling staff to understand new language associated with changes and transformation (Massey & Williams, 2006). This failure to invest in and support people to understand language and terminology can leading to misunderstandings and disengagement which highlight the importance of establishing a shared language across the organisation to ensure alignment of goals and ambitions (Macfarlane et al., 2013).

Empowering staff to experiment and learn from mistakes can help increase their engagement and freedom to act (Gözükara et al., 2018) ultimately improving professionals engagement and commitment to change as they feel they are trusted and empowered (Janamian et al., 2022). The failure to allow staff to make mistakes and learn from them can stifle innovation and change and undermines its sustainability (Issel & Narasimha, 2007) and healthcare organisations must embrace a culture where mistakes are viewed as learning opportunities.

The final theme the author has identified through the literature is the lack of recognition or reward for professionals working within the system when they deliver change, and this lack of recognition may impact the success or failure of change initiatives (Shaikh, 2020). Mosadeghrad argues that without adequate recognition staff may feel undervalued and disengage from the process (Mosadeghrad, 2013), and although recognition can take many forms, from financial rewards to public acknowledgment overall reward and recognition are key for maintaining motivation and ensuring that changes are sustained over time (Al-Balushi et al., 2014).

Figure 8 shows the relational aspects of the key aspects of failures resulting from the literature review.

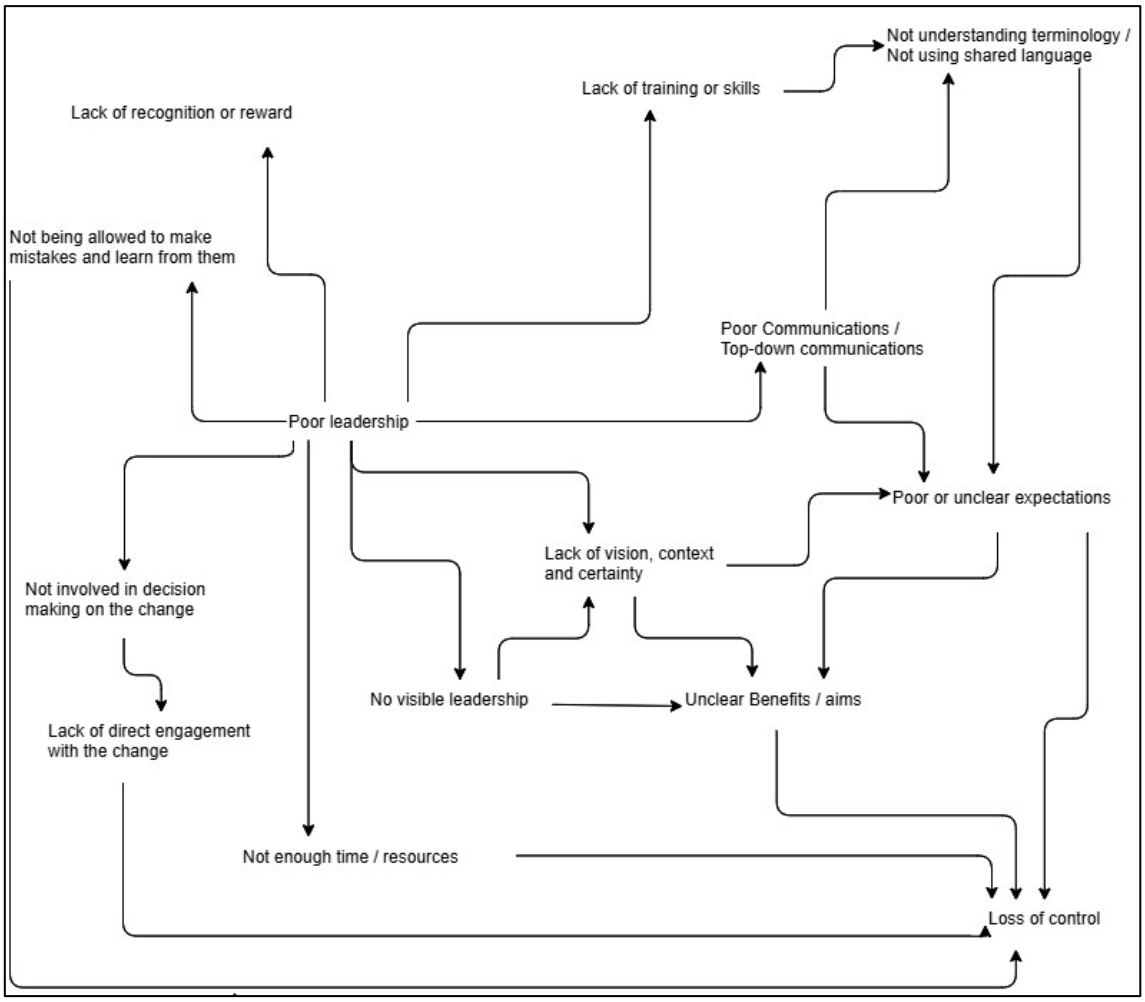


Figure 8 - Past Healthcare Change Experiences Causal Loop Diagram (Source: The Researcher - Marc Penny 2025)

In summary, the literature review has identified the common themes that were identified as important to sustainable delivery of change in the healthcare context and how previous experiences of change initiatives have influenced the perception of future calls to change – including disengagement with any proposed 'burning platform' (Figure 9).

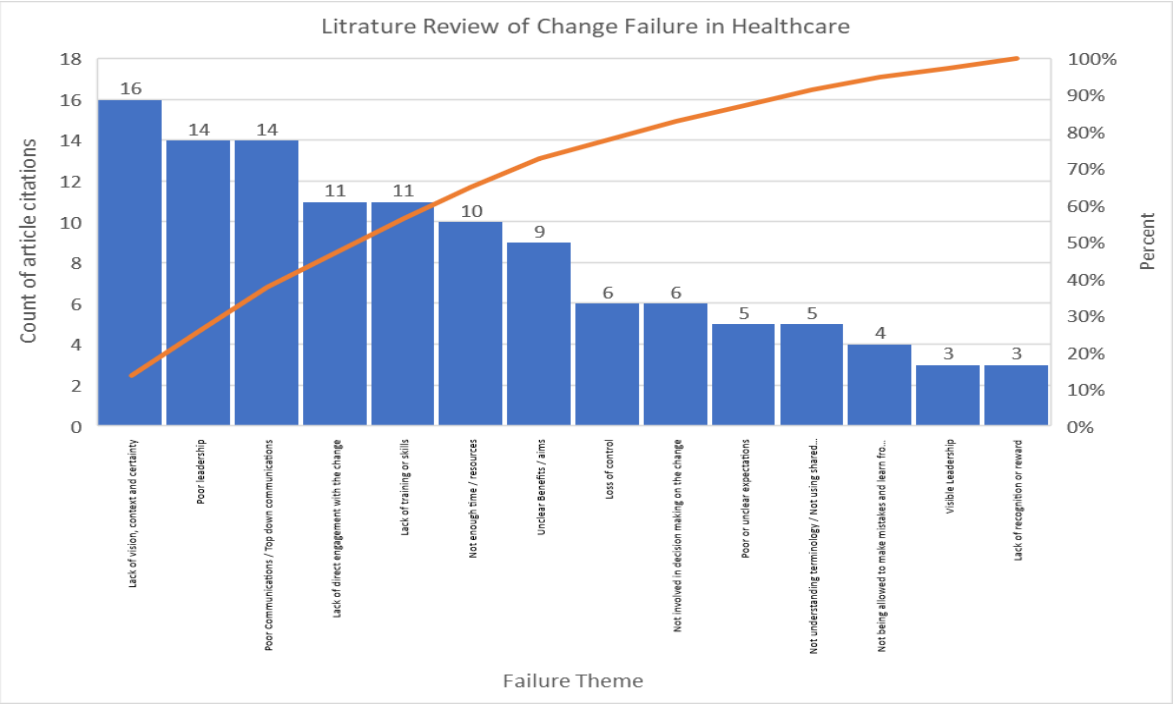


Figure 9 - Pareto Chart for Previous Change Failure in Healthcare Themes (Source: The Researcher - Marc Penny 2025)

2.9.2. Professional Regulation in UK Healthcare and Organisational Dissonance

Organisational dissonance is a concept derived from cognitive dissonance theory and refers to the misalignment or conflict between organisational structures, organisational goals and the expectations of the workforce especially professionals working within it. 'Dissonance' can be seen in different forms including differences between organisational targets, the working experiences of employees and/or the demands of external regulatory bodies and organisations (Harmon-Jones, 2019). Over the last decade, organisational dissonance has become a new area of management study. In the NHS, organisational dissonance has been a key element in shaping healthcare delivery (intentionally or unintentionally) and this has influenced professional satisfaction and patient outcomes. The tensions between the demands of the UK government, professional bodies (like the Royal Colleges and local healthcare organisations) have led to significant challenges within the NHS.

In the UK, professional regulatory bodies and Royal Colleges aim to maintain high standards and protect patient safety where misalignments occur between the regulatory frameworks and the practical needs of healthcare professionals delivering services.

A seminal paper, developed from a systematic literature review of 103 journal papers of organisational change, is *'Diffusion of Innovations in Service Organisations: Systematic Review and*

Recommendations' (Greenhalgh et al., 2004). The authors focus on how innovations are adopted and diffused within service organisations like the NHS. They argue that the adoption of new practices and technologies is often met with resistance due to misalignment between innovation or change and existing organisational structures and work requirements. This misalignment or "organisational dissonance" hinders successful change and creates tensions in the workplace which affects both professionals and patients.

The potential areas of misalignment affecting professionals (whose conduct is dictated by regulatory bodies and clinical licences) include excessive administrative burdens (due to regulatory requirements or national targets) financial constraints, poor administrative support and lack of medical secretaries which is exacerbated by perpetual budget cost cutting. Furthermore, detailed investigations and associated documentation (auditing and compliance), frequent appraisals, mandated personal development reviews, and continuing professional development targets compound professional engagement and enhancement of professional value (Braithwaite et al., 2017). These conflicts were determined as systemic of the healthcare professions which involved professionals from Australia, Canada, Denmark, England, the Netherlands, New Zealand, Scotland and the United States via sets of nationally consistent indicators. Survey and interview research of 60+ NHS People Directors (England) identified that the time and effort required to meet these professional commitments took staff away from direct patient care leading to frustration and burnout among professionals (West et al., 2002). Supporting improvement activities therefore requires professionals in health services to invest significant discretionary effort outside their normal working hours and contractual terms.

Regulatory standards and bodies often require certain or minimum staffing levels (e.g. NHS in Wales has a legal safe minimum staffing level for nurses and skill mixes) that may not be possible in the face of workforce shortages. This acute skills shortage is a current acute problem in the UK (2023). Staff shortages place additional stress on remaining staff and may lead to regulatory breaches (Buchanan et al., 2005) as well as a lack of capacity to undertake new work or get involved in VBHC deployments. The Kings Fund report (2012) found requirements for continuous learning and quality improvement projects can be challenging to meet in such under-resourced settings (Ham et al., 2012).

Regulatory bodies set standards and impose protocols/guidelines to ensure consistency and safety by determining best professional practice of clinicians (and their freedom to act or not), see Flynn (2002). Misalignment of these pressures and accommodating patient "wants" and their desired outcomes

may conflict and restrict innovative change in clinical practice(Braithwaite et al., 2017). These issues potentially reduce a professional's willingness to support VBHC programmes.

Work demands and pressure to comply with regulatory standards results in stress, the fear of punitive action for non-compliance and increases staff burnout (West et al., 2002) and errors in such stressful chaotic environments can cause safety incidents that risk the professional's licence and livelihood. (Maslach et al., 2001).

Misalignment of professional perceptions of role, work pride and conflicting organisational targets in healthcare settings creates increases organisational dissonance and has resulted in collective action and overt conflict between national government targets (e.g. Welsh Government targets for NHS Wales service performance) and the standards of professional bodies like the Royal Colleges. For example, the Royal College of Surgeons may issue guidelines focused on clinical excellence and patient safety (greater professional value) while the government dictate productivity metrics assuming no trade-off in patient and process quality/safety.

The difference in requirements between professional regulatory bodies and the needs of healthcare professionals can have significant implications for both the quality of care given to patients and the well-being of professionals and can cause a disconnect between what is being asked of professionals from their regulatory bodies and the expectations set within the framework of VBHC. Whilst the author has tried to understand this impact from the perspective of this research it will be noted as a potentially contributory factor that may need to be considered further however the explicit link between professional regulatory alignment or misalignment will not be considered in the further scope of this research. The wider impacts of misalignment between regulatory bodies, governmental objectives and local requirements are bound to have impacts on the ability for professionals to deliver consistent change and links into elements already covered around understanding of shared goals and objectives as well as elements related to working environment and value.

Locally NHS organisations are responsible with balancing these competing demands often with constrained resources and a series of significant change failures at the organisational and specialist service directorate levels. It is no wonder that such conductions can lead to confusion and frustration among healthcare professionals and as well as significant organisational dissonance, stress, burnout

and scepticism towards any modern improvement initiative (Armstrong & Taylor, 2020). For modern service delivery, VBHC offers the potential to reconcile technical professional value, enhance patient care and VBHC could therefore enhance personal patient value).

VBHC has the potential to align professional and organisational goals, reducing the organisational dissonance caused by conflicting demands. By focusing on patient outcomes and recognising professional value, it provides an opportunity to streamline processes, reduce administrative burdens and enhance engagement, helping to address professionals burnout while improving job satisfaction. VBHC provides an opportunity to harmonise the objectives of regulatory bodies, governments and local organisations, fostering collaboration and shared goals. This alignment would enable healthcare professionals to deliver consistent, high-quality care while feeling valued and motivated, promoting sustainable improvements in healthcare delivery without competing targets and demands.

2.9.3. Previous Models and Interventional Changes in Healthcare and their Sustainability: Literature Review Summary

This chapter has reviewed the key lessons from past healthcare change processes, focusing on factors that affect the success and sustainability of these initiatives. It has identified several recurring interconnected themes from the extant literature concerning complex healthcare systems. These key findings are summarised below and in a force field map (Figure 10):

- Loss of Professional Control
    - Staff disengage from change initiatives when they feel excluded from decision-making processes, contributing to resistance. Rigid hierarchies can exacerbate feelings of powerlessness, undermining the sustainability of reforms.
- Lack of System and Organisational Vision and Certainty
    - Poorly communicated organisational visions or frequent shifts in goals leave professionals feeling disconnected and uncertain, which negatively impacts their commitment to reforms.
- Unclear Expectations and Benefits of new change models
    - Without clear goals or an understanding of the benefits, professionals struggle to implement changes effectively, leading to confusion and inconsistent application of reforms.
- Time and Resource Constraints detracting from Professional Engagement and enhancement of professional value

  - Insufficient time and resources hinder the proper planning and execution of change initiatives. Rushed or incomplete efforts, resulting from these constraints, often undermine the sustainability of reforms.
- Direct Engagement and Involvement
  - Active staff participation in planning and decision-making processes is essential for the success of healthcare reforms. Exclusion from these processes contributes to resistance and a lack of ownership over outcomes.
- Organisational Leadership Failures
  - Poor leadership, including ineffective communication and a lack of visible leadership, weakens change initiatives. Transformational leadership is highlighted as crucial for fostering engagement and sustaining reforms.
- Inconsistent and ineffective Training and Shared Language
  - Insufficient training and the absence of a shared language around new initiatives create misunderstandings, contributing to resistance, particularly in interdisciplinary settings.
- Lack of Empowerment and Innovation
  - Staff must be empowered to experiment and learn from mistakes in order to sustain change. A failure to cultivate a culture that supports innovation stifles both the implementation and longevity of change initiatives.
- Recognition and Reward
  - The absence of adequate recognition or reward for professionals who contribute to successful change initiatives can lead to disengagement, affecting the long-term sustainability of reforms.
- Organisational Dissonance
  - Organisational dissonance refers to the misalignment between regulatory frameworks, organisational goals, and the day-to-day needs of healthcare professionals. This misalignment often leads to frustration, stress, and burnout among staff, hindering the successful implementation of sustainable changes.

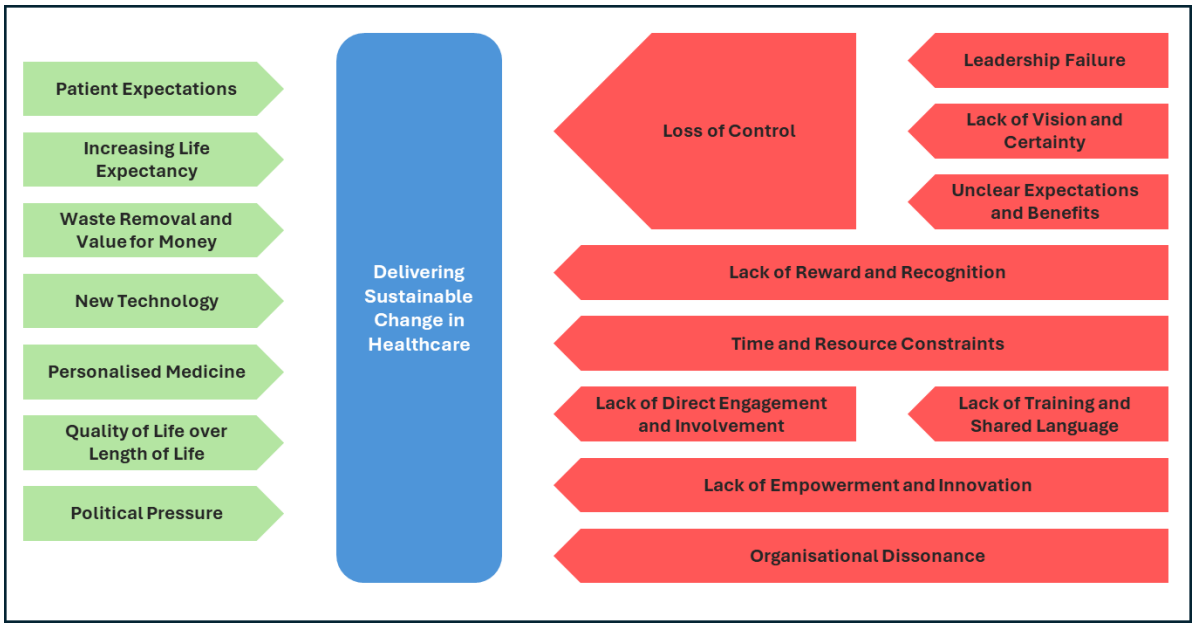


Figure 10 - Healthcare Change Failure Themes Force Field Map (Source: The Researcher - Marc Penny 2025)

The overwhelming forces pushing against the success of change models and experimental approaches is high and these threaten the viability and sustainability of VBHC from the professionals perspective within the healthcare organisational setting. The next section of this chapter will explore what is meant by professional value and its application.

2.10. Defining Professional Value

2.10.1. Introduction to Professional Value

The concept of 'Professional Value' (PV) is critical for understanding what employees seek from their employment and what motivates them in the workplace. In organisational environments PV extends beyond monetary remuneration to encompass a broad range of intrinsic and extrinsic factors that contribute to an employee's overall job satisfaction, engagement and commitment (Deci & Ryan, 2013; Hackman, 1976). These factors include personal growth and development, alignment with shared goals, a sense of contributing to society, engagement in meaningful work and autonomy in decision-making. ‘Self-Determination Theory’ highlights the importance of intrinsic motivation, suggesting that autonomy, competence and relatedness are key drivers of workplace satisfaction (Deci & Ryan, 2000). Herzberg's Two-Factor Theory (1956) emphasises the role of intrinsic motivators such as recognition and achievement, which closely align with PV (Herzberg et al., 2011).

Anthony (1977) argues that the evolution of work has evolved past purely economic or technical outputs and has grown to also include the societal value placed on working and its wider contribution to society. This aligns with more contemporary research by Pratt & Ashforth (2003), who stress that meaningful work not only fosters individual fulfilment but also strengthens organisational commitment (Pratt, 2003). Additionally, organisational alignment with societal values has been linked to improved job satisfaction and retention (Glavas, 2016). Table 13 provide a summary of PV aspects and descriptions.

ASPECT	DESCRIPTION	KEY THEORIES/AUTHORS
Core Concept	PV encompasses what employees seek from their employment and workplace motivations, extending beyond monetary rewards.	(Deci & Ryan, 2013) (Hackman, 1976)
Intrinsic Factors	Includes personal growth, meaningful work, autonomy, and alignment with shared goals.	Self-Determination Theory (Deci & Ryan, 2000) Herzberg's Two-Factor Theory (Herzberg et al., 2011)
Extrinsic Factors	Recognition, achievement, and societal contributions enhance PV.	Herzberg's Two-Factor Theory (Herzberg et al., 2011) (Anthony, 1977)
Workplace Satisfaction Drivers	Autonomy, competence, and relatedness are key drivers of satisfaction, engagement, and commitment.	Self-Determination Theory (Deci & Ryan, 2000)
Societal Contribution	Work's evolution includes societal value and wider contributions beyond economic outputs.	(Anthony, 1977) (Pratt, 2003)
Meaningful Work	Enhances individual fulfilment and strengthens organisational commitment.	(Pratt, 2003)
Organisational Alignment	Alignment with societal values is linked to improved job satisfaction and retention.	(Glavas, 2016)

Table 13 - Professional Value Definition Summary (Source: The Researcher - Marc Penny 2025)

2.10.2. What is a Professional and a Professional Service

A professional can be defined as an individual with specialised knowledge, skills and qualifications who are often certified through training or apprenticeship experience within a specific field and evaluated by a more experienced and competent (professionally qualified) overseer. In the healthcare context,

professionals such as doctors, nurses and allied health practitioners use their expertise to deliver patient wellbeing, high-quality care and outcomes. They are bound by codes of conduct that reinforce a duty to maintain standards, make evidence-based decisions and engage in continual learning (Eraut, 2004; Evetts, 2011; Freidson, 2001).

Professional services involve specialised support provided by qualified experts, who are usually bound by professional body standards that focus on quality and ethical responsibility. In healthcare, services cover patient care and consultative or managerial roles that support organisational effectiveness, particularly in managing change within complex regulatory environments (Abbott, 1988; Dopson et al., 2008). Healthcare professionals bring substantial value by integrating technical expertise with critical thinking, judgment and adaptability which are key in delivering care and patient outcomes. They not only address immediate needs but also drive innovation, quality improvement and resilience in organisational change initiatives (Eraut, 2004; Fitzgerald et al., 2002; Suddaby & Greenwood, 2001).

While these definitions provide a foundation, existing research has largely failed to address the evolving complexity of professionals' roles in ensuring the sustainability of change. Critically, there is a limited examination of how professionals balance their dual responsibilities to both organisational goals and broader societal expectations. This highlights the need for further research into the intersection between professional values, systemic change and long-term change sustainability. Additionally, gaps remain in exploring the dynamic tension between professional autonomy and organisational compliance in healthcare (Spyridonidis et al., 2015).

Altruism is a significant concept and feature of professionals in healthcare and derives from the care commitments of such professionals. Contributing, or feeling a role in contributing to society is a key component of PV that aligns closely with the STS emphasis on meaningful work. Employees and especially those working in healthcare derive a sense of purpose and fulfilment when they feel their work positively impacts society which is a crucial motivator for engagement and retention. When employees feel valued in work and feel that they are providing value they feel more satisfied (Weir, 2024). Kalleberg argues through the empirical research undertaken covering 1,469 participants that work values including societal contribution significantly influence job satisfaction and organisational commitment (Kalleberg, 1977).

These studies often generalise across sectors, neglecting the unique challenges within complex healthcare settings, where professionals must manage conflicting demands of care quality, resource constraints and organisational change. Research suggests that over-reliance on intrinsic motivators such as altruism can lead to burnout when external pressures such as organisational constraints are not addressed (Maslach & Leiter, 2016; West et al., 2020). Further research that reviews these tensions in specific healthcare contexts and settings is required.

Engagement in meaningful work is an element of PV that can be effectively understood. Kahn through theory generating studies identified engagement is characterised by an employee's emotional and psychological investment in their work which is closely linked to the perception that their work is meaningful and valuable (Kahn, 1990). A human factors framework for designing work systems that enhance employee engagement by ensuring that both social and technical factors are optimised to support meaningful work experiences.

The use of a Job Characteristics Model aligns with STS principles by emphasising the importance of job design in fostering engagement and motivation (Hackman, 1976) which was tested and validated via 658 employees who worked in 62 different jobs in seven organisations. The Job Characteristics Model identifies five core job characteristics; skill variety, task identity, task significance, autonomy and feedback — that contribute to meaningful work and job satisfaction.

However, these frameworks have been found to lack contextual adaptability, particularly in high complexity environments such as healthcare. For example, while autonomy is generally seen as a driver of engagement, excessive autonomy without structured support may lead to inefficiencies or risks to patient safety (Morgeson & Humphrey, 2008). This raises questions about how job design models can be refined or adapted to better reflect the realities of healthcare settings.

From an STS perspective these characteristics can be enhanced by designing work systems that integrate social support structures (such as team collaboration and feedback mechanisms) with technical tools that enable task variety and autonomy. This approach suggests potential limitations in applying STS principles to enhance engagement particularly in routine or monotonous jobs. In these types of jobs STS theory would advocate for redesigning work processes to introduce more variety, challenge and opportunities for growth which would enhance engagement. This perspective aligns

with current views on job design and crafting which emphasise the role of employees or professionals in shaping their work experiences to enhance meaning and engagement (Wrzesnieewski & Dutton, 2001).

Despite its theoretical strengths, the socio-technical perspective has been criticised for its limited applicability in addressing the systemic and institutional constraints faced by healthcare professionals. Rigid hierarchies and resource limitations may undermine the flexibility required to implement such work systems effectively. This underscores the need for a context-rich, theory-building approach that considers organisational, cultural and policy-level factors (Peters et al., 2013).

Creating work environments that support psychological safety (where employees feel safe to take risks, express their ideas and engage fully in their work) is new to healthcare but has strong prevalence. Research from 3,149 employees and 223 managers in the fast food industry found that openness and psychological safety improved employee satisfaction (Detert & Burris, 2007). This emphasis on psychological safety aligns with recent research on high-performing teams and was validated via a study of 51 different work teams in manufacturing, which highlights the importance of creating environments that foster trust and open communication (Edmondson, 1999), with similar findings from wider change management reviews (Shaikh, 2020).

Translating findings from non-healthcare sectors into healthcare contexts requires caution with healthcare professionals facing unique challenges in their roles such as life-and-death decision-making that make the implementation of psychological safety frameworks more complex. This highlights a gap in existing research, particularly the need for studies that explore psychological safety within multidisciplinary healthcare teams (Carmeli et al., 2009; Nembhard & Edmondson, 2006).

By integrating social support systems with technical tools that facilitate collaboration and communication organisations can create work environments that support engagement and meaningful work experiences.

As previously discussed, autonomy and control over work are associated with PV and modern organisational behaviour theories. Autonomy is closely linked to employee motivation, job satisfaction

and overall well-being as it allows employees and professionals working within the system to exercise control over their work tasks and decisions (Deci et al., 1999). STS theory argues the importance of designing work systems that provide employees with the autonomy to make decisions and control their work processes while ensuring that technical systems support this autonomy.

It can also be argued that providing too much autonomy without adequate support and guidance can lead to inconsistencies, reduced coordination and a random approach to work and improvement in the healthcare settings. A balanced work environment would blend sufficient autonomy while maintaining necessary controls and support systems to ensure alignment with organisational goals and specialist body best practices. Such an approach aligns well with accounts of agile and flexible work practices which emphasise the importance of balancing autonomy with structure and support (Highsmith, 2004).

Modern management approaches to change in health and care systems emphasise autonomy and proposes it should be supported by a culture of trust and empowerment, where employees feel confident in their ability to make decisions and take ownership of their work (Deci et al., 1999). This emphasis on trust and empowerment aligns with research on employee engagement and well-being which highlights the importance of creating work environments that support autonomy, competence and relatedness (Deci & Ryan, 2000). By aligning social support systems with technical tools that facilitate autonomy and control, organisations can create work environments that enhance employee satisfaction, engagement and performance.

The concept of PV is critical to understanding how effective change creates results and sustainability. The concept is multi-dimensional, encompassing a range of intrinsic and extrinsic factors that contribute to employee satisfaction, engagement and commitment to the organisation. STS theory provides a useful framework for understanding how these various aspects of professional value can be fostered and developed within organisations and their impact on VBHC. By considering the connection between social and technical systems STS theory offers insights into how organisations can create work environments that meet the diverse needs of employees while achieving organisational objectives. The application and delivery of STS principles in practice requires careful consideration of the unique contexts and challenges faced by each organisation, as well as ongoing adaptation and refinement to ensure the continuous alignment of social and technical systems.

The researcher believes that PV can be viewed through the prism of STS theory (discussed indepth as a theoretical lens at the end of this chapter). The key elements found through this critical review can be considered under the following themes (Table 14):

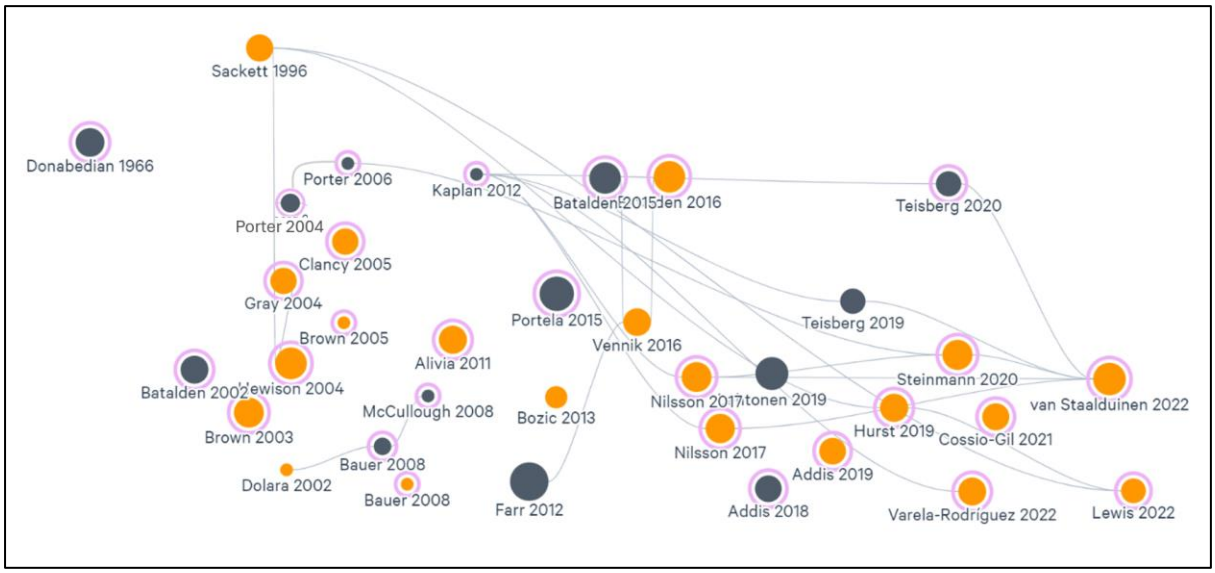
THEME	KEY ELEMENTS	CITATION
Engagement	- Meaningful work - Task variety - Contribution to society - Involvement with change and decisions	(Weir, 2024) (Kalleberg, 1977) (Kahn, 1990) (Hackman, 1976)
Individual Consequence	- Individual consequence - Personal growth - Wellbeing - Personal satisfaction	(Kalleberg, 1977) (Kahn, 1990) (Detert & Burris, 2007)
Ownership	- Autonomy and control - Involvement in decision making - Co-design of work - Continuous learning	(Hackman, 1976) (Wrzesnieewski & Dutton, 2001) (Deci et al., 1999) (Highsmith, 2004)
Shared Aims	- Shared Goals - Shared Purpose and Vision	(Kalleberg, 1977) (Iles & Sutherland, 2001) (Massey & Williams, 2006)
Skills & Capacity	- Learning and development - Personal growth - Continuous learning - Mentoring and support	(Massey & Williams, 2006) (Antony et al., 2021) (Macfarlane et al., 2013)

Table 14 - Professional Value Themes and Elements (Source: The Researcher - Marc Penny 2025)

For the purposes of this research the author is defining 'Professional Value' as '*Professional Value refers to actions that enhance (and do not undermine) engagement, personal impact, ownership, shared goals and capability'.*

2.11. Value Based Healthcare Genealogy and Potential for Professional Value Enhancement

The final sphere of influence for the researcher to explore is that of the modern healthcare approach termed VBHC. This section of the literature review concerns the focal subject literature and the citation map below is a pictoral format of VBHC (Figure 11) citation genealogy. The genealogy review will critically review the literature and expose gaps linked to the overall research aim and questions. It is clear to see from Figure 11 a number of interlinked publications spanning over 20 years of evolution of the VBHC concept. The gaphic shows a number of unlinked publications (individuals and small groups which may have had a bearing on the development in thinking) and the references cited by VBHC have been identified, some of which will be explroed where the author believes them to be relevant.



[4]*Figure 11 - Value Based Healthcare Genealogy Citation Map (Source: The Researcher - Marc Penny 2025)*

2.11.1. Genealogy of Value Based Healthcare

The current model and evolution of VBHC as a concept and also as a methodology can be traced to Porter and Teisberg who coined the term Value Based Healthcare (Porter & Teisberg, 2006), but its development can be traced to a number of other authors and healthcare models. Donabedian's seminal paper "Evaluating the Quality of Medical Care" remains a key approach to healthcare quality assessment (Donabedian, 1966). It introduced the 'structure-process-outcome' framework which are constituent elements of healthcare service provision and is widely known and acknowledged for its clarity and ease of understanding (Best & Neuhauser, 2004). The framework provides healthcare a structured way to assess quality and its adaptability to healthcare settings. However when assessing patient outcomes it's important to also understand the macro and micro influences (Table 15) as these often affect patient need, and outcomes being influenced by external factors such as socio-economic conditions, making outcomes solely a result of quality of care provided limited (Portela et al., 2015). A criticism of Donabedian's work is the fact it didn't consider at the time wider system impacts and treating the whole healthcare pathway as a system (Berwick & Fox, 2016).

INFLUENCE CATEGORY	ASPECT	MACRO INFLUENCE	MICRO INFLUENCE	IMPACT ON RESEARCH
Quality Framework (Structure-Process-Outcome)	Standardised Quality Assessment	Focus on large-scale healthcare quality frameworks (e.g., Donabedian's model)	Implementation of quality standards at a clinical or department level	Provides a clear assessment framework for the study, though it may need adaptation for VBHC focus on broader system views.

[4] Developed using Litmaps® https://www.litmaps.com/

INFLUENCE CATEGORY	ASPECT	MACRO INFLUENCE	MICRO INFLUENCE	IMPACT ON RESEARCH
Socio-Economic Conditions	Patient Outcomes	Economic factors and access disparities influencing population health	Individual patient needs and access to healthcare services	Highlights socio-economic disparities as a potential factor affecting patient engagement in VBHC models.
IT Systems and Automation	Digital Transformation	Integration of healthcare IT systems and AI to streamline patient data management	Use of automation in clinical decision-making and patient monitoring	Supports the study's exploration of efficiency but may present data privacy and training challenges.
Artificial Intelligence (AI)	Data Analysis and Insights	Macro-level use of AI to identify population health trends and forecast healthcare demands	Use of AI to support clinical decisions in patient care settings	Enables robust data-driven insights for VBHC; impacts on clinician reliance and technology bias should be assessed.
Personalised / Genomic Medicine	Tailored Treatment	Advances in genomics and personalised medicine impacting healthcare models at a policy level	Personalised treatment plans based on individual genetic and health profiles	Brings depth to VBHC by considering individualised care but may increase costs and training requirements.
Patient Expectations	Patient Engagement	Growing patient demand for value-driven, outcome-based, and transparent healthcare services	Patient participation and active engagement in care decisions	Highlights the necessity of patient engagement in VBHC and may affect the assessment of professional value and outcomes.
Healthcare Workforce	Professional Engagement	Macro challenges such as workforce shortages and policy limitations on professional development	Professional autonomy, morale, and engagement in everyday clinical practices	Requires consideration of workforce dynamics and training needs to sustain engagement in value-based care models.
Economic Pressures	Cost Efficiency	National or regional funding constraints in healthcare systems	Departmental budget management impacting resources for VBHC	Emphasises the importance of cost-effective practices in VBHC; may influence the researcher's focus on cost-benefit balance.
Systemic Change and Integration	Healthcare Pathway Optimisation	Push for integrated healthcare pathways to streamline patient experience across multiple providers	Departmental coordination and cross-functional team collaboration in patient care	Promotes holistic understanding of VBHC and adds complexity to tracking patient outcomes across various touchpoints.

Table 15 - Patient Outcomes Macro and Micro Influences (Source: The Researcher - Marc Penny 2025)

Donabedian's research emphasises patient outcomes and is embedded in the rhetoric of modern day VBHC which focuses on achieving the best outcomes for patients relative to the cost of delivering care (Porter, 2010). However Donabedian does not link these outcomes and quality to finance and affordability, an element all healthcare systems face, and which is particularly acute in the NHS in the U.K.. When looking at VBHC and the work of Donabedian you can see a clear link and lineage as a forerunner to more comprehensive approaches that link healthcare quality with cost efficiency and patient-centred outcomes.

VBHC was born out of the U.S.A. and specifically influenced by the Bismarck model and Out-of-Pocket model for healthcare provision, which prioritise cost-efficiency and financial incentives. These models, based on market-driven healthcare, contrast with the equity-focused principles of publicly funded systems like the NHS. Donabedian's framework emphasised patient outcomes without a financial lens, reflecting its ethical focus. VBHC explicitly ties quality to cost-efficiency, risking disparities in access and equity. Adapting VBHC to the NHS requires addressing key challenges, such as the socio-economic determinants of health, which may be sidelined by profit-oriented approaches. VBHC's profit-motivated origins require adaptation to ensure its focus on cost-efficiency does not undermine equity, access or the broader ethical goals of universal healthcare systems like Beveridge model or National Health Insurance model.

Co-Production

Elinor Ostrom first used the term 'co-production' in the 1970s to describe how individual choices impact the production of public services and goods (Ostrom, 1996). In healthcare co-production as a concept traces its roots back to the 1980s when the Kings Fund introduced the co-production concept in health. Co-production describes a method of involving patients voices (Alford, 2002) and 'need in health service provision' with a partnership relationship (Farr, 2012) between the voice of the professional (Realpe & Wallace, 2010) and the voice of the patient (Batalden et al., 2016b; Loeffler et al., 2013). The "patient voice" in healthcare generally refers to the active involvement and input of patients in their own care, as well as in healthcare decision-making, research and policy development. In building a model of healthcare co-production Batalden et.al argue that both patients and professionals are as important in the concept of co-production where both parties need the necessary skills and competencies to deliver a true partnership of care (Batalden et al., 2016b).

Research published in 2016 represents one of only a few qualitative studies into co-production which is based on 5 Dutch hospitals and 27 interviews. The research found that professionals involved were generally enthusiastic on co-production, however there were barriers that needed to be overcome including time, change of relationship with the patient and changing priorities due to work demands (Vennik et al., 2015). These barriers reflect organisational and cultural factors that are not unique to the Netherlands and are likely to be typical in healthcare systems in Wales and elsewhere. Time pressures and the need to transform traditional hierarchical relationships are common issues in public sector organisations including healthcare settings such as the NHS, where resource limitations and embedded ways of working often present barriers to implementing co-production effectively.

Evidence Based Medicine and Value Based Medicine

Evidence based medicine (EBM) is a concept which can trace its roots back through the 19th and 20th centuries. Sackett et.al describe EBM as *'the contentious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice… means integrating individual clinical expertise with the best available external evidence from systematic research'* (Sackett et al., 1996) where decisions are not influenced by clinicians power, tradition or politics (Brown et al., 2006). Gray (2004) discussed the many names and different framing of 'evidence based' health activities such as Evidence Based Medicine, Evidence Based Policy Making, Evidence Based Clinical Practice and Evidence Based Care (Gray, 2004), which all aim to link best practice and knowledge to the values of the patient and populations; however this focus on patient value tends to be viewed through the lens of 'value' meaning length of life ignoring quality of life value (Brown et al., 2003) and needing to take full account of the patients 'perceived' value. Similarly, its argued that evidence alone will never act as a single factor when making decisions that affect patients and populations (Clancy & Cronin, 2005). In the book 'Evidence-based to Value-based medicine' Brown et.al propose a move from evidence-based to value-based decision making (Brown et al., 2005). Brown et.al states a number of value-based medicine standards including Patient Value, Costs, Cost utility and sensitivity analysis. VBHC builds on value-based medicine (VBM) by incorporating a broader definition of value, while EBM and VBM focus primarily on clinical outcomes and costs, VBHC takes a more comprehensive approach by considering a wide range of patient-defined outcomes, including quality of life and patient satisfaction (Porter, 2010). This morphosis integration of value into EBM to VBM to VBHC reflects a shift from individual evidence to system level value creation (Kelly et al., 2015). VBHC represents the next step in the evolution of evidence-based healthcare, integrating clinical effectiveness with economic efficiency and patient-centred care. Additionally, a number of pillars are described when it comes to value (Table 16).

Pillar [2]	Explanation
Every patient deserves the medical intervention that confers the greatest *patient value*.	Just as it reads
Patient value trumps financial value	The *patient value* conferred by an intervention is always of primary importance
Financial value become important when the *patient value* conferred by one or more interventions is similar	Only when *patient value* is similar, does cost enter the scenario. In this instance, the preferred intervention is that which is least expensive
Standardization is critical	Without standardization, very few cost-utility analyses can be compared. The great majority of published cost–utility analyses are not comparable
Patient preferences are critical	The use of patient utilities is crucial, since studies have shown that utilities obtained for the same health state can vary dramatically among patients who live with that health state and surrogate respondents (community, physicians, experts, relatives, caregivers, experts, etc.)
Just making the diagnosis of a disease generally produces a diminution in quality-of-life	Do not label a person with a disease lightly, especially if there is associated uncertainty. Diagnosing an ocular problem, despite 20/20 vision bilaterally, decreases an ophthalmic utility from 1.00 to 0.97 [6]
Practice the Power of Hope. Above all, be honest with patients. But remember that something positive can often be found in even the most negative healthcare conditions	Leaving a person on a more negative note, versus a more positive note, can decrease the quality-of-life loss associated with a specific condition by 70% [21]
Never base therapeutic decisions upon cost–effectiveness alone	Laser therapy for neovascular age-related macular degeneration costs US$7,000/QALY, while ranibizumab therapy costs close to US$50,000/QALY. Laser therapy, however, confers a 4% patient value gain, versus 16% with ranibizumab. There is no doubt that ranibizumab is the preferred therapy
Value-Based Medicine information systems should be made user-friendly, transparent, and available to all stakeholders in healthcare	In this fashion, the highest quality standards will be defined and healthcare costs will decrease when interventions that confer negative, no, or negligible value

[5]*Table 16 - Pillars of Value-Based Medicine (Source: Brown et.al., 2013)*

Throughout this literature there is very little reference to the need and requirement of the professional, with the exception of identifying the conflict which can exist between clinical perceived value and patient perceived value (Gray, 2004). Little discussion exists on the value to the professional working within the system. There is clearly a requirement that to deliver VBM and Value-Based Practice consideration must be given to the culture required to delivery these interventions and how the professionals in the system will deliver it (Hewison, 2004). A report in 2022 identified a number of key aspects to delivering VBHC including involving patients in their own care and involving citizens in decision-making, however this report still neglects to talk about involving the professional as key to sustaining and delivering VBHC (Smith et al., 2022).

Slow Medicine

A concept developed in Italy termed 'Slow Medicine' emerged in the early 2000's (Dolara, 2002). It advocates the development of an organisational culture where fast medicine (the rush to introduce intervention) may not always be in the best interest of the patient (McCullough, 2008) and that a

[5] Brown, M. M., & Brown, G. C. (2013). Update on Value-Based Medicine. *Current Opinion in Ophthalmology*, *24*(3). https://journals.lww.com/co-ophthalmology/Fulltext/2013/05000/Update_on_Value_Based_Medicine.3.aspx

slower more reflective approach to medical education is needed (Wear et al., 2015), with slow medicine resulting in better understanding of the person and enabling co-production. This concept aligns with similar mainstream management thinking being developed at the time such as the work developed by Daniel Kahneman, who's book *Thinking, Fast and Slow* (2011) describes how people make decisions through two different modes of fast and slow. Slow thinking requires conscious effort and although takes longer is less susceptible to bias or error (Kahneman, 2011). The focus of 'slow medicine' is similar to EBM and may miss the value the patient sees, and advocates listening to the patient and collaborating on desired values, outcomes and understanding the patient first, before deciding on a course of action (Bauer, 2008b). Identifying some of the issues experienced relating to eagerness of practitioners to treat, measurement targets which drive behaviours and the system they work in may in practice be of detriment to the patient. These themes start to identify the role of the professional in the success or failure of the concept and potential gaps in skill or focus on understanding and identifying value.

A summary of the key concepts explored of the genealogy of VBHC can be found in Table 17.

KEY CONCEPT	ENABLER	FOCUS	KEY QUOTES	RESEARCH IMPACTS
Structure-Process-Outcome Framework	Quality Assessment	Healthcare Service Quality	"The framework provides healthcare a structured way to assess quality." (Donabedian, 1966)	Guides quality assessment with a clear model; highlights need to consider wider system impacts on outcomes (e.g. socio-economic context). (Portela et al., 2015) (Berwick & Fox, 2016)
Co-Production	Patient-Professional Partnership	Patient Involvement	"Both patients and professionals need skills to deliver a true partnership of care." (Batalden et al., 2016)	Emphasises co-production as vital to engagement and value, especially as patient expectations increase. (Ostrom, 1996) (Alford, 2002) (Realpe & Wallace, 2010) (Farr, 2012) (Loeffler et al., 2013)
Evidence-Based Medicine	Clinical Evidence	Decision-Making	"Integrating individual clinical expertise with the best available external evidence." (Sackett et al., 1996)	Supports the need to balance clinician expertise with evidence, impacted by rising tech and automation. (Gray, 2004)

KEY CONCEPT	ENABLER	FOCUS	KEY QUOTES	RESEARCH IMPACTS
				(Brown et al., 2003) (Clancy & Cronin, 2005) (Kelly et al., 2015)
Value-Based Medicine	Outcome Measurement	Cost and Value Efficiency	"Value in health care is measured in terms of the patient outcomes achieved per dollar expended." (Kaplan & Porter, 2011)	Reinforces a shift to outcome-based metrics; highlights need to align clinician-patient views on value. (Brown et al., 2005) (Porter, 2010) (Smith et al., 2022)
Slow Medicine	Reflective Decision-Making	Patient-Centred Care	"A slower, more reflective approach… resulting in better understanding of the person." (Dolara, 2002)	Encourages cautious, personalised care approaches; impacts need for time-focused engagement models. (McCullough, 2008) (Wear et al., 2015) (Bauer, 2008a)

Table 17 - Summary of Key Concepts of VBHC Genealogy (Source: The Researcher - Marc Penny 2025)

The emerging dominant model, now termed Value Based Healthcare heralds from the U.S.A. It has evolved throughout the 20th Century (especially in the U.S.A. and its private healthcare system). The development of this thinking into a clear vision of high performance health and care was the seminal text - '*Redefining Health Care Creating Value-Based Competition on Results'* (Porter & Teisberg, 2006). The approach focuses on value and not just costs and includes understanding the value for patients experiencing a service (Bozic, 2013). The publication articulated the principles of value and VBHC as well as its application to the complex relationships and different types of value which are embodied for health care provision; and from multiple stakeholder perspectives (patient, staff, process, organisation etc.). VBHC thinking has some similarities with the theory of salutogenesis or the difference between medically measured parameters versus the experience of the patient (Antonovsky, 1979). Porter's work focuses on health care systems and structures in delivering care viewed through the prism of value as a function of outcomes against cost. But a question remained around how to change and sustain a system that seeks to improve value (Porter, 2008). Salutogenesis requires all involved in the care to have the skills, knowledge and ability to understand the holistic needs of the patient, however advocates that final decision making is based on their clinical judgement whereas VBHC would advocate a joint decision making based on outcomes and value (Alivia et al., 2011).

In 2011, Kaplan and Porter proposed through their position paper '*The Big Idea: How to Solve the Cost Crisis in Health Care*' in the Harvard Business Review that the proper goal for any health care delivery system is to improve value delivered to patients. Value in health care can be measured in terms of the patient outcomes achieved per $ expended (Kaplan & Porter, 2011), with them articulating an outcome measurement hierarchy which focuses on the value to patients through three tiers of measurement. There are similarities in the premise and aims Kaplan and Porter were trying to achieve with the Cleveland Health Quality Choice Coalition, to use outcome data to support better procurement and market engagement and included elements such as measuring patient satisfaction along with outcomes. Initially viewed as a success in instituting market-based strategy for health care reform (Rosenthal & Harper, 1994), the Cleveland Health Quality Choice Coalition ended in 1998, this was due to changes in the private health market in Cleveland with the merger of a number of organisations and a change in the political ideology (Neuhauser & Harper, 2002).

There is clearly an alignment of thinking and premise between this initiative in Cleveland and the development of Kaplan and Porter VBHC, both focusing on outcomes as a measurement of cost drivers, initially by procurement and market based spend. In 2016 an explorative interview-based study (comprising 19 informants) focused on VBHC implementation at a Swedish Hospital. Table 18 summaries the 3 key findings identified:

KEY FINDING	DESCRIPTION	MEANING
Anchoring to create engagement	Sustained efforts are needed to engage staff and patients in VBHC. As one participant noted, "We were busy trying to understand what VBHC actually was ourselves", making early anchoring challenging.	Engagement is an ongoing process critical to gaining and maintaining stakeholder commitment for successful VBHC implementation.
Parity of engagement with professionals and patients	Equal involvement of healthcare professionals and patients is essential. Participants reflected that patients "should have been involved right from the beginning" and better prepared for their role.	Balancing input from both patients and professionals ensures inclusivity and shared ownership of VBHC initiatives, enhancing their effectiveness and impact.
Engaging staff and building skills	Staff need sufficient knowledge and preparation to implement VBHC effectively. One participant remarked, "We had no prior knowledge about VBHC" and stressed the importance of "conceptual maturity" before starting.	Equipping staff with the skills and understanding of VBHC is essential to align professional efforts with the system's goals and sustain long-term improvements.

Table 18 – Key Findings From an Interview Based Study at a Swedish Hospital (Source: Nilsson et al., 2018)

The findings revealed an issue with "sustainability" highlighting issues with data accessibility for cost and outcome tracking, which are key for measuring and ensuring sustainable health outcomes.

Sustainability in VBHC requires continuous learning, engaging patients and staff, and ensuring resources like administrative support and IT systems are well-allocated (Nilsson et al., 2018). The issues concern how staff, given the difficulties explored earlier can maintain VBHC and see it as integral and not remote from their day-to-day work of professional care delivery. VBHC also demanded increased engagement of care providers which also was difficult to sustain (Nilsson et al., 2017c). The critical importance of stakeholder engagement (essentially human factors) was demonstrated by this study, with few additional studies (beyond individual case reports) existing that close this gap as to how people engage with, implement and sustain VBHC. Similarly its argued that partnerships and relationships need to exist internally and externally with partner organisations for VBHC to succeed (Rich et al., 2023). More recently studies have included the following.

Prudent Healthcare

In 2013 the Welsh Government commissioned the Bevan Commission[6] to consider how Wales makes the most effective use of available resources to ensure high quality and consistent care across Wales (Aylward et al., 2013; *A prudent approach to health: Prudent health principles*, 2015). Based on this work, Welsh Government launched its Prudent Healthcare policy in 2016. This talked about and developed further co-production where professionals share power with the patient and work together in partnership to deliver the health outcomes for people (*Prudent Healthcare: Securing Health and Well-being for Future Generations*, 2016). Further development of Prudent Healthcare in Wales has seen a recommendation of a move away from purely clinical outcomes measures to personal and social outcomes measures (*Exploiting the Welsh Health Legacy: A New Way of Thinking: The Need for a Prudent Model of Health & Care.*, 2017). The synergies between Prudent Healthcare principles and VBHC delivery models start to be explored and identified, focusing on principles and ideology. Similarly in the U.S.A. a programme was developed called 'Choosing Wisely', which focused on reducing inappropriate tests and treatments where they did not add value to patients, reducing un-necessary care, harm and waste (Brody, 2010). Prudent Healthcare can be an enabler and support to delivering greater professional value and Table 19 provides a summary of this support via its principles.

[6] The Bevan Commission is Wales' leading health and care think tank, hosted and supported by Swansea University. Established in 2008, it provides independent advice and guidance on health and care-related matters to the Welsh Government

PRUDENT HEALTHCARE PRINCIPLE	HOW IT SUPPORTS BETTER PROFESSIONAL VALUE
Do no harm	Encourages professionals to prioritise patient safety by avoiding unnecessary interventions and minimising risks, thereby fostering trust and enhancing care quality.
Care for those with the greatest health need first	Promotes equity and fairness by focusing resources on the most vulnerable and underserved, aligning professional practice with ethical standards and maximising societal impact.
Only do what is needed	Ensures efficient use of time and resources, reducing unnecessary workloads and costs while allowing professionals to focus on interventions that yield the greatest benefit.
Enable patients to play an active role	Strengthens patient-professional collaboration, leading to improved adherence to treatments, better health outcomes, and enhanced professional satisfaction from shared decisions.
Reduce variation	Standardises care delivery based on best practices, improving predictability of outcomes and enabling professionals to maintain high-quality care while reducing inefficiencies.
Promote evidence-based interventions	Supports professionals in delivering treatments and services proven to be effective, enhancing confidence in care decisions and reducing waste from ineffective practices.
Increase resource efficiency	Encourages thoughtful allocation of resources, enabling professionals to achieve better outcomes with limited inputs while improving overall system sustainability.

Table 19 - Prudent Healthcare and Supporting Professional Value (Source: The Researcher - Marc Penny 2025)

European Implementation of VBHC

In 2019 the European Commission defined VBHC as a comprehensive concept built on four value pillars: appropriate care to achieve patients' personal goals (personal value), achievement of best possible outcomes with available resources (technical value), equitable resource distribution across all patient groups (allocative value) and contribution of healthcare to social participation and connectedness (societal value).

Investment in healthcare has continuously increased while evaluation against traditional matrixes such as life expectancy, although still increasing is delivering diminishing returns. New ways of thinking such as VBHC principles have started to be developed and evaluated across health systems and offer an opportunity to refocus how we evaluate and understand the 'value' of health interventions and outcomes. It's also clear to see the lineage of this development and research undertaken on the concept of VBHC such as Kaplan and Porter measurement hierarchy and evaluations around the value

deployment has started to deliver. However, it leaves a question around how effective is the deployment of VBHC across health systems?

The EIT Health Report *'Implementing Value-Based Health Care in Europe: Handbook for Pioneers'* (2020) on implementing VBHC in Europe stresses the key role of healthcare professionals, highlighting that effective VBHC implementation relies on team-based care and a culture of collaboration. Key findings indicate that 20% of healthcare spending could be avoided by eliminating ineffective practices, yet professionals face challenges in shifting to outcome-based practices due to limited training and systemic resistance. The report critiques the lack of structured support for professionals transitioning to VBHC and calls for better-defined metrics and interdisciplinary support (EIT_Health, 2020).

This EIT framework positions VBHC as a transformative concept across healthcare systems, not just in the UK, but as a concept legitimised in European Union wide policies and broader international frameworks. Beyond the national recognition of VBHC's potential, its role has been acknowledged at the EU level and endorsed in global policy contexts, demonstrating a move towards more efficient and patient-centred care. The European Commission's position on VBHC aligns with other major research, including Kaplan and Porter's (2011) work on measurement hierarchy, underscoring the importance of value-oriented outcomes in healthcare. With the potential to reduce healthcare spending by up to 20%, VBHC's legitimacy is evident in both European and international policy, calling for clearer metrics and better support for healthcare professionals.

Value Based Healthcare Deployment

A study of the implementation of VBHC in Sweden (2016) reported 3 main themes associated with requirements for successful VBHC implementation. From interviews with people involved in the programme. These were resource allocation, anchoring to create engagement and dedicated leadership (Nilsson et al., 2018) as previously discussed in this chapter and in Table 18. The review found participants lack of knowledge and understanding of VBHC at the beginning of its deployment, and despite increasing peoples' knowledge, it was difficult to maintain the engagement of staff – similar to findings on barriers to Prudent Healthcare (Addis et al., 2019). Research studies started to identify the 'people' change element's role within VBHC deployment (Nilsson et al., 2017c) and the "human impact" on success or failure. Porter states that *'if value improves, patients, payers, providers, and suppliers can all benefit'* (Porter, 2010) but neglects to mention the benefit to the professional

working in the system or delivering the clinical interventions needed. Many reviews and studies continue to focus on the patient and system but not the professional individual within the system, perhaps because a lot of the literature is written from the view point of the professional so it is omitted or overlooked, this can be seen in 'Redefining Health: Implications for Value-Based Healthcare Reform' (Putera, 2017) where focus is on patients and systems.

VBHC and its adoption and deployment could be viewed as a collection of activities and projects delivering defined areas of value, however the question remains on its sustainability in deployment and continuation. In the context of a 'drive' towards VBHC thought needs to be given to the deployment methodology itself, is VBHC a process, a culture or a group of projects? Although research exists into VBHC, there is little available from a discourse perspective or critical evaluation, partly due to the measurement horizons needed to truly evaluate the impacts of value. Some research and academic discussion has taken place citing how dependency of success sits with certain 'actors' or 'organisations' in VBHC success (Steinmann et al., 2020).

Similarly, a report based on an international, multicentre consensus process *'The Roadmap for Implementing Value-Based Healthcare in European University Hospitals—Consensus Report and Recommendations',* looked at what was needed to implement VBHC based on experiences from European University Hospitals. Identified through this work (Table 20) were 8 core components and 3 additional components (Cossio-Gil et al., 2022). The findings also set out a framework for deploying VBHC which touches upon the need for organisational engagement, communications, change management and leadership.

	The hospital/s are or have:
Core Components of the agenda of VBHC	Organised into integrated practice units or Re-designing and improving the pathways in order to add value to patients
	Routinely measuring outcomes that matter to patient: Clinical outcomes
	Routinely measuring outcomes that mailer to patient: PROMs
	Routinely measuring experience that matter to patient: PREMs
	Routinely measuring costs at patient level
	A built and enabled information technology platform
	Integrated care delivery across separate facilities
	Moving for bundled payments for Value for clinical condition
Others	Using those outcomes for making clinical decisions and for improving the care of the patients
	Evaluating changes in the culture of your organisation
	Including patients in the clinical but also organisational decisions

Table 20 - 8 Core Components and 3 Additional Components of Value Based Healthcare (Source: (Cossio-Gil et al., 2022))

The deployment of VBHC combines organisational, cultural and individual professionals dynamics. While resource allocation, engagement and leadership are key elements and well understood the human element and particularly the professional staff understanding and engagement plays a key role in its success. The literature largely prioritises patient and system outcomes but often neglects or minimises the experiences and contributions of healthcare professionals. To ensure sustainability, VBHC must evolve from a collection of projects into an integrated culture, backed by robust evaluation frameworks and leadership-driven change management. Addressing these connected elements can strengthen the long-term sustainability and impact of VBHC.

Value Based Healthcare and the Focal Case for This Study

A review of Aneurin Bevan University Health Board in 2018 describes components of VBHC as Outcomes, Costs, Informatics underpinned by Language and Culture (*Value Based Healthcare: Learning from practice*, 2018) working with patient, carers and clinical teams to build a value culture. Similarly Mjaset et al suggested that in instituting a VBHC culture among providers there was a risk to deployment from top down implementation (Mjåset et al., 2020) and the need to motivate the professional in delivery of sustainable change (Nilsson et al., 2017b). Similar findings have been found through a review of VBHC within Australia arguing a transformational and cultural change is needed to deliver person-centred care (Dawda et al., 2022).

While the previous section examined the development, adoption and deployment of VBHC principles, including the human factors and organisational dynamics crucial for sustainable integration, it also raised questions about the broader implications of these changes. The next section explores the influence of professional perspectives and education which are essential in fostering a healthcare culture that aligns with patient values.

In the book '*The Making of a Doctor: Medical Education in Theory and Practice'*, Downie & Charlton (1992) described a *'whole person understanding'* concept as a shortfall in current medical training and practice. New entrants to the medical profession had little knowledge or exposure to a diverse patient cohort and with a lack of training and focus on how to engage and understand the whole patients need. Weatherall argued that a shortfall in education of clinicians to cover areas such as poor communications, impacts their ability to deliver what society expects and a greater focus of education should be on ethics, communications and earlier exposure to patients and their families (Weatherall,

1994). A concept of 'organisational silence' argues that cultures in organisations can withhold certain information stifling and hindering change (Morrison & Milliken, 2000) - although an opinion article expressing the authors view, the author is a well-regarded Professor of Medicine at Oxford University, and the opinion piece is supported by a number of other academic citations. Elements such as better communication with patients, aligning care to the wants and needs of the patient and understanding wider health and social needs are often identified as key to better understanding and engaging with patients (Sensor, 2015), but again little articulation is provided on what is needed from the 2nd person in the relationship – the professional.

Similarly, understanding the need and value of the patient could be at odds or creating conflict with the professional treating the individual (Gray, 2004), creating a 'source of annoyance' or where the systems we expect our professionals to operate in restrict their ability to slow things down and take time to understand the value of the patient (Bauer, 2008b) and linking back to earlier theories such as Slow Medicine and Slow and Fast Thinking.

Porter argues the first step in changing a system to deliver value is ensuring the priority for all people involved is to define value as the goal (Porter, 2008). The question though is with different people involved in healthcare (professionals, patient and management) from what perspective can or should value be determined. Porter avoids such a discussion and states that value and innovation should be aligned to reimbursement, which is a function within the US private healthcare system, however this poses the question of how this translate into a national healthcare system such as the U.K. NHS.

From this critical review and wider literature, a summary can be drawn of previous improvement programmes within healthcare which have been found to be lacking in sustainability of delivery and realisation of their full potential due to limited cultural focus and people-oriented change (Table 21).

FOCUS	AUTHORS	POSITION	CRITICISM
Prudent Healthcare	Aylward et al., 2013	Prudent healthcare encourages people to consider what care they need, including whether they can look after themselves (self-care), and to use the most appropriate service for their clinical need, not the nearest or most familiar.	Lack of knowledge and difficulty in maintaining engagement. **(Addis et al., 2019)**
Structure-Process-Outcome	Donabedian 1966	Categorises healthcare into three key elements which include structure, process and outcomes. Provides healthcare a structured way to assess quality	One dimension measure focusing on outcome in isolation of other impacts **(Portela et al., 2015)**
Value Based Healthcare	Porter & Teisberg, 2006	Value-based healthcare is the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences for every person.	Parity of engagement with professionals working in the system, engaging with staff and skills. Difficult to sustain as staff see it as remote from their core job. **(Nilsson et al., 2018)** **(Nilsson et al., 2017c)** **(Steinmann et al., 2020)**
Slow Medicine	Dolara, 2002	Advocates a change of culture from rushing to introduce interventions to one where time is taken to listen to and understand the patient before deciding on a course of action.	Identifies the professional's role in success or failure of the concept with potential gaps in skill or a focus on understanding patient value. **(Bauer, 2008b)**
Evidence Based Medicine & Value Based Medicine	Sackett et al., 1996	Evidence based medicine is the conscientious, explicit, judicious and reasonable use of modern, best evidence in making decisions about the care of individual patients. EBM integrates clinical experience and patient values with the best available research information.	Conflict can exist between clinical perceived value and patient perceived value. **(Gray, 2004)** and issues with implantation from the complexity of healthcare systems **(Titler, 2010)**
Co-Production	Kings Fund	A way of working where service providers and users work together to reach a collective outcome	Barriers need to be overcome including time, change or relationship with the patient and changing work priorities due to work demands. **(Vennik et al., 2015)**

FOCUS	AUTHORS	POSITION	CRITICISM
Total Quality Management (TQM)		A management framework based on the belief that an organisation can build long-term success by having all its members, from low-level workers to its highest-ranking executives, focus on improving quality and, thus, delivering customer satisfaction.	The most frequently mentioned reasons for TQM implementation failures include insufficient education and training, lack of employees' involvement, lack of top management support, inadequate resources, deficient leadership, lack of a quality-oriented culture, poor communication, lack of a plan for change and employee resistance to the change programme. **(Mosadeghrad, 2014)**
Lean		The goal of Lean process improvement is to enable teams to systematically find ways to deliver more value to their customers faster. It does this by providing a systematic, scientific approach to practicing continuous improvement as a part of daily work.	Unrealistic expectations regarding effort and results and too much focus on short-term improvements instead of long-term capability building. **(Hensley, 2017)** and failure to measure improvement outcomes and benefits **(Shojania & Grimshaw, 2005)**
Six Sigma		Six Sigma is a process that makes use of statistics and data analysis to analyse and reduce errors or defects.	Challenges are related to the culture and the resistance to culture change. **(Albliwi et al., 2014)**

Table 21 - Improvement in Health Cultural Suitability (Source: The Researcher - Marc Penny 2025)

In summary, VBHC may be viewed as an evolution of previous management thinking and an extension that unites a number of different trends - some of which have coalesced into what many recognise as VBHC. With this view in mind, VBHC is likely to be unwelcomed by professional staff as another management model which causes more discretionary effort and productivity without a corresponding improvement in professional value and care delivery. If there is still some confusion and disagreement in the definition of VBHC and what it is and isn't then this will be seen as a negative to professionals, especially if they are not engaged in shaping VBHC and its translation into the NHS settings of service delivery. Without professional engagement then implementation may be localised or no progress will be made, as PDSA models will remain with their limited focus on tasks and process stages. In the researchers reasoned view, drawing from experience and the literatures, there is a genealogy in VBHC

development and alignment in theories focused on value, patient voice and engagement (Figure 12), raising hopes that VBHC will result in performance improvement and greater value for professionals.

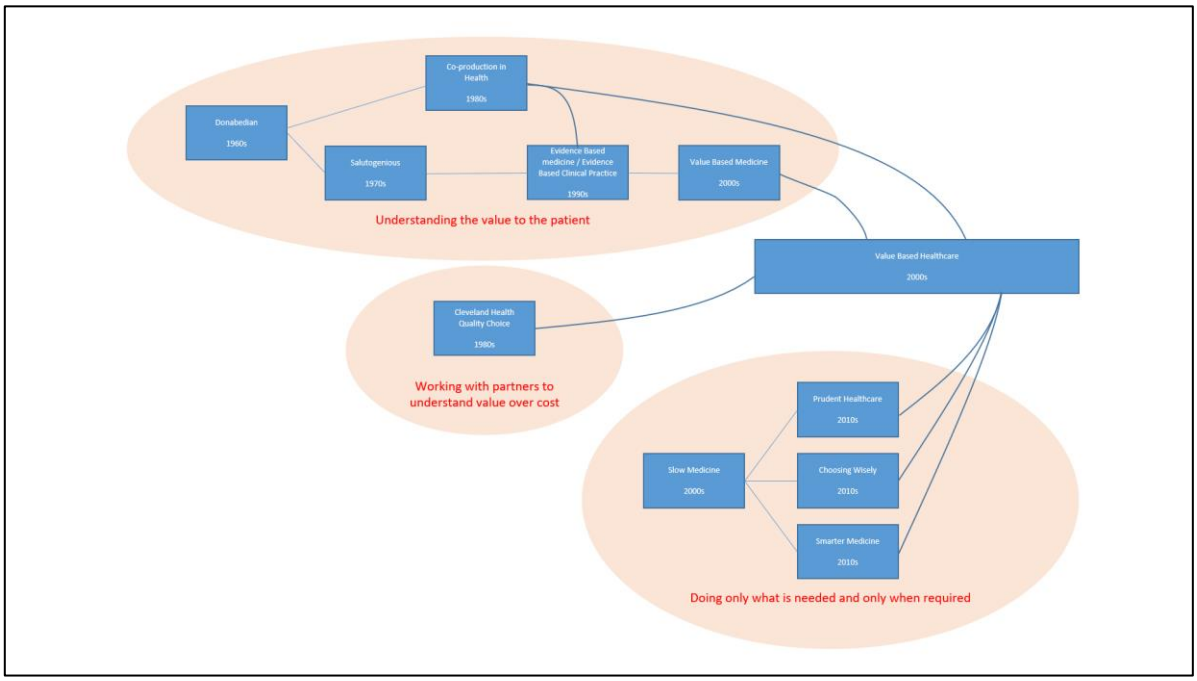


Figure 12 - Genealogy of Value Based Healthcare (Source: The Researcher - Marc Penny 2025)

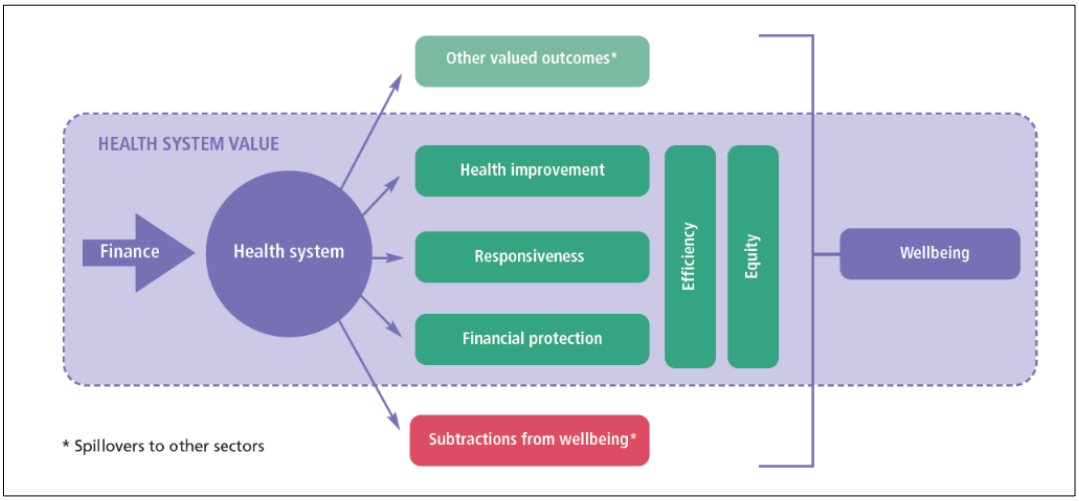
VBHC is also presented as a new dominant model for organisational and process improvement to realise new levels of value (Porter, 2008), but progress beyond the conceptual attractiveness of the approach is questionable. The relationship of people in this most complicated STS is almost wholly absent from any form of modern debate. The gap, identified by the researcher, therefore explores the role of the human and professional in VBHC and to address general weaknesses in the treatment of the professional as largely passive (e.g. value based medicine approach omits details of the professional within the system or against its pillar of value based medicine (Brown & Brown, 2013b)) and the source of annoyance that intentional or unintentional professional isolation from VBHC and improvement has shown to trigger (Gray, 2004).

The Swedish movement for VBHC (Nilsson et al., 2017b; Nilsson et al., 2018) proposes sustainability issues with staff engagement, time and it not being seen as core to the role. The concept of discretionary effort provides past evaluation of the impacts on effort above and beyond what is contractual for an employee, often organisations take for granted employee's discretionary effort to deliver above and beyond their core role, risking the sustainability of delivery and the goodwill of the employee which can ultimately lead to a failure to sustain change. Findings from the longitudinal study concluded the need to ensure understanding of the intrinsic drive of healthcare practitioners and

harness this for success at delivery (Nilsson et al., 2017c). However, most studies to date have purely focused on patient and systems not the professionals working within that system (Fakkert et al., 2017; Kapitein, 2017; Putera, 2017).

Batalden et.al in their studies identified further issues, they concluded their study by questioning the process and content of co-production including education of professionals in skills and knowledge to co-produce. They identify building better relationships between patients and professionals as problematic and conclude that healthcare is not a produced but rather a service co-created between patients and professionals (Batalden et al., 2016b). If these authors are right then the focal research questions of what role do professionals have in the concept of VBHC and what value does this concept provide to them are highly relevant to modern best practice through the deployment of VBHC. Further research identifies barriers to professionals implementing and enacting co-production (Vennik et al., 2015).

To explore and position the concept of value in service provision, the following model (Figure 13) for value from a health system perspective was developed by Smith et.al (2022), and provides a useful summary of the debate thus far. The figure shows the elements relating to the value for the patient, financial and societal. However, there is an argument that value is also generated for the practitioner and also for the resilience of the whole system by having a role to play in job satisfaction and stability of workforce which can contribute to effective delivery of services, organisational commitment, productivity and quality (de Menezes, 2012).



[7]*Figure 13 - Smith et al VBHC Model (Source: Smith, P. et.al. 2022)*

[7] Smith, P., Sagan, A., Siciliani, L., Panteli, D., McKee, M., Soucat, A., & Figueras, J. (2022). Building on value-based health care: Towards a health system perspective (HEALTH SYSTEMS AND POLICY ANALYSIS, Issue. https://www.europeanallianceforvalueinhealth.eu/wp-content/uploads/2022/02/policy-brief-37-1997-8073-eng.pdf

In overall terms, there is little available research, from a discourse perspective or critical evaluation, on the utility of this model (partly due to the measurement horizons needed to truly evaluate the impacts of value and deployment of VBHC). Few academic discussions have taken place citing how dependency of success sits with certain 'actors' or 'organisations' in VBHC success. It could be argued that there are a number of 'actors' (Steinmann et al., 2020) in the VBHC approach who are knowledge workers and professionals who add value within the system, by diagnostic and physical services and are themselves dependent on other 'Managerial', 'Clinical' and 'Medical' staff to do so. These groups of professionals, within the system, all have a role to play in the successful delivery and sustainability of VBHC as a set of principles and methodology. There individual professional cultures and governance structures (Royal colleges, professional bodies and chartered institutes) may all have a role to play in the delivery of VBHC bringing together the actors of patient and professional in a co-production of health outcomes based on value and need.

The publication, *'Value in Healthcare: Laying the Foundation for Health System Transformation'* (2017) provides insight into the types and potential combination of enablers. It identifies 4 such key enablers in the delivery of VBHC (Informatics, Benchmarking, Payments and Delivery Organisation). Interestingly $^{No.}$4 is declared as the 'delivery organisation' with a focus on the case for change, organisational context and change management. This is one of very few articles which start to describe the importance of the change process within VBHC deployment and touches upon the role of the professional in the context of roles and training (Teisberg et al., 2020). Research from 2021 identifies the need for a number of cultural requirements as part of a deployment (Cossio-Gil et al., 2022) with a focus not just on strategy but a number of cultural elements and those effecting professionals working in the system needed.

Research in this subject area has identified the professional's lack of knowledge and understanding of VBHC at the beginning of its deployment and despite increasing peoples' knowledge found it was difficult to maintain the engagement of staff (Nilsson et al., 2017c). This research has similarly started to identify the 'people' change element's role within VBHC deployment and its impact on success. Porter argues the premise of reward is important as the reimbursement from an organisational perspective is for them the value (when the system is a private health system). In a National healthcare system do we need to view the value from not only the patients perspective but also the professional in the system, providing them with the drive and 'reward' to ensure patient outcomes are at the heart

of treatment (Porter, 2008). It is argued that "Doing what is needed and right for patients" must be the goal, and to achieve this everyone must be aligned to the goal of value including the professional in the system (Porter, 2009) along with patients, payers, providers and suppliers (Porter, 2010). However, the seminal text from Arrow 'Uncertainty and the welfare economics of medical care' (1978), argues that healthcare systems cannot be treated like other markets due to their complexity, and prevalence of uncertainty (Arrow, 1978).Laing et al, argues that for VBHC to succeed then it must span the supply chain between supplier and provider, and focus on key elements which include empowerment, culture, skills and cross organisational learning (Laing & McHale, 2022). Porter however neglects the role the professional within the system and the impact they may have in delivering and sustaining a VBHC system, some of which starts to be explored by Laing et al. In the U.S.A. there continues to be shift in healthcare provision focusing on VBHC approaches which also need to take into account measurement and collaboration with partners. The CMS Innovation Centre's Quality Pathway approach which priorities quality over quantity still lacks consideration of professionals working within the system (Bernheim et al., 2024).

The recent paper '*Value-Based Supply: Developing Internal Readiness'* (2024) by Laing et.al. investigates how internal alignment can facilitate VBHC deployment by focusing on organisational readiness among healthcare suppliers. The study utilises qualitative interviews and case studies to identify key enablers such as leadership commitment, patient-centred partnerships and data sharing while noting areas like employee well-being and diversity, equality and inclusion. Findings showed (Table 22*)* respondents ranked the following by importance with 'A patient centric approach in product/service design' number 1.

Critical success factors	Industry	Non-industry
A patient centric approach in product/service design	1	1
Visible Executive leadership	2	3
Partnerships for value	3	4
An effective process for sharing learning and knowledge	4	2
A strong diversity, equality and inclusion culture	5	9
A comprehensive digitalization strategy	6	6
A well-developed sustainability strategy	7	7
Employee incentivization linked to creating value	8	8
A commitment to colleague well-being	9	5

[8]*Table 22 - Ranking of previously identified critical success factors by Industry & non-Industry respondents (Source: Laing et.al. 2024, p2)*

[8] Laing, H., Rich, N., Yu, H., & McHale, J. (2024). Value-Based Supply: Internal Readiness. https://www.europeanallianceforvalueinhealth.eu/wp-content/uploads/2024/04/VBS-Internal-Readiness-FINALv2.pdf

Drawing on the above discussions, it can be seen that "rounded" and multi-skilled professionals (technical and interpersonal skills) with the right skills and support of others upon whom they are dependent enables better patient focus (Weatherall, 1994) and determination of patient values (Downie & Charlton, 1992). This competence presents itself as a key element in the delivery of VBHC and instituting a culture of VBHC for its sustainability (Mjåset et al., 2020) and likelihood of success. Schein, from the mainstream change literature, argues that organisational change is built upon the embedded "culture" of an organisation, and can be assessed against and driven by 3 concepts of artefacts, values and assumptions (Schein, 2017). These concepts when combined provide an ability to understand an organisations current culture which is needed before it can be changed.

The researcher suggests that these findings underscore the key role of cultural elements and professional engagement in the success of VBHC initiatives. This review shows that sustaining change requires more than procedural alignment; it necessitates the active participation and alignment of healthcare professionals working within the system whose motivation and cultural fit within the system are essential. This would imply that any study of VBHC will need to address and assess these indicators of culture to identify those that best enable VBHC success.

Overall, there is little research and thought about the professional role within the successful delivery of VBHC. Despite the best efforts of the likes of W. Edwards Deming and Joseph M. Juran who advocated and developed theories of improvement (Deming, 1982) and change in the early 20th century with a focus on a culture of improvement and the human dimension of change sustainability (Juran, 1989), over 100 years on these lessons and foundations of change still appear lacking in current improvement models. Whilst a few papers have started to be produced on this element many of them mealy state further research is required and can be argued are critical to enabling and enacting change (Schein, 2017).

2.11.2. Lessons from Value Based Healthcare Implementations

The literature on VBHC success in application to practice offers the potential to improve patient outcomes while optimising healthcare resources. However, its deployment has faced several challenges from the studies reviewed and summarising the key lessons from past VBHC implementations the author has focused on the barriers, enablers and strategies needed for successful adoption. It is unclear in the literature whether there are any trade-offs in moving to such a model or

how professionals see and engage with the VBHC movement. Traditional forms of improvement have typically been greeted with scepticism or a belief that the management fad is purely an attempt to raise productivity (Wanous et al., 2000) with the concept of 'Cynicism About Organisational Change' (CAOC) developed by researchers such as Wanous, Reichers, and Austin in the 1990s.

A significant lesson from previous case studies of VBHC deployment, is the need for sustained engagement of healthcare professionals – with an emphasis on sustaining engagement - where these studies (from Sweden) found initial enthusiasm for VBHC reduced over time because many professionals felt it was disconnected from their daily work (Nilsson et al., 2018). Training, continuous engagement and fostering a sense of ownership are essential for integrating VBHC into routine practice (Teisberg et al., 2020). VBHC must be viewed as a team approach crossing specialisms and delivering for patients through a multi professional approach (Lewis, 2022; Teisberg et al., 2020; van Staalduinen et al., 2022) and lead to a culture of VBHC (Cossio-Gil et al., 2022; Daniels et al., 2022).

Co-production where patients and professionals collaborate on healthcare decisions is central to the delivery of VBHC and is a key philosophy within NHS Wales, although its actual adoption and deployment has been somewhat unmeasured. However, practical challenges like time constraints and shifting priorities can and have been shown to hinder its effectiveness (Vennik et al., 2015). To overcome this healthcare systems including the NHS must support flexible care pathways and ensure sufficient time for meaningful patient-professional partnerships.

Effective leadership and cultural change are crucial for embedding VBHC within healthcare organisations (Varela-Rodriguez et al., 2021). The Swedish literature highlighted the importance of leadership in modelling and promoting VBHC principles (Nilsson et al., 2018) and again leaders must align VBHC with the organisation's vision and goals while motivating its people by linking its relevance to individuals work.

Many healthcare improvement programmes reviewed by the author have struggled with long-term sustainability, for example the Cleveland Health Quality Choice Coalition, whilst initially successful in driving reforms ultimately failed due to changes in the private healthcare market (Neuhauser & Harper, 2002). Although this is less relevant in an organisation such as the NHS, the need for VBHC deployments to focus on long-term strategies with ongoing education and stakeholder engagement

is key to ensure they last and are sustained along with ongoing situational awareness. A scoping review study in 2022 where 1,729 publications were screened and 62 used for qualitative and quantitative analysis found many implementation of VBHC focused purely on measurement of patient outcomes and failed to consider the wider requirements needed to embed VBHC into the healthcare organisations day to day culture and structures (van Staalduinen et al., 2022).

Change management and other improvement programmes has suffered from implementation issues and deployments often encounter tension between professional and patient values, as well as differences between national and local targets. EBM integrates clinical expertise with research but patient priorities may differ from clinical outcomes or those being set nationally, focusing more on quality of life (Gray, 2004). To overcome this the research argues that the professionals need to develop skills in communication and shared decision-making (Allvin et al., 2021) to align treatment with patient values. Porter's and Kaplan's interpretation of VBHC focuses on patient outcomes relative to cost arose out of the U.S.A. private healthcare market and has needed evolution and adjustment for healthcare systems like the NHS (Kaplan & Porter, 2011). Flexibility in VBHC implementation is essential to accommodate diverse healthcare environments and differences in model, this means assessing and deploying based on local and national context for success.

2.11.3. Identified Gaps in VBHC Literature

VBHC provides a promising approach for driving organisational and process efficiency to achieve greater value for patients, society and taxpayers. However, contemporary discourse overlooks the crucial role of individuals and professionals within this complex socio-technical system, creating a gap in current research and understanding (Hewison, 2004). A focus in involving citizens and patients is prevalent but little exists on the role and involvement of professionals, an omission seen in a number of the research journals and reports reviewed including *'Building on value-based health care: Towards a health system perspective'* (Smith et al., 2022) and '*Accelerating the pace of value-based transformation for more resilient and sustainable healthcare'* (Noel, 2022). This gap is particularly notable concerning healthcare professionals, whose involvement the author believes is essential for successful and sustainable implementation.

Studies have identified challenges with staff engagement, time constraints and the failure to integrate VBHC into professionals' core responsibilities (Brown & Brown, 2013a; Gray, 2004). The lack of engagement and involvement of employees in the change and their buy in to the future direction can

hinder any attempt to implement change (Talmaciu, 2014). Additionally, the concept of discretionary effort, where employees exceed their contractual obligations, is vital for sustainable delivery but often overlooked. While some research highlights the importance of understanding healthcare professionals' motivations for successful delivery (Nilsson et al., 2017c; Nilsson et al., 2018), most studies focus solely on patients and systems, neglecting the professionals' perspectives.

As previously discussed, questions arise regarding the involvement of professionals in co-producing healthcare services and the 'value' VBHC brings to them. Despite some recognition of the need for professionals' involvement, barriers to implementing co-production remain largely unaddressed. Enablers such as organisational change management theory (Batalden et al., 2016a) are crucial for VBHC implementation, emphasising the importance of recognising the role of professionals in driving and sustaining change (Cossio-Gil et al., 2022) and embedding VBHC into organisations structures and day to day business (van Staalduinen et al., 2022), including objectives and performance (van Elten et al., 2023).

However, professionals' lack of knowledge and understanding of VBHC (Nilsson et al., 2017b; Nilsson et al., 2017c) poses a significant challenge, despite efforts to increase awareness (Daniels et al., 2022). Considering professionals' perspectives, particularly in terms of rewards and incentives is important (Porter, 2008, 2009, 2010) as their alignment with the goal of delivering VBHC is essential for success.

A culture of VBHC, built upon professionals with the right skills and support, is key to sustainable change and delivery of benefits (Bandurska et al., 2023). Organisational change emphasises understanding an organisation's current culture before implementing change (Schein, 2017). In conclusion, there's a lack of research and consideration of the professional role in VBHC with only recent research starting to articulate the need for professional involvement and integration into VBHC, with a focus on employees and their needs (Laing et al., 2024). Despite early 20th-century theories emphasising the human dimension of change, improvement models often overlook this aspect.

While some papers acknowledge the need for further research, the current knowledge gap underscores the need for deeper exploration of the professional's role in VBHC implementation which is what the authors research aims to contribute towards. A systematic review of VBHC literature in 2022 which analysed 1,243 articles and found that there was no identified or definitive roadmap or guidelines for implementing VBHC and further research is warranted (Vijverberg et al., 2022). Similarly a review in 2021 of the Swedish experience of implementing VBHC failed to identify the person involved in its delivery as a key element of lesson learnt (Krohwinkel et al., 2021).

2.11.4. Value Based Healthcare Literature Review Summary

The authors review of the literature relating to VBHC provides a detailed review of its evolution and deployment, highlighting the critical factors for its success and barriers encountered in delivery and sustaining. One major lesson from the review is the importance of engaging healthcare professionals in the process and ensuring that they are aligned with VBHC principles through continuous education and cultural adaptation. Co-production, leadership and the need for sustainable engagement are also essential for ensuring that VBHC can be effectively implemented and maintained across healthcare systems and the negative impact not having these in place have on professionals.

The literature shows challenges particularly in maintaining staff engagement and bringing together the sometimes-conflicting values and requirements of professionals and patients.

The author believes that the deployment of VBHC holds significant potential positive benefits for improving patient and societal outcomes whilst optimising resource allocation. However, its success depends on overcoming the cultural barriers highlighted ensuring that all stakeholders especially healthcare professionals are fully engaged and supported in its implementation. The question arises as to what 'value' does VBHC provide to the professional delivering the service.

2.12. Key Thematic Elements from the Literature

The researcher has undertaken a qualitative thematic review and grouping of the key themes identified from the literature. The author has used the review of 'professional value' to help derive the list of thematic areas from the qualitative literature review (Figure 14).

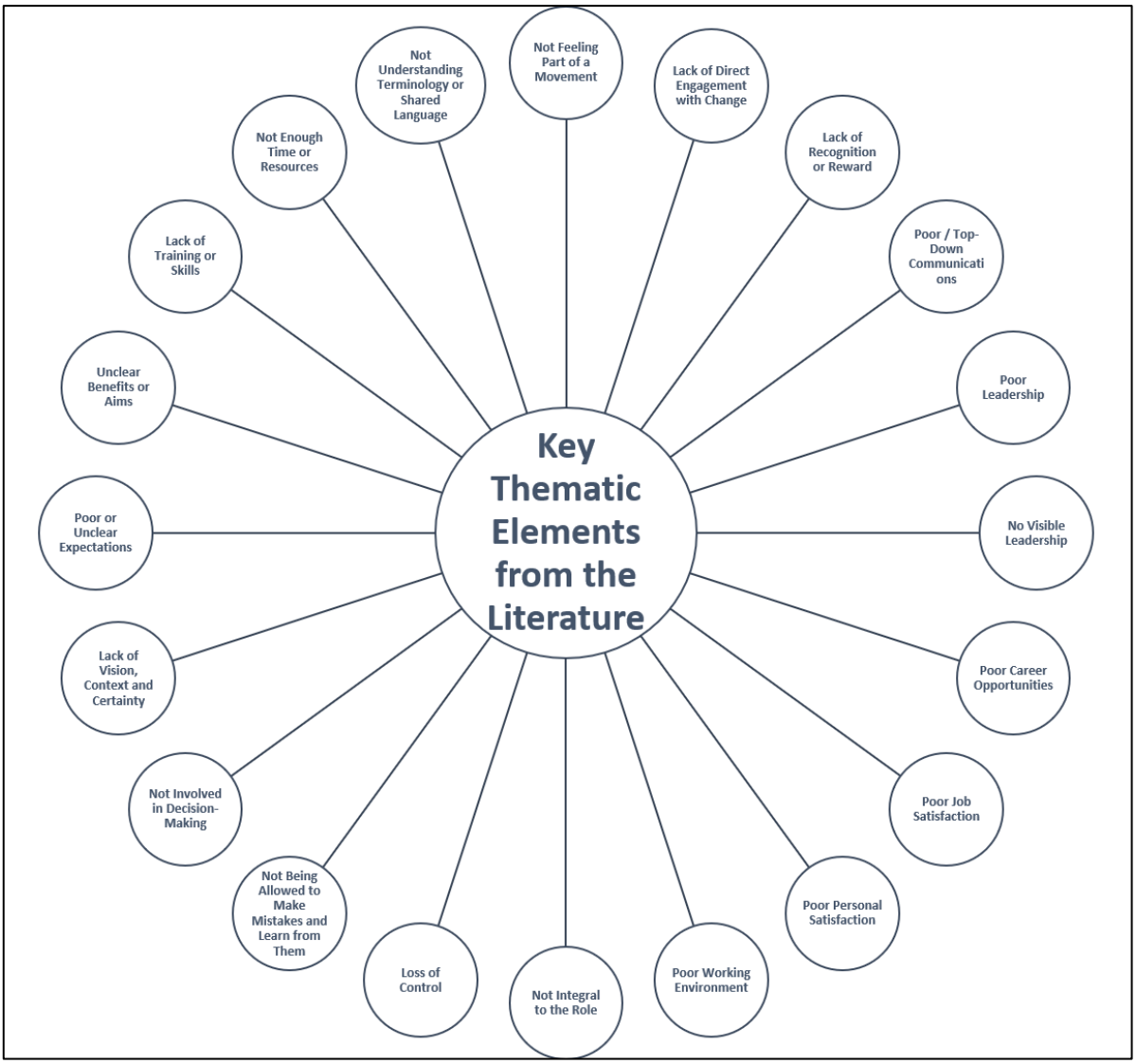


Figure 14 - Key Thematic Elements from the Literature (Source: The Researcher - Marc Penny 2025)

Not Feeling Part of a Movement

Many change models including those applied in healthcare often fail to engage healthcare professionals as integral parts of the change process making them feel disconnected from broader initiatives. The literature reveals a recurring issue where professionals feel that VBHC is not aligned with their day-to-day work. For instance, Nilsson et al. found that healthcare workers viewed VBHC as somewhat remote from their roles and engagement levels dwindled over time because the system did not foster a sense of collective purpose (Nilsson et al., 2018). This detachment can hinder the sustainability of VBHC as professionals do not feel part of a movement driving meaningful change.

Lack of Direct Engagement with Change

Healthcare professionals often experience a lack of direct involvement in decision-making processes, leading to disengagement. Bamford and Daniel highlight that when healthcare professionals are excluded from planning or decision-making (Bamford & Daniel, 2005) they are less likely to commit to change initiatives (Talmaciu, 2014). When looking to implement and deliver VBHC the engagement of professionals is crucial for long-term sustainability, but when decisions are imposed without input professionals may feel disconnected from the change, diminishing their commitment and efforts to sustain it (Harrison et al., 2021).

Lack of Recognition or Reward

The literature identifies a lack of recognition or reward for professionals as a significant barrier to sustaining healthcare reforms. Mosadeghrad argues that when staff feel undervalued or their contributions go unrecognised they are likely to disengage from change initiatives (Mosadeghrad, 2013). When looking at this in relation to VBHC where the focus is often on patient outcomes and cost efficiencies professionals may feel that their efforts are overlooked, further reducing their motivation to sustain VBHC implementations (Laing et al., 2024).

Poor / Top-Down Communications

Communication is a critical factor (Elving, 2005) in the success of healthcare reforms, yet top-down communication often leads to a disconnect between leadership and staff (Rawson & Davis, 2023) especially when information is withheld or not seen as important to share (Morrison & Milliken, 2000). Harrison et al. found that ineffective communication hinders staff engagement and creates confusion around the goals and benefits of change initiatives (Harrison et al., 2021). For VBHC, where interdisciplinary collaboration and clear objectives are key, poor communication can lead to misunderstandings, resistance and ultimately failure to sustain the change (Massey & Williams, 2006).

Poor Leadership

Poor leadership is frequently cited as a major contributor to the failure of healthcare initiatives with leaders who fail to engage with or support their staff end up creating environments where change efforts are likely to fail (Longenecker & Longenecker, 2014). For VBHC to be successfully implemented and sustained, leadership must be inclusive and foster an environment of collaboration (Sancak, 2023), something that is often lacking when leadership is ineffective or disconnected from the professionals working within the system.

No Visible Leadership

Visible leadership is key for maintaining momentum in change initiatives, leaders must be actively involved and visible (Gupta & Moriates, 2017; Laing et al., 2024) to staff to ensure engagement and alignment with organisational goals (Erskine et al., 2013). In the absence of visible leadership professionals may question the legitimacy of VBHC initiatives leading to disengagement and failure to sustain the change.

Poor Career Opportunities

The literature suggests that healthcare professionals often experience a lack of career progression opportunities during change initiatives. Kotter's change model for example, tends to focus on organisational needs rather than individual career development potentially leading to disengagement (Kotter, 1996). Professionals may feel that their role in delivering VBHC does not contribute to their career growth which could undermine their long-term engagement with the change.

Poor Job Satisfaction

Job satisfaction is a critical factor in the successful delivery and sustainability of healthcare reforms. Job satisfaction can be defined as enjoying the work that you do, the team that you work with and the environment that you work in. The ADKAR model acknowledges the importance of job satisfaction recognising that individuals must understand and desire the change for it to be sustainable (Hiatt, 2006). If professionals do not derive satisfaction from their work or feel that VBHC does not align with their personal or professional goals they may resist the change thus limiting its sustainability (van Engen et al., 2021).

Poor Personal Satisfaction

Personal satisfaction which is closely tied to job satisfaction is essential for sustaining change initiatives. The difference between job and personal satisfaction is the lens its viewed through. For personal satisfaction the person may not enjoy where they work or who they work with but do derive satisfaction from the work and impact they make. Again ADKAR emphasises the role of personal satisfaction in ensuring that professionals remain committed to change (Hiatt, 2006). When professionals do not feel personally fulfilled by their work or do not see the relevance of VBHC to their own values the implementation of VBHC may not be sustainable.

Poor Working Environment

A poor working environment can significantly impact the success and sustainability of healthcare reforms with the McKinsey 7S model highlighting the need for organisations to address both hard and soft elements of change, including staff satisfaction and the working environment (Peters, 1982). If the working environment does not support professionals in delivering VBHC their engagement will likely be reduced impacting on delivery and sustainability of change.

Not Integral to the Role

For change to be sustainable professionals must feel that it is integral to their role. The ADKAR model argues the importance of aligning change with personal and professional goals (Hiatt, 2006). If professionals do not see how VBHC fits within their role they are unlikely to remain engaged making it difficult to sustain the change in the long term.

Loss of Control

Healthcare professionals may feel a loss of control (Shaikh, 2020) when they are not involved in decision-making processes leading to resistance. Iles and Sutherland found that when professionals are excluded from decision-making they are more likely to disengage from change initiatives (Iles & Sutherland, 2001). When looking at loss of control in context of VBHC professionals may feel that their autonomy is diminished particularly if the system is imposed top-down leading to a lack of commitment to its sustainability with a balance needed and nudges to support staff in the change and continually reinforcing the change needed (Parekh, 2022).

Not Being Allowed to Make Mistakes and Learn from Them

The failure to allow professionals to make mistakes and learn from them can stifle innovation and hinder the success of change initiatives (Rawson & Davis, 2023) and can be argued that professionals need the freedom to experiment and learn from their experiences to remain engaged and committed to change (Gözükara et al., 2018). A culture that discourages experimentation may limit the system's adaptability and sustainability.

Not Involved in Decision-Making

Exclusion from decision-making is a key factor in the failure of past healthcare reforms (Ball & Regan, 2010). When professionals are not involved in planning or decision-making they are less likely to commit to change initiatives (Bamford & Daniel, 2005). For VBHC to succeed it is crucial that

professionals are engaged in decision-making processes to ensure their buy-in and long-term commitment to sustaining the system.

Lack of Vision, Context and Certainty

A lack of clear vision and context can lead to confusion and disengagement among healthcare professionals. Iles and Sutherland found that poorly communicated visions or frequent shifts in goals can undermine staff commitment to reforms (Iles & Sutherland, 2001; Rawson & Davis, 2023). Professional need a clear understanding of the system's goals and how it fits within their work to ensure long-term sustainability of VBHC (Laing et al., 2024; Sancak, 2023).

Poor or Unclear Expectations

Unclear expectations can contribute to the failure of healthcare initiatives. If professionals do not have a clear understanding of what is expected of them in delivering VBHC they may struggle to implement the system effectively, this can lead to inconsistent practices and ultimately hinder the sustainability of VBHC (Longenecker & Longenecker, 2014).

Unclear Benefits or Aims

Unclear benefits or aims of change initiatives can lead to resistance from professionals with Antony et al. highlighting that professionals are less likely to invest in change if they do not see the tangible benefits (Antony et al., 2021). For VBHC, if the aims and benefits of the system are not clearly articulated professionals may be less motivated to engage with it impacting on its delivery and long-term sustainability.

Lack of Training or Skills

The lack of training or skills necessary to implement and sustain change is a major barrier in healthcare reforms. Without adequate training professionals may struggle to adopt new systems like VBHC consistently (Massey & Williams, 2006). Ensuring that professionals have the necessary skills and knowledge is essential for the sustainability of VBHC (Laing et al., 2024).

Not Enough Time or Resources

Time and resource constraints are often cited as barriers to the successful implementation of change initiatives in healthcare. When professionals are expected to implement changes without sufficient

time or resources the results are often incomplete and unsustainable (Longenecker & Longenecker, 2014). For VBHC to be effective, organisations must provide adequate time and resources to support professionals in delivering VBHC.

Not Understanding Terminology or Shared Language

A lack of shared language and understanding of terminology can lead to confusion and disengagement during healthcare reforms. Its argued that healthcare professionals often struggle to understand the language of change initiatives which can lead to resistance (Massey & Williams, 2006). To deliver change and VBHC, ensuring that all professionals understand the terminology and language of value-based care is crucial for alignment and sustaining the system.

The Research Questions and Their Importance

The researchers questions - how professionals derive value from being involved in and delivering VBHC and what features of professional value offer the greatest benefits to those engaged in VBHC - are key for understanding the sustainability of this approach. The literature repeatedly highlights challenges such as disengagement, inadequate recognition and poor communication, which arise when VBHC initiatives fail to align with professionals' roles and values. These gaps leave healthcare professionals working within the system feeling disconnected from broader organisational goals, impacting on their motivation and commitment. By investigating how professionals perceive and derive value from VBHC, this research seeks to provide practical strategies for aligning initiatives with professional goals and creating a sense of ownership. Identifying the features of PV that drive satisfaction can inform approaches to mitigate common barriers, such as unclear expectations, insufficient training and lack of career progression.

Addressing these research questions is essential, as healthcare professionals are seen as pivotal by the researcher to the delivery and sustainability of VBHC. Gaining insight into their experiences will help organisations build systems that engage, support and motivate professionals, ensuring the long-term success of VBHC reforms. The authors research questions address critical gaps in the literature by focusing on how professionals perceive and derive value from VBHC and identifying features that enhance their engagement. Given the essential role of healthcare professionals in implementing and sustaining VBHC, answering these questions is fundamental to ensuring the system's success and long-term viability.

2.13. Key Literature Review Summary

The purpose of Chapter 2 is to provide a comprehensive literature review that explores the key themes of VBHC, organisational change and lessons from the sustainability of previous healthcare reforms along with defining 'professional value'. This chapter provides the starting point for the authors research and is Phase 1a:

Phase 1a: Literature Review and Desktop Exercise

Output of '*Reflection and refinement of research question with links to the literature and key works. Identification of any gaps and thematic development of change failure. Identification of key themes and topics to be tested as part of the research.*', with further details on the authors research phases found in Chapter 3.11 'The Research

The researcher created a Venn diagram (Figure 3) which goes beyond theoretical alignment, it anchors the research in real-world, practical relevance by mapping academic insight to the lived context of healthcare delivery, professional values and national cultural influences. This Venn intersection provides a unique research opportunity into elements not explored together previously. Based on these areas the author has conducted a detailed analysis of the genealogy of VBHC, change management theories and previous healthcare reforms whilst exploring the concept of professional. The review identified that successful implementation of VBHC depends heavily on professional engagement, cultural adaptation and leadership. Thematic analysis has revealed gaps in the current literature particularly concerning the role of healthcare professionals in delivering and sustaining VBHC. The author has detailed the key failure themes identified in Figure 15 and allocated them a unique reference number for tracking.

Failure Themes	
FT1	Not feeling part of a movement
FT2	Lack of direct engagement with change
FT3	Lack of recognition or reward
FT4	Poor / Top down communications
FT5	Poor leadership
FT6	No visible leadership
FT7	Poor career opportunities
FT8	Poor job satisfaction
FT9	Poor personal satisfaction
FT10	Poor working environment
FT11	Not integral to the role
FT12	Loss of control
FT13	Not being allowed to make mistakes and learn from them
FT14	Not involved in decision making
FT15	Lack of vision, context and certainty
FT16	Poor or unclear expectations
FT17	Unclear benefits or aims
FT18	Lack of training or skills
FT19	Not enough time or resources
FT20	Not understanding terminology or shared language

Figure 15 - Literature Review Thematic Analysis (Source: The Researcher - Marc Penny 2025)

The review highlights that while VBHC aims to optimise patient outcomes relative to costs the success of its deployment is often limited by a lack of sustained engagement from healthcare professionals. Previous healthcare reforms have frequently struggled with sustainability due to poor communication, unclear expectations and insufficient involvement of staff in decision-making processes. The author also found that many change models overlook the importance of individual engagement, job satisfaction and professional value in delivering long-term organisational change. Key barriers to the successful implementation of VBHC include the failure to fully integrate its principles into daily practices, insufficient training and the absence of continuous leadership.

In the remaining part of this chapter the researcher will build on the insights gained from the literature review to develop their conceptual framework and understand how this sits within the theoretical lens of socio-technical systems. This will include exploring how STS theory and PV can guide the sustainable implementation of VBHC with a focus on understanding the critical role of healthcare professionals. This foundation will support the study's research questions and empirical analysis in subsequent chapters.

2.14. Introduction to Authors Conceptual Framework

The author through earlier sections of chapter 2 explored the key literature to understand the origins of VBHC, elements of its success and failure and the current thinking from an improvement and change theoretical position. Through exploring past change success and failure in NHS organisation as well as wider lessons from change models and theories the author identified 20 failure themes and completed the research phase 1a 'Literature review and desktop exercise', resulting in the identification of research gaps and the 20 change failure themes relating to the authors definition of 'professional value'.

In the following section of this chapter the researcher will explore and develop their conceptual framework and undertake research phases:

PHASE 1B: Conceptual Framework Development

With output – Thematic analysis and draft conceptual framework

By the end of this chapter the author will have developed and presented a draft conceptual framework ready to be validated by experts and the development of the authors quantitative survey element.

2.15. Conceptual Framework Development and Draft Framework

In the development of the conceptual framework associated with this research the author has undertaken a qualitative analysis of existing knowledge and research to provide a foundation for the framework as discussed in earlier sections of chapter 2. Building theory through qualitative analysis of existing literature and theories the author will develop a conceptual framework based on this and influenced through a lens of STS theory.

2.15.1. Identified Drivers, Measurements and Inputs

The author through the literature review has identified the key inputs into a VBHC model that are based on existing literature relating to the drivers for VBHC as discussed in earlier sections of chapter 2, as well as key inputs and measurements currently used and accepted within VBHC (Allvin et al., 2021), including:

- **Driver** - Healthcare expenditures has seen improvements in care and life expectancy however data shows increasingly diminished returns on investment where more investment has ever decreasing impact on life expectancy (Roser et al., 2013)

- **Driver** - One-fifth of all health spending could be channelled to better use by identifying and removing inefficiencies in healthcare delivery (OECD, 2017) - In the United States of America alone some $1 trillion could be saved
- **Driver** - Countries continue to see year on year increases in healthcare spending, in the UK spending on healthcare by the UK Government has increased each year and since 2009/2010 increased by 35.9% (*NHS expenditure programme budgets: April 2019 to March 2020*, 2021)
- **Driver** - Healthcare spending in most countries expected to outstrip GDP by mid-2030 (*Health spending set to outpace GDP growth to 2030*, 2019)
- **Measurement** - Inclusion of accepted measurement and assessment criteria including Patient Reported Outcome Measures (PROMS), Patient Reported Experience Measures (PREMS), Clinical Reported Outcome Measures (CROMS) and Benchmarking
- **Inputs** - Infrastructure inputs include a mix of institutions, people and resources which include Academia, Industry, Patients and Communities, Digital and Informatics

2.15.2. Literature Review & Themes

The thematic review conducted by the author identifies a number of key factors influencing the success or failure of implementing VBHC and other healthcare reforms and changes. Through a qualitative literature review these key themes were derived focusing on how professionals perceive and engage with these changes.

A significant issue identified is that healthcare professionals often do not feel part of a collective movement leading to disengagement. Research shows that VBHC is perceived as disconnected from the daily work of healthcare workers (Nilsson et al., 2018) which reduces long-term employee engagement. This lack of involvement and engagement can be exacerbated by the exclusion of professionals from decision-making processes and when professionals are not directly involved, their commitment to sustaining change decreases (Bamford & Daniel, 2005), while imposed decisions leads to employee disengagement (Harrison et al., 2021).

Another theme the author has identified is the lack of recognition and reward for healthcare workers, which can be seen as a critical barrier (Mosadeghrad, 2013) for sustainable change. The focus on patient outcomes in VBHC may leave professionals feeling undervalued which undermines their motivation to sustain such initiatives and long-term transformation. Poor communication, especially when it is top-down creates confusion and resistance. Ineffective communication weakens and

reduces engagement which is a crucial element for interdisciplinary collaboration within VBHC (Harrison et al., 2021) and wider NHS. Poor leadership both in terms of quality and visibility is a major reason for the failure of healthcare reforms past and present. Leadership needs to be supportive, inclusive and actively visible to ensure professionals remain aligned with the goals of VBHC (Erskine et al., 2013; Longenecker & Longenecker, 2014).

Career development and job satisfaction have been found to be recurring concerns identified through the literature. Kotter's model suggests that healthcare reforms often overlook individual career progression (Kotter, 1996) which can lead to professionals disengaging. Job satisfaction is key for long-term success and sustainability of change and is highlighted by the ADKAR model which acknowledges the importance of professionals finding personal and professional fulfilment in their work (Hiatt, 2006). A poor working environment can further contribute to disengagement with McKinsey's 7S model articulating that both the physical environment and organisational culture must be conducive to supporting professionals in implementing VBHC (Peters, 1982) and the right infrastructure to succeed (Gupta & Moriates, 2017).

Healthcare professionals may also struggle when they do not see how VBHC fits within their roles or wider organisation strategy and is an element identified as part of the ADKAR model (Hiatt, 2006). If professionals perceive the change irrelevant then long-term engagement and sustainability is unlikely. A perceived loss of control particularly when decision-making is centralised and removed from employees can foster resistance, with research suggesting that excluding professionals from decision-making undermines their autonomy (Iles & Sutherland, 2001) making them less likely to commit to change.

An element that is frequently seen in the literature is allowing employees the ability to make mistakes and learn from them (Gözükara et al., 2018) and that professionals need the freedom to experiment within a supportive system. A rigid, command and control, unforgiving environment can restrict innovation and adaptability which literature identifies as essential for sustaining VBHC. Professionals need to be actively involved in decision-making processes and failure to engage staff in these processes leads to a lack of long-term commitment (Bamford & Daniel, 2005).

The literature finds that a clear vision, set expectations and understood benefits are key for sustaining VBHC, with vague or shifting goals leading to confusion and disengagement (Iles & Sutherland, 2001). When professionals do not understand the benefits of VBHC or have unclear expectations they can struggle to implement change effectively leading to inconsistent practices. A lack of necessary training and skills creates additional barriers as professionals cannot adopt new systems without proper support (Massey & Williams, 2006), impacting on the change sustainability and effectiveness.

The author also found that insufficient time and resources are often cited as key obstacles to sustaining change, and that without adequate resources change and transformation becomes unsustainable (Longenecker & Longenecker, 2014). A lack of shared language or understanding of key terminology can exacerbate confusion and resistance to change and limit professionals involvement and engagement in it (Massey & Williams, 2006). Ensuring all professionals grasp the language of VBHC is important for aligning efforts and maintaining VBHC in the long term.

The authors literature review and qualitative analysis of the themes indicates that the sustainability of VBHC relies on addressing these elements, ensuring professionals feel included, supported and adequately prepared for the changes being implemented (Figure 15).

Failure Themes	
FT1	Not feeling part of a movement
FT2	Lack of direct engagement with change
FT3	Lack of recognition or reward
FT4	Poor / Top down communications
FT5	Poor leadership
FT6	No visible leadership
FT7	Poor career opportunities
FT8	Poor job satisfaction
FT9	Poor personal satisfaction
FT10	Poor working environment
FT11	Not integral to the role
FT12	Loss of control
FT13	Not being allowed to make mistakes and learn from them
FT14	Not involved in decision making
FT15	Lack of vision, context and certainty
FT16	Poor or unclear expectations
FT17	Unclear benefits or aims
FT18	Lack of training or skills
FT19	Not enough time or resources
FT20	Not understanding terminology or shared language

Figure 15 - Literature Review Thematic Analysis (Source: The Researcher - Marc Penny 2025)

2.15.3. Conceptual Framework Design

A key challenge for complex organisations such as healthcare systems is ensuring that change and transformation is sustainable, and to enable that, ensuring any initiatives are rooted in the engagement of healthcare professionals, the alignment of organisational goals with professional values and the provision of adequate resources and skills to facilitate these changes as discussed by the author in chapter 2.10. The literature reviewed consistently shows the need for both structural and cultural shifts for sustainable change, highlighting that without the involvement of professionals even the most well-intentioned initiatives risk failure. The researcher in the previous section of this chapter explored the 'Failure Themes' identified from the literature and will now explore some of the wider overarching themes which are linked to PV. This section will seek to deliver the authors research phase 1B - Conceptual Framework Development, and by the end of the chapter provide a thematic analysis and draft conceptual framework.

The introduction of VBHC in healthcare systems often encounters resistance from the people within the system as it requires a transformation not only in the way healthcare is delivered but also in how professionals see their roles within this new framework. Professionals often find it difficult to integrate VBHC principles into their day-to-day work (Nilsson et al., 2018), potentially seeing it as a remote initiative disconnected from their immediate responsibilities and the requirements set down by overarching royal colleges and national targets. This detachment can cause issues as sustained engagement from healthcare professionals is key to the success of such changes. When professionals working within the system do not perceive a direct link between their roles and the broader organisational changes their commitment to these initiatives diminishes over time.

The author has found that historically there has been a lack of a shared vision and clear communication within the healthcare sector when implementing changes such as VBHC. VBHC is measured by patient outcomes relative to cost (Porter, 2010) but the researcher believes that a key challenge is in aligning this concept of value with the daily practices and priorities of healthcare professional. Without clear communication of the goals and benefits of VBHC, professionals struggle to see how these reforms align with their own professional values and the needs of their patients (Nilsson et al., 2017c). This disconnect is further exposed when leadership fails to create an environment that fosters a collective understanding and ownership of these changes. Leadership must not only drive the change but also

ensure that the professionals in the system feel that their contributions are part of and key to achieving the objectives of VBHC.

In addition to leadership and communication the literature shows a gap in the recognition and rewards systems for healthcare professionals engaged in VBHC or other change initiatives and when professionals feel undervalued or that their efforts are not adequately recognised, they are more likely to disengage from change initiatives (Mosadeghrad, 2013). This is key in VBHC where the focus is often on patient outcomes and cost efficiencies leaving healthcare professionals feeling that their contributions and needs are overlooked. The lack of recognition for the role of professionals in these changes can lead to a sense of alienation and detachment further undermining the sustainability of the change or transformation.

The success of VBHC is dependent on the capacity of healthcare professionals to adapt to new systems and ways of working which takes time, capacity and the required skills. The literature shows that the success of change initiatives depends on the provision of adequate training and adequate resources along with training and development of employees to enable them to deliver the changes required (Massey & Williams, 2006). Without sufficient time and resources, professionals may feel overwhelmed by the added responsibilities of implementing VBHC alongside their normal day to day duties. This imbalance often results in rushed and incomplete efforts which leads to the failure of the long-term sustainability of the change (Longenecker & Longenecker, 2014).

The concept of co-production where healthcare professionals and patients collaborate in the decision-making process has been identified as a key element in the effective delivery of VBHC (Batalden et al., 2016a). The literature suggests that while this approach is being adopted by organisations such as the NHS in Wales, practical challenges such as time constraints and competing priorities often limit its effectiveness (Vennik et al., 2015). To overcome these barriers healthcare systems must support flexible care pathways and provide professionals with the necessary tools and resources to engage meaningfully in co-production efforts.

As the author has found and articulated throughout this chapter PV plays a key role in the sustainability of VBHC and the engagement of healthcare professionals in its implementation. The concept of PV encompasses the intrinsic and extrinsic factors that influence job satisfaction, career

development and motivation within a healthcare setting (Hewison, 2004). For VBHC to succeed it must not only deliver value to patients but also align with the professional values of those delivering the care. As Porter and Teisberg state, VBHC aims to improve outcomes for patients (Porter & Teisberg, 2006) but the omission of how these systems impact the professionals themselves can lead to disengagement and resistance as professionals may feel that their own needs and contributions are being ignored.

The author has sort to draw these insights together arguing that the success of VBHC is reliant on a number of interconnected themes. Using the literature review research and the analysis in this chapter the identified 'Change Failure Themes' have been grouped by the author to create 5 'Conceptual Framework Theme' areas, all relating to 'Professional Value' as explored in chapter 2.10 along with the previous section in this chapter and aligned with the authors research question(s). The author proposes the following key overarching framework themes based on the literature analysis undertaken and the identification of the Failure Themes:

- **Engagement**:
    - Healthcare professionals must be actively involved in the planning and delivery of change with a clear understanding of how their roles contribute to the overall goals.
- **Individual Consequences**:
    - Job satisfaction and career development must be considered as professionals are more likely to commit to and support change that align with their personal and professional goals.
- **Ownership**:
    - Professionals need to feel empowered to take charge of the changes rather than having them imposed from above.
- **Shared Aims**:
    - There needs to be shared aims between leadership and staff throughout the organisation ensuring that everyone is working towards a common goal.
- **Skills and Capacity**:
    - Adequate training, resources and time are key for sustainable change and buy-in from employees to enable healthcare professionals to implement and sustain VBHC in the long term.

The 20 Failure Themes have been grouped by the 5 overarching Conceptual Framework Themes as can be seen below in Table 23 and Figure 16:

FAILURE THEMES		CONCEPTUAL FRAMEWORK THEME	
FT1	Not feeling part of a movement	CFT1	Engagement
FT2	Lack of direct engagement with change	CFT1	Engagement
FT3	Lack of recognition or reward	CFT1	Engagement
FT4	Poor / Top-down communications	CFT1	Engagement
FT5	Poor leadership	CFT1	Engagement
FT6	No visible leadership	CFT1	Engagement
FT7	Poor career opportunities	CFT2	Individual Consequence
FT8	Poor job satisfaction	CFT2	Individual Consequence
FT9	Poor personal satisfaction	CFT2	Individual Consequence
FT10	Poor working environment	CFT2	Individual Consequence
FT11	Not integral to the role	CFT3	Ownership
FT12	Loss of control	CFT3	Ownership
FT13	Not being allowed to make mistakes and learn from them	CFT3	Ownership
FT14	Not involved in decision making	CFT3	Ownership
FT15	Lack of vision, context and certainty	CFT4	Shared Aims
FT16	Poor or unclear expectations	CFT4	Shared Aims
FT17	Unclear benefits or aims	CFT4	Shared Aims
FT18	Lack of training or skills	CFT5	Skills & Capacity
FT19	Not enough time or resources	CFT5	Skills & Capacity
FT20	Not understanding terminology or shared language	CFT5	Skills & Capacity

Table 23 - Conceptual Framework Themes and Failure Themes Grouping (Source: The Researcher - Marc Penny 2025)

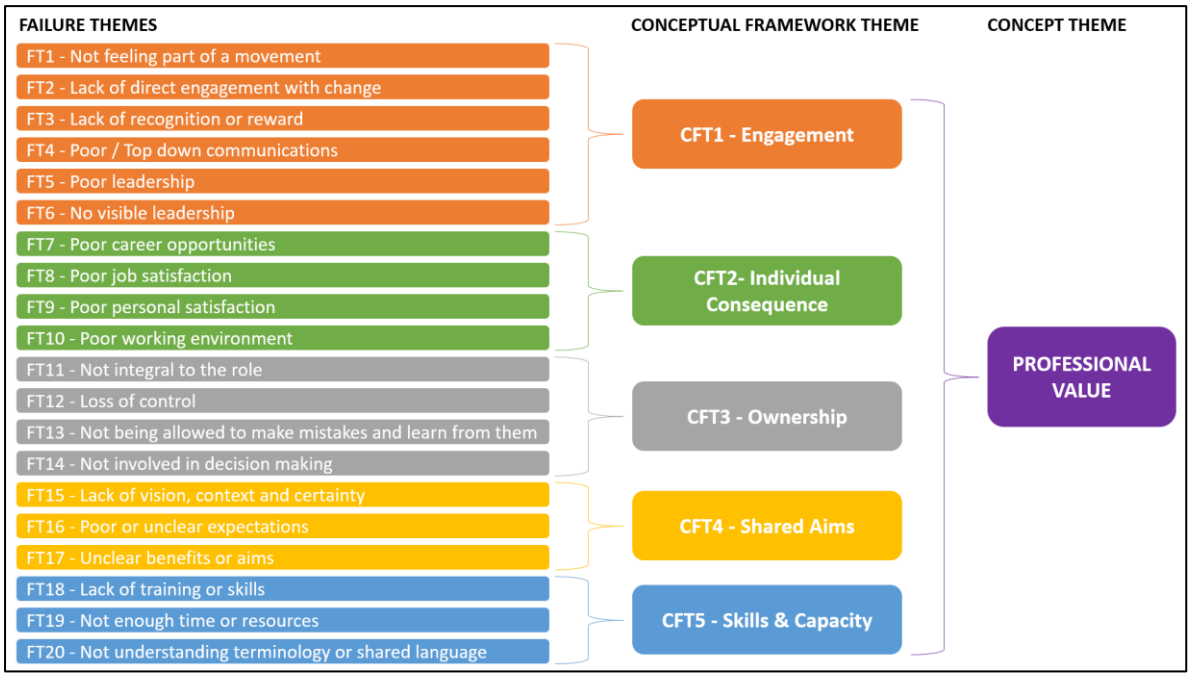


Figure 16 - Conceptual Framework Themes and Failure Themes Grouping (Source: The Researcher - Marc Penny 2025)

The failure themes, leading into the overarching conceptual framework themes develop the concept of PV as defined by the author in chapter 2.10 that: 'professional value' can be described as those activities which contribute toward and do not detract from 'involving the individual and individual consequence', 'ownership and oversight', 'clear aims and objectives' and 'development'.

The author has developed a failure theme linkage analysis diagram to help understand which themes may be linked and to understand those themes which may have more linkages than others. Figure 17 shows the failure themes and their potential relationships with one another, with the blue X highlighting a potential link.

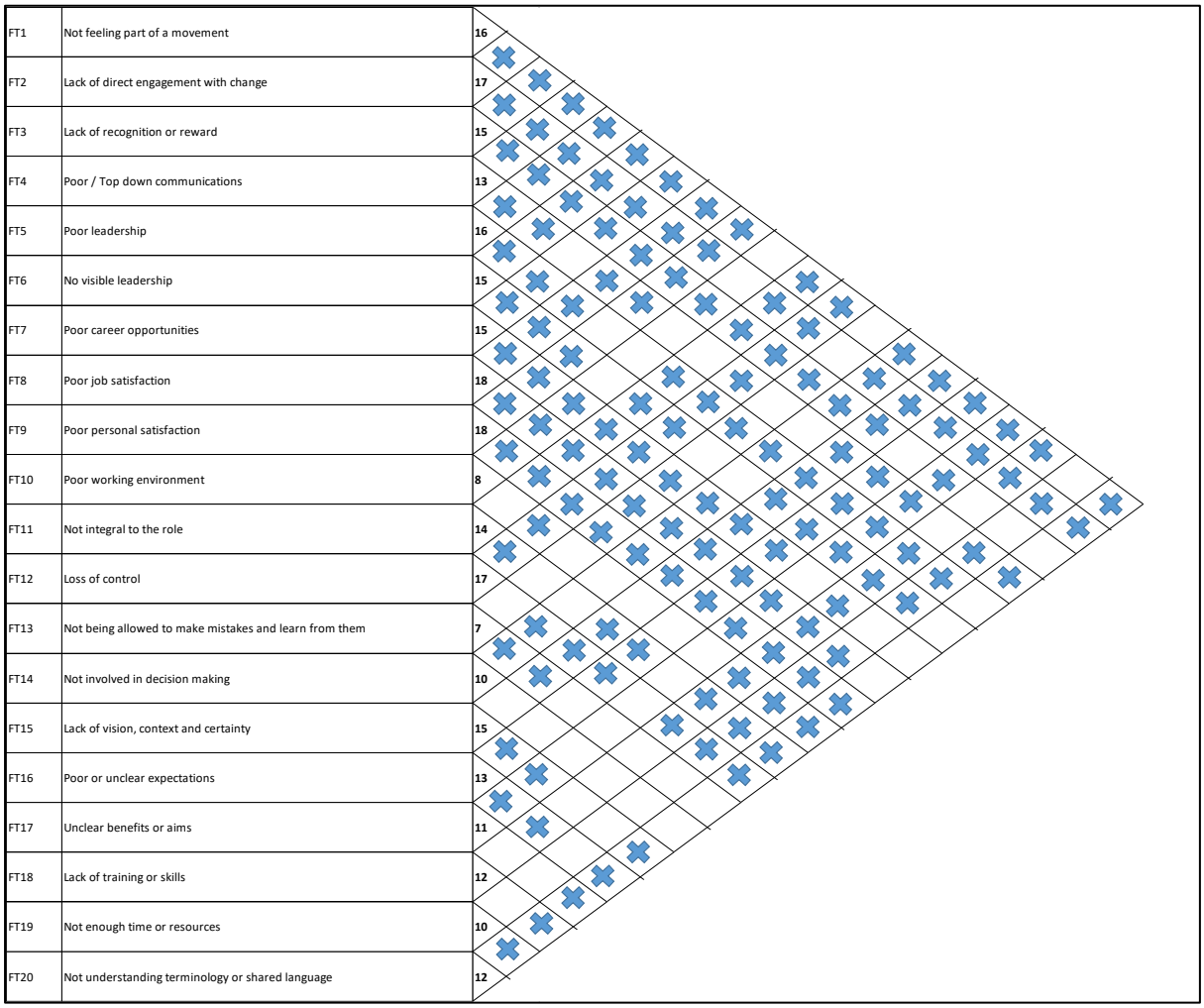


Figure 17 - Failure Theme Linkage Analysis Diagram (Source: The Researcher - Marc Penny 2025)

The failure themes linkages count is show in Table 24 ordered from most linkages to least linkages. Based on this analysis from the researchers perspective, the top 3 failure themes with the highest number of linkages are:

- FT8 Poor job satisfaction

- FT9 Poor personal satisfaction
- FT2 Lack of direct engagement with change

FAILURE THEME		LINKAGE COUNT
FT8	Poor job satisfaction	18
FT9	Poor personal satisfaction	18
FT2	Lack of direct engagement with change	17
FT12	Loss of control	17
FT1	Not feeling part of a movement	16
FT5	Poor leadership	16
FT3	Lack of recognition or reward	15
FT6	No visible leadership	15
FT7	Poor career opportunities	15
FT15	Lack of vision, context and certainty	15
FT11	Not integral to the role	14
FT4	Poor / Top down communications	13
FT16	Poor or unclear expectations	13
FT18	Lack of training or skills	12
FT20	Not understanding terminology or shared language	12
FT17	Unclear benefits or aims	11
FT14	Not involved in decision making	10
FT19	Not enough time or resources	10
FT10	Poor working environment	8
FT13	Not being allowed to make mistakes and learn from them	7

Table 24 - Failure Theme Linkage Count (Source: The Researcher - Marc Penny 2025)

Based on these potential relationships the author has undertaken a VOXI relationship analysis (VOXI is a sub-method used in Interpretive Structural Modelling (ISM), developed by Warfield 1973) to

determine the direction of any relationships that may exist between the different change failure themes. The VOXI analysis determines relationships based on the following categorisations:

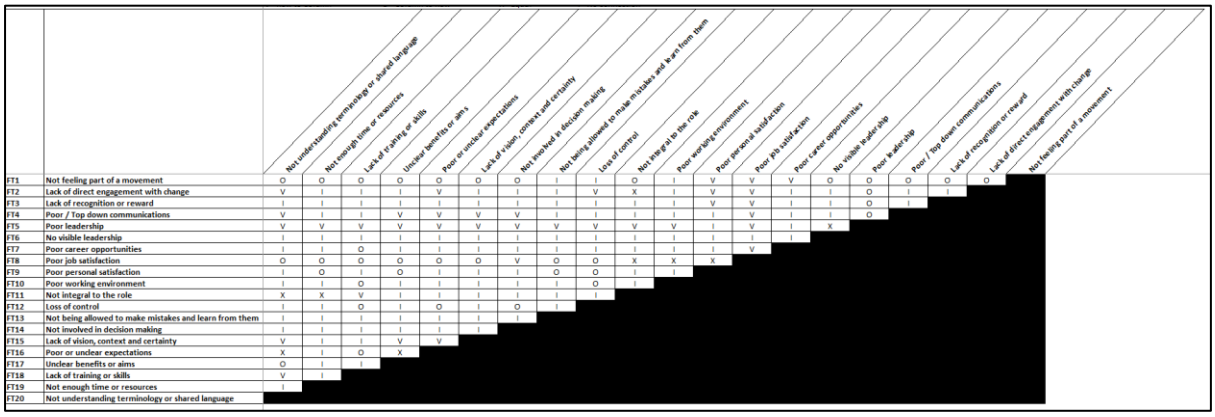
V – Relationship is Row to Column

O – Relationship is Column to Row

X – Relationship is equal in both directions

I – No relationship exists

Figure 18 shows the VOXI analysis undertaken by the researcher and the basis for review by the expert interviewees for validation.



		Not understanding terminology or shared language	Not enough time or resources	Lack of training or skills	Unclear benefits or aims	Poor or unclear expectations	Lack of vision, context and certainty	Not involved in decision making	Not being allowed to make mistakes and learn from them	Loss of control	Not integral to the role	Poor working environment	Poor personal satisfaction	Poor job satisfaction	Poor career opportunities	No visible leadership	Poor leadership	Poor / Top down communications	Lack of recognition or reward	Lack of direct engagement with change	Not feeling part of a movement
FT1	Not feeling part of a movement	O	O	O	O	O	O	O	I	I	O	I	V	V	V	O	O	O	O	O	
FT2	Lack of direct engagement with change	V	I	I	I	V	I	I	I	V	X	I	V	V	I	I	O	I	I		
FT3	Lack of recognition or reward	I	I	I	I	I	I	I	I	I	I	I	V	V	I	I	O	I			
FT4	Poor / Top down communications	V	I	I	V	V	V	V	I	I	I	I	I	V	I	I	O				
FT5	Poor leadership	V	V	V	V	V	V	V	V	V	V	V	I	V	I	X					
FT6	No visible leadership	I	I	I	I	I	I	I	I	I	I	I	I	I	I						
FT7	Poor career opportunities	I	I	O	I	I	I	I	I	I	I	I	I	V							
FT8	Poor job satisfaction	O	O	O	O	O	O	V	O	O	X	X	X								
FT9	Poor personal satisfaction	I	O	I	O	I	I	I	O	O	I	I									
FT10	Poor working environment	I	I	O	I	I	I	I	I	O	I										
FT11	Not integral to the role	X	X	V	I	I	I	I	I	I											
FT12	Loss of control	I	I	O	I	O	I	O	I												
FT13	Not being allowed to make mistakes and learn from them	I	I	I	I	I	I	I													
FT14	Not involved in decision making	I	I	I	I	I	I														
FT15	Lack of vision, context and certainty	V	I	I	V	V															
FT16	Poor or unclear expectations	X	I	O	X																
FT17	Unclear benefits or aims	O	I	I																	
FT18	Lack of training or skills	V	I																		
FT19	Not enough time or resources	I																			
FT20	Not understanding terminology or shared language																				

Figure 18 - Draft Conceptual Framework Themes and Failure VOXI Analysis (Source: The Researcher - Marc Penny 2025)

2.16. The Researchers Conceptual Framework

Combining the existing literature along with the researchers identified 'Conceptual Framework Themes' (Figure 18) the author proposes a new draft Conceptual Framework for VBHC sustainability of delivery. Figure 19 shows the proposed authors conceptual framework with the 'Change Failure Themes' grouped into their 'Conceptual Framework Themes' along with the relational directions if they exist.

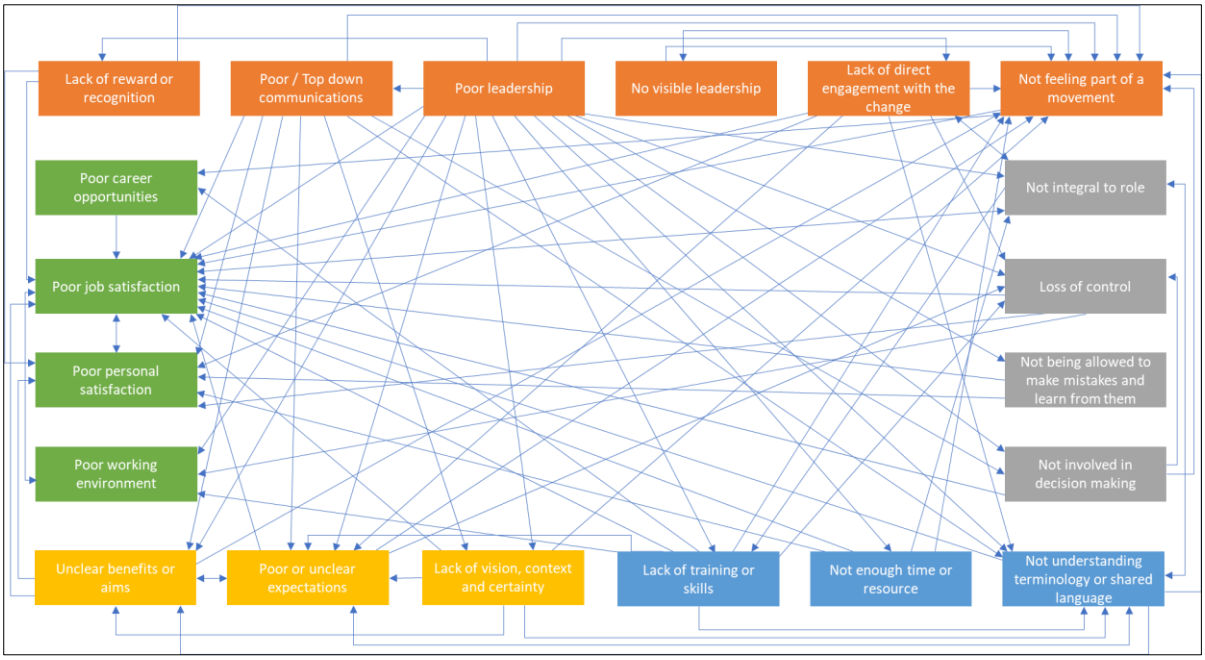


Figure 19 - Draft Authors Conceptual VBHC Sustainability Framework (Source: The Researcher - Marc Penny 2025)

Figure 19 visualises the authors draft conceptual framework as an academic framework, this framework is complex and although provides the required detail from an academic perspective the authors pragmatic position and desired requirements for easily usable framework for a practical application requires an 'easy read' version. Figure 20 provides a visualisation more aligned to practical use in healthcare organisations.

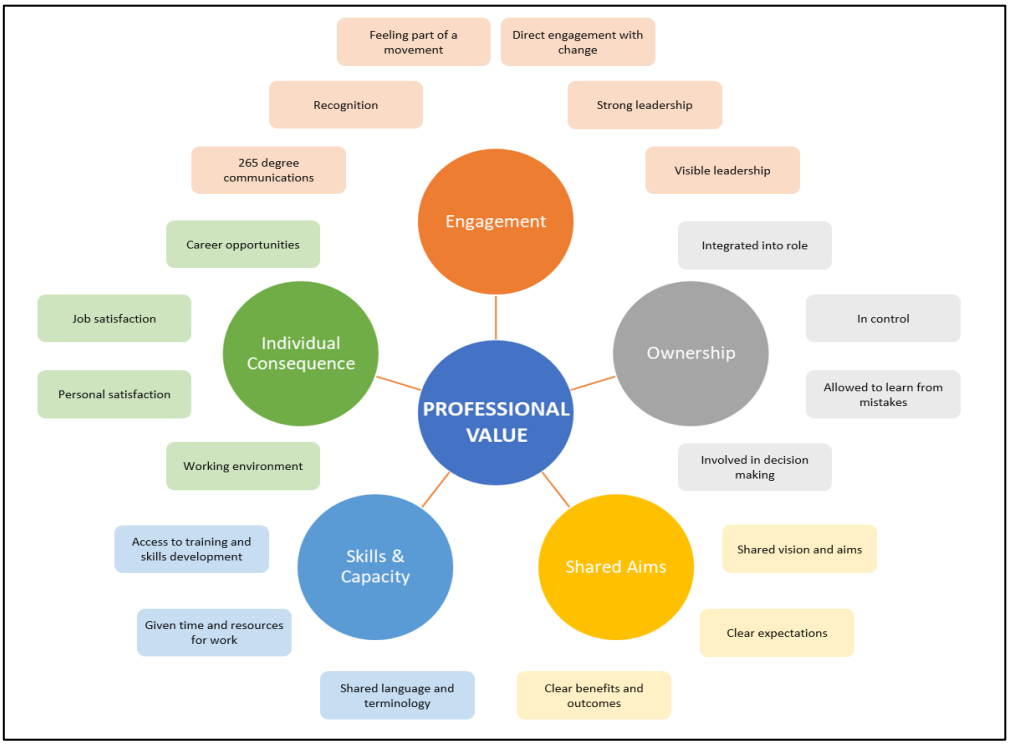


Figure 20 - Draft Authors Conceptual VBHC Sustainability Framework Easy View (Source: The Researcher - Marc Penny 2025)

As explored earlier in this chapter (2.15) the author has identified a number of key 'Drivers', 'Inputs' and 'Measurements' for VBHC. The outputs for the authors Conceptual Framework are the accepted value areas of VBHC, with the addition of these benefits being sustainable in their deliver and realisation:

- Personal Value - patients personal goals
- Technical Value - achievement of best possible outcomes with available resources
- Allocative Value - equitable resource distribution across all patient groups
- Societal Value - contribution of healthcare to social participation and connectedness

Drawing together all the elements of Drivers, Measurement, Inputs, Outputs and the researchers draft drivers of professional value the author has produced a draft conceptual VBHC sustainability framework practical visualisation (Figure 21).

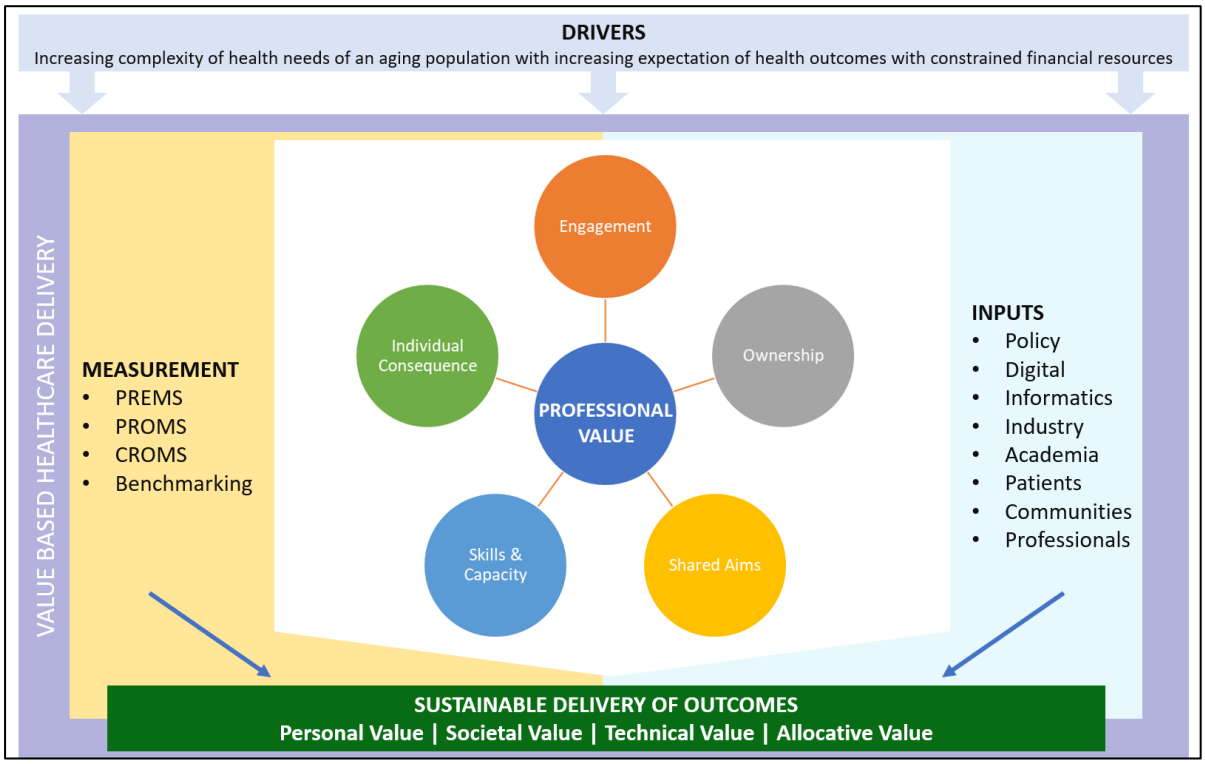


Figure 21 - Draft Authors Conceptual VBHC Sustainability Framework Practical Visualisation (Source: The Researcher - Marc Penny 2025)

This section concludes the authors research 'Phase 1B: Conceptual Framework Development' delivering the output of a thematic analysis and draft conceptual framework ready for validation during research phase 2a – Semi-Structured Interview Expert Review.

2.17. History and Development of Socio-Technical Theory a Theoretical Lens

Socio-technical theory is an organisational theory that emerged in the mid-20th century primarily developed by researchers at the Tavistock Institute of Human Relations in London. The theory was initially developed in response to the failures of early mechanistic approaches to work design which often missed the social aspects of work in favour of technical efficiency. The seminal work by Trist and Bamforth on the coal mining industry in the U.K. highlighted the key interconnection between social systems (people and organisational culture) and technical systems (tools, machines and work processes), with further consolidation of the principles that emerged in the 1950s and 1960s in '*Sociotechnical Systems: A Sourcebook'*, (Trist, 1978). Their research demonstrated that both systems need to be jointly optimised to improve job satisfaction and productivity (Trist & Bamforth, 1951b).

The socio-technical system approach is based on the belief that the best organisational outcomes are achieved when there is a balanced optimisation of both the social and technical components of a system. This perspective contrasts with traditional Taylorist models which primarily focused on task efficiency and standardisation without considering the human factors influencing productivity and worker well-being or the professional working in the system. Taylorism and scientific management treated workers as extensions of machines with little regard for their social needs or psychological well-being. STS theory challenges these assumptions by suggesting that people are not simply motivated by external rewards but also by internal factors such as a sense of purpose, autonomy and social belonging.

Since its first development STS theory has evolved to influence a wide range of disciplines including organisational behaviour, human resource management and information systems. Key developments in the theory include the incorporation of participatory design principles which advocate for greater employee involvement in the design and implementation of work systems. Participatory design or co-design assumes that those professionals who use and work in the system should have a say in its design, ensuring that the system meets their needs and enhances their work and professional experience. This principle aligns with the broader STS objective of achieving joint optimisation of social and technical elements (Mumford, 2006).

Despite its wide application STS theory has faced some criticism for its perceived lack of specificity and practical guidance for implementation (Baxter & Sommerville, 2011) as argued by Baxter & Sommerville in their critical review and analysis 2011. Some argue that the theory's broad conceptualisation of "joint optimisation" is difficult to deliver in practice, especially in large complex organisations with diverse stakeholder needs such as the NHS. The theory has been critiqued for its Western-centric perspective which may not fully account for cultural differences in organisational behaviour and work practices (Clegg, 2000), this may be no different however to other management methodologies such as '*The Toyota Production System'* which has also been criticised for reflecting and trying to lift and shift 'Eastern' values into Western organisation. Some argue the theory's flexibility allows it to be adapted to various organisational contexts and challenges making it a valuable framework for examining the complexities of modern work environments. This has been seen with the adoption and adaption of the Toyota Production System (Ohno, 1988) into Western organisations and shows deployment of these types of theorise need to be context specific.

In recent years STS theory has further developed by incorporating insights from other fields such as cognitive science, systems theory and complexity theory. Current views of the theory emphasise the importance of adaptability and resilience in STS recognising that organisations operate in increasingly complex and unpredictable environments (Walker et al., 2004). This evolution reflects a move away from a focus solely on stability and control towards an emphasis on flexibility, learning and continuous adaptation. STS theory provides a valuable framework for understanding how organisations can design work systems that are not only efficient but also adaptable to changing conditions and capable of supporting employee well-being and development.

2.17.1. Socio-Technical Theory Theoretical Lenses

STS is an approach to complex organisational work design that understands and focuses on the interaction between people and technology in workplaces. The theory aims to optimise the social and technical systems of an organisation as an interconnected whole which is particularly pertinent to complex systems like healthcare and the NHS.

STS theory provides a robust theoretical framework and lens for examining the authors research question: 'To what extent does professional value and engagement play a role in the sustainable delivery of VBHC?' The theory's core principles of holism, fit, dependency, hierarchy, feedback and

efficiency will help frame the authors exploration of how professionals' roles, engagement and satisfaction contribute to the sustainability of VBHC. By examining the relationships between professionals and the systems they operate within the author hopes to discover insights into how healthcare organisations can better support their workforce to achieve long-term Value-Based outcomes for patients and society.

The key elements of STS theory include holism, fit, dependency, hierarchy, feedback and efficiency. These elements can be interpreted through different theoretical lenses:

Holism

Holism in STS theory argues the importance of viewing systems as interconnected wholes rather than isolated parts. In the context of VBHC, holism emphasises that professionals' roles, values and engagement are inseparable from the technical systems and broader organisational structures. This interconnectedness will be key when exploring the authors research question 'To what extent does professional value and engagement play a role in the sustainable delivery of VBHC?'

By viewing the research through the lens of STS theory, ensuring a holistic view the author will consider not only how healthcare professionals engage with VBHC but also how their roles, workflows and motivations are influenced by the systems in which work. Holism seeks to ensures that any investigation into PV considers the broader ecosystem of patient care, financial models and healthcare outcomes. Holism may support the argument that without recognising the professional's role within the entire healthcare framework and system VBHC risks failing to acknowledge a critical part of the system, namely the professionals in the system that sustains it.

Fit, Learning, Adaptation and Multi-Skilling

The concept of fit in STS theory refers to the alignment between social and technical elements within an organisation. For the author's research question on professional engagement in VBHC, fit involves assessing how well the professionals' values, skills, and motivations align with the technical systems and outcomes-focused nature of VBHC.

Poor fit between professionals and the systems they work in could lead to disengagement, inefficiencies and unsustainable outcomes for patients and the organisation. If professionals feel that

VBHC systems are cumbersome or do not adequately reflect their clinical expertise or day-to-day experience, they may be less motivated to engage fully with the model. Understanding the fit between professionals and VBHC implementations could highlight misalignments that have caused failures or reduced sustainability, such as systems that do not integrate with existing clinical workflows or place unrealistic demands on healthcare workers. Fit is crucial for determining whether professionals feel valued by their participation in VBHC and, if not, what changes are necessary to improve alignment and make the system more effective for them.

In addition to fit, the principles of learning, adaptation and multi-skilling are vital in ensuring STS can evolve in response to new challenges and opportunities. Learning refers to the continuous process through which organisations and individuals acquire insights, skills and behaviours that enable them to adapt to changing circumstances. For VBHC, this may mean fostering an environment where professionals can reflect on their experiences, share best practices and refine processes to enhance alignment between social and technical elements. Adaptation builds on this learning by enabling the organisation to adjust its systems, policies and practices to address emergent issues or optimise existing processes, which is especially important in complex organisations such as healthcare.

Multi-skilling enhances learning and adaptation by ensuring professionals develop diverse competencies, enabling them to respond flexibly to the demands of VBHC systems. For example, healthcare professionals might benefit from acquiring skills in data interpretation, technology usage, or cross-disciplinary collaboration, allowing them to engage more effectively with VBHC initiatives. However, multi-skilling must be approached thoughtfully to avoid overburdening staff or undermining their core professional expertise. By investing in multi-skilling, organisations can enhance workforce resilience and engagement, creating a stronger foundation for the sustainable delivery of VBHC.

Dependency

Dependency within STS theory refers to the interdependence between different components of a system which is especially important in complex systems such as healthcare. For VBHC this means that the successful delivery of value-based care depends on the co-operation between all stakeholders including healthcare professionals, patients, management and technological systems. The authors research will explore how professionals' roles depend on the broader VBHC system to provide resources, support and feedback mechanisms that allow them to perform effectively.

For the authors main research question, dependency is key to understanding how professional engagement impacts sustainability. If professionals are highly dependent on VBHC systems for decision-making but those systems are inadequate it could lead to a breakdown in engagement and a lack of sustainability (Ball & Regan, 2010). Recognising the dependency between the professional and VBHC outcomes may support the creation of a PV domain as it would acknowledge the essential role that healthcare workers play in the delivery of Value-Based outcomes.

Empowerment and Hierarchy

In STS theory, hierarchy refers to the structured levels of roles and responsibilities within an organisation. The healthcare environment is typically hierarchical and complex, with managerial, clinical, and operational levels that must work together effectively, often involving differing reporting lines. In relation to VBHC, this structure can influence how well VBHC principles are adopted at various organisational levels and how professionals engage with these principles.

For the author's research question, understanding the hierarchy is critical to exploring how leadership and managerial decisions impact professionals' engagement with VBHC. If professionals feel that VBHC is imposed through a top-down approach without their input, they may resist its implementation, potentially affecting its sustainability. Examining the hierarchy in past VBHC deployments can reveal how leadership structures have either facilitated or obstructed professional engagement, offering lessons into what approaches are most sustainable. Understanding these hierarchical dynamics could strengthen the argument for a PV domain within VBHC, ensuring that professionals' contributions are recognised across all levels of the organisation.

Empowerment complements the concept of hierarchy by focusing on the ability of individuals or teams to make autonomous decisions, take ownership of their roles and influence outcomes within the constraints of the organisational structure. Empowerment entails providing employees with the authority, resources and confidence to contribute effectively to organisational goals. In the context of VBHC, empowering healthcare professionals means ensuring they have a meaningful voice in designing and implementing initiatives, fostering a sense of ownership over outcomes and aligning their professional values with organisational objectives.

Empowerment is particularly significant in healthcare because it can mitigate some of the potential drawbacks of rigid hierarchies. When healthcare professionals feel empowered they are more likely to innovate, collaborate and engage deeply with VBHC principles. For the research question, understanding how empowerment operates within the organisational hierarchy sheds light on whether professionals feel valued and trusted in their roles. Empowerment can act as a counterbalance to hierarchical rigidity, enabling organisations to harness the expertise and insights of professionals at all levels.

Feedback

'Feedback' mechanisms are vital in STS theory for ensuring continuous improvement and adaptability within systems, especially important in large complex systems. In healthcare feedback loops between professionals, patients and managers are necessary to adapt VBHC practices to real-world conditions and improve sustainability, delivering a true multi-professional approach to healthcare delivery (Bandurska et al., 2023). Without effective feedback mechanisms professionals may feel that their contributions and insights are not valued leading to disengagement from VBHC initiatives.

In relation to the research question feedback systems are critical for understanding how professionals engage with VBHC over time. Do professionals feel heard and valued when they provide feedback on VBHC initiatives? This can affect the sustainability of the system. Feedback is essential for professionals to feel that their role in VBHC is valuable. If feedback mechanisms are weak or non-existent professionals may struggle to see how their work contributes to VBHC success. Exploring feedback systems in previous deployments can offer insight into how feedback loops have been used to refine VBHC practices, improve professional engagement and sustain long-term outcomes.

Efficiency

Efficiency in STS theory looks at technical efficiency but incorporating the social elements that contribute to a smoothly functioning system. In the context of VBHC efficiency is not only about reducing costs and improving patient outcomes but also about ensuring that the professionals responsible for delivering care are fully supported and engaged.

For the authors research question efficiency will be a key measure of how professional value and engagement influence the sustainability of VBHC. If professionals are not fully engaged or if the system

does not support them efficiently VBHC may struggle to meet its multiple goals. Efficiency considerations may reveal that acknowledging professional contributions more explicitly through a dedicated PV domain could enhance the overall efficiency of VBHC systems by ensuring professionals remain engaged and motivated.

Feedforward, Information Flows, Goals and Values

Feedforward refers to proactive planning and foresight in organisational systems, ensuring that future challenges are anticipated and addressed effectively. In STS theory, feedforward complements feedback by focusing on pre-emptive rather than reactive actions. In the context of VBHC, feedforward processes enable organisations to anticipate and plan for potential barriers to implementation, such as misaligned workflows or resource constraints (which are widely prevalent in current healthcare organisations), fostering improved integration of VBHC principles into existing practices.

Closely linked to feedforward is effective information flows which are critical to supporting VBHC systems. These flows ensure that data, insights and directives are disseminated across all levels of the organisation, promoting transparency, alignment and collaboration. Inadequate information flows can create silos, reduce trust and hinder the collective ability to achieve VBHC goals. The use of data within VBHC is a key element and the collection of Patient Reported Outcomes / Experience Measures (PROMs / PREMs) are fundamental to understanding and improving outcomes for patients.

Goals and values form the foundation of STS by aligning organisational objectives with the intrinsic motivations of professionals. In VBHC, shared goals such as improving patient outcomes must align with healthcare professionals' core values, including providing ethical, high-quality care. If organisational goals appear misaligned with PV — for example, by prioritising cost-cutting and cash releasing savings over patient care, disengagement and resistance may occur.

2.17.2. Applying Socio-Technical Theory to Professional Value

STS theory provides a valuable lens through which to evaluate various aspects of PV. Considering the connection between social and technical factors the theory helps to understand how organisations can create work environments that fulfil both the psychological and material needs of employees. This section explores how STS principles can be applied to understand and enhance PV such as personal growth, shared goals, societal contribution, engagement and autonomy.

2.17.3. Personal Growth, Development and Value

Personal growth and development are essential components of PV that can be effectively analysed through STS theory. According to STS theory work systems should be designed to promote not only technical efficiency but also employee development and well-being. For example, a study using a meta-analysis to review and synthesise existing empirical research on mentoring relationships highlights the importance of social support systems in fostering personal growth and career advancement (Allen et al., 2004). Within a STS framework such mentoring can be seen as part of the social system that interacts with the technical aspects of work to enhance employee development.

STS theory suggests that for mentoring and development programmes to be effective they must be integrated with the technical components of the organisation. Digital platforms for e-learning and virtual mentoring can complement face-to-face mentoring relationships providing a holistic approach to employee development. This integration ensures that the technical systems support the social dynamics necessary for effective mentoring thereby aligning with the principles of STS theory. This perspective also aligns with the Human Capital Theory by Nobel Prize recipient Gary Becker, which argues that investments in employee and professional development enhance organisational competitiveness (Becker, 1964). STS theory extends this thinking by emphasising the need for a balanced approach that also considers the social context in which learning occurs.

Self-Determination Theory which emphasises autonomy, competence and relatedness as core psychological needs aligns with STS theory (Deci & Ryan, 2000). STS theory suggests that work systems should be designed to enhance these psychological needs by providing opportunities for skill development, fostering supportive relationships and offering autonomy in work delivery, which is closely linked with elements of Maslow's hierarchy of need (Ștefan et al., 2020). This approach ensures that both the social and technical aspects of the work environment are optimised to support personal and professional growth and development which enhances the overall PV.

The delivery of STS principles can enhance professional development by fostering a culture of continuous learning and innovation. By promoting a balance between social and technical factors organisations can create environments that encourage experimentation, risk-taking and learning from failures which are critical for personal and professional growth. The STS approach also emphasises the

importance of feedback loops both formal and informal as mechanisms for learning and development (Reason, 1990) along with building resilience and adaptability (Carayon, 2006). This perspective aligns with current views on learning organisations which emphasise the importance of creating systems and processes that facilitate continuous learning and adaptation (Senge, 1993).

2.17.4. Shared Goals and Purpose

The alignment of personal and organisational goals is another key aspect of PV that benefits from a STS lens. STS theory emphasises the importance of designing work systems that align with both organisational objectives and employee values fostering a sense of shared purpose and commitment which are key for successful change delivery (Eaton, 2010; Sancak, 2023). Chatman's Person-Organisation Fit model supports this view suggesting that alignment between an employee's values and those of the organisation leads to higher job satisfaction and performance (Chatman, 1989). Achieving this alignment requires a balance between the technical design of work processes and the social elements of organisational culture. It can be argued that high-performing teams and organisations are characterised by a shared sense of purpose and goals which is helped by both social cohesion and well-designed work processes. In a STS framework this means that organisations should invest in both team-building initiatives and robust project management tools to foster alignment and shared goals (Katzenbach & Smith, 1993).

STS theory also highlights the importance of communication and collaboration in achieving shared goals. Effective communication is seen as a key element of the social system enabling employees to understand and align with organisational objectives. By ensuring that social and technical systems are aligned to support communication and collaboration, organisations can enhance goal alignment and foster a sense of shared purpose among employees.

A critical analysis of this approach suggests potential challenges in maintaining this alignment, particularly in dynamic and complex environments where organisational goals may shift frequently, or objectives change such as within the NHS. STS theory would argue for adaptable work systems that can evolve in response to changing organisational needs while still supporting professionals' values and motivations. This interplay between stability and flexibility is a core principle of STS design emphasising the need for continuous feedback and iterative improvement, which must include objectives, feedback and performance (van Elten et al., 2023). In this context STS focus on adaptability

and resilience can provide valuable insights into how organisations can manage the tensions between stability and change (Walker et al., 2004) especially in complex organisational environments.

2.17.5. Contribution and Social Alignment

A STS view of contribution would imply an emphasis on the need for work systems that allow employees or professionals to see the broader impact of their efforts, again within healthcare line of sight from intervention to outcome is strong. STS for example in healthcare are designed to ensure that technical processes (such as patient record management systems) are aligned with social goals (such as patient care and well-being). This alignment ensures that healthcare professionals not only perform their tasks efficiently but also derive a sense of satisfaction from contributing to patient health and well-being (Baxter & Sommerville, 2011) through this line of sight.

A STS perspective highlights potential tensions between technical efficiency and social goals. In high-pressure environments like healthcare the emphasis on efficiency and throughput can sometimes conflict with the social goal of providing compassionate care as already discussed in section 2.9.2. A STS approach suggests a system that balance these competing demands ensuring that technical efficiency does not undermine the social purpose of work. This perspective is particularly relevant in the context of public sector organisations and healthcare where societal contribution is a core value, but resources are often constrained necessitating careful balancing of social and technical factors.

STS principles can be applied to enhance the societal impact of work in other sectors such as education, social services and non-profit organisations. By designing work systems that integrate technical tools and processes with social objectives organisations can create environments that support both efficiency and societal contribution. This approach aligns with contemporary views on corporate social responsibility which emphasise the importance of aligning organisational practices with broader societal goals (Carroll, 1999).

2.17.6. Socio-Technical Theory Application and Consideration Against Conceptual Framework

STS theory emphasises the need to balance both technical systems and human factors offers a lens through which to understand the importance of PV in VBHC. Professionals must see how VBHC fits within their roles not only from a technical perspective (such as the deployment of PROMS) but also in terms of their own personal and professional fulfilment. When VBHC systems are imposed without

considering the impact on professional value they risk being perceived as burdensome and irrelevant to the professionals' daily work (Gray, 2004). The key elements of STS theory include holism, fit, dependency, hierarchy, feedback and efficiency.

During the draft conceptual framework development the author has sort to ensure that the 6 elements of STS theory have been taken into consideration and will evaluate and consider this later in the discussion chapter 5.

2.18. Overall Chapter Summary, Uniting Thread and Conclusion

Building on the foundational context established in Chapter 1, this chapter critically explores the theoretical and practical dimensions shaping the study of VBHC. While Chapter 1 outlined the global and national challenges faced by healthcare systems, Chapter 2 delves deeper into the academic and professional literature to review the mechanisms, limitations and potential of VBHC within these complex systems. By situating VBHC within the broader domains of organisational change, healthcare reform and professional value, this chapter strengthens the argument that a sustainable VBHC model requires a nuanced understanding of both systemic factors and human dynamics.

The researcher has examined the intersection of VBHC, organisational change management success and failure and professional engagement within healthcare systems. Key theories such as STS theory provided a framework for understanding how professional motivation and engagement contribute to sustainable healthcare improvements. The researcher highlighted critical barriers to VBHC success such as misalignment between organisational goals and professional autonomy, lack of engagement in decision-making and the loss of control professionals' feel. This chapter identified and defined the concept of "professional value" as a key aspect covering factors like meaningful work, autonomy and alignment with organisational goals.

The three research spheres - organisational change success and failure, past healthcare reforms and the genealogy of VBHC - are interconnected and highlight critical gaps and opportunities in the existing literature. Particular emphasis is placed on the role of healthcare professionals as both agents and recipients of change, linking directly to the themes introduced in Chapter 1 regarding the importance of professional value, engagement and discretionary effort.

The researchers analysis implies that any study of VBHC must assess cultural indicators - such as shared goals, leadership engagement and professional autonomy. By examining VBHC through the lenses of PV and STS theory, this research offers a conceptual framework for addressing the complex challenges of implementing and maintaining VBHC in healthcare organisations. The researcher has developed and presented their conceptual framework and in the next chapter they will build on the insights gained from the literature review to develop their philosophical and research strategy and develop the data gathering artefacts.

Ultimately, this chapter connects theoretical inquiry to practical application, reinforcing the notion that successful VBHC implementation depends not only on organisational strategies but also on fostering a culture of collaboration, adaptability, and shared purpose among professionals. This thread of PV, which emerged in Chapter 1 and is further expanded here, continues to weave through the thesis, ensuring coherence and alignment with the overarching research objectives. The next chapter will present and defend the research strategy and methodology that was designed for this study.

CHAPTER 3 - PHILOSOPHICAL POSITION AND RESEARCH STRATEGY

3. Introduction to Philosophical Position and Research Strategy

This chapter will explore the philosophical foundations and research strategy designed by the researcher to ensure valid knowledge is derived from this research and the research question may be answered effectively. The question is stated as:

- To what extent does professional value and engagement play a role in the sustainable delivery of Value Based Healthcare?

The previous chapter identified gaps in the literature particularly the role of healthcare professionals in the sustainable implementation of VBHC and the need for professional engagement, cultural adaptation and leadership to ensure successful and sustainable change. These findings highlighted the importance of developing a robust research framework that addresses the complex dynamics of professional value and organisational change in healthcare settings. Such an immature field of study (VBHC) requires a contextually rich understanding of the phenomenon and a theory building approach to understanding the complexities of STS in the context of modern health and care service provision and its improvement.

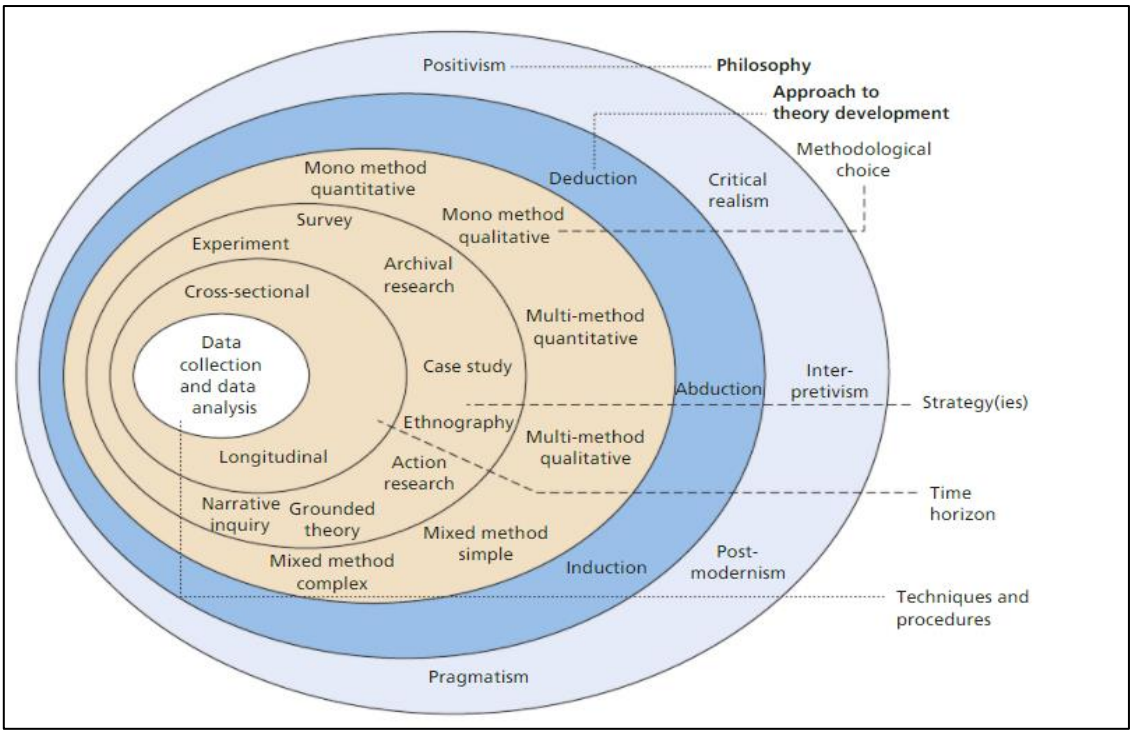
The chapter explores the philosophical positions that underpin the authors research with a focus on pragmatism (and praxis) as the most suitable approach given the practical motivations and objectives of the study. By grounding the research in STS theory and professional value this chapter will help frame the rest of this document by providing an academic framework to test the conceptual framework through empirical research in subsequent chapters. The philosophical considerations presented here will serve as the foundation for exploring how PV can drive sustainable VBHC outcomes as established in the literature.

3.1. Research Design

The practical motivation and intent of this research means it will focus on what is described as 'Mode 2' applied research (Gibbson et al., 1994), where an academic grounding and underpinning of philosophy is united with the actual practice of management and its *"real world"* setting and impacts of VBHC (Starkey & Madan, 2001), which is aligned to the researchers practical desire for real world application. The study seeks to add practical implications for professionals and practitioners (working in complex health and care organisations) and shaping a meaningful definition of VBHC. For such applied studies there is a heightened need to explain and defend the methodological choices, rigor

and quality assurance of this study and its practical impact and influence. This chapter will present and defend the chosen research design.

A useful conceptualisation of the research process is provided by the 'Research Onion'. Saunders, Lewis and Thornhill first proposed the 'Research Onion' as a helpful concept to visualise the different layers of research philosophy and theory development, leading to the formation of an overall research strategy and the author will use this to explore and articulate the research position and strategy (Saunders et al., 2019) Figure 22.



[9]*Figure 22 - The 'Research Onion' (Source: Saunders, Lewis and Thornhill 2019)*

The researcher will use the 'Research Onion' (Saunders et al., 2019) for the ease of the reader and to provide greater clarity concerning the study design, inherent choices and why certain methods were selected over others to form the research strategy.

Ultimately the goal of this research is to conceptualise, design and implement a research project and generate legitimate new knowledge for STS theory and for the practice of VBHC in the NHS in Wales and wider healthcare management systems. "*While research methodology is rooted in theoretical*

[9] Saunders, M., Lewis, P., & Thornhill, A. (2019). *Research Methods For Business Students* (8th ed.). Pearson.

principles, its real value lies in how effectively these principles are translated into practice. A well-designed research project not only contributes to knowledge but directly informs business decisions and strategies." (Aityan, 2022) which resonates with the approach the author will take in delivering their research.

As already declared the focus of this research for the researcher is its practical use within their organisation and wider healthcare systems and isn't about the researchers ability to implement change or VBHC, and the researcher has already stated their preference for a pragmatic focus. This pragmatic focus aligns and plays into the inadequacy of current research in the VBHC field, the research objectives of this research and the researchers natural pragmatic tendencies.

3.2. Research Questions

The literature review revealed a gap in the current body of knowledge and the important omission of the professional as a change agent to ensure success of VBHC interventions and programmes, as discussed in section 1.4 the research question(s), derived from the literature review gap, which guides this study is declared as:

To what extent does professional value and engagement play a role in the sustainable delivery of Value Based Healthcare?

The sub-questions to explore dimensions of this main question include:

- How do professionals derive value from being involved in and delivering Value Based Healthcare?
- What features of 'Professional' value offer greatest benefits to professionals engaged in Value Based Healthcare?

3.3. Philosophical Foundations

At the heart of all research is a philosophical set of traditions concerning knowledge and how best to legitimise it. In designing an overall research strategy it if fundamental to understand both the system of beliefs and assumptions linked to the acquisition and development of knowledge (Crossman & Bordia, 2021; Leavy, 2014; Saunders et al., 2019). Saunders, Lewis and Thornhill describe such a research philosophy as a system of beliefs and assumptions relating to knowledge development. There are a number of philosophical models and theories concerned with; the nature 'of' and 'how' we

perceive reality known as Ontology, how we understand knowledge and accept it as valid or legitimate known as Epistemology and finally Axiology which assesses the role of values, beliefs and ethics in the research (Bell et al., 2022) – whether in the context of the research participants and data or the researchers own beliefs & values and the potential impact this may have on delivery and interpretation.

3.3.1. Ontology

Ontology concerns itself with fundamental questions such as 'What does it mean to exist?' or 'What does existence mean?' and the nature of relativity and determining if that reality exists. Individuals can and will perceive ontology through their own prism of believes and values determining the world that they see and how they see it (Leavy, 2014; Saunders et al., 2019). Ontology poses questions which take theory or things which may be abstract and seeks to establish if they exist or not (Hennink et al., 2020). Ontology is a continuum from one extreme to another such as 'realism' and 'constructionism' (Crossman & Bordia, 2021) and a number of different and emerging paradigms. The author will appraise and declare their position in chapter 3.4.

3.3.2. Epistemology

Ontology concerns *'What is the world like?'* whereas epistemology asks questions such as *'How do we know what the world is like?'* and *'How do we know what is true and what is false?'* (Bell et al., 2022; Johnson & Duberley, 2000). Epistemology explores what knowledge is, is that knowledge worth knowing and how do we communicate that knowledge (Burrell & Morgan, 2017; Saunders et al., 2019). In exploring epistemology, the researcher has sort to understand what constitutes good and bad knowledge and data quality and what is seen as acceptable such as numbers and opinions. Importantly with epistemology it also concerns itself with the role of the researcher and the relationship between researcher and participant (Hennink et al., 2020; Leavy, 2014). The author will appraise and declare their position in chapter 3.4.

3.3.3. Axiology

Axiology is another branch of philosophy and concerns the values, beliefs and ethics to the research and the stance that the researcher adopts. In doing so the researcher must recognise that this stance is likely to be directly impacted by said researchers own values and beliefs – and biases (Denzin & Lincoln, 2018; Saunders et al., 2019). Axiology also considers the role or the participant in research. Questions such as '*Do I try and remove my own values from research, or do I embrace them?*' or '*Do I*

accept I have my own values and identify these but try to mitigate any impact these may have on the research?'. The author will appraise and declare their position in chapter 3.4.

3.4. Philosophy Appraisal

In developing the research strategy the author has reviewed the 5 different philosophical traditions (Aldawod & Day, 2017; Saunders et al., 2019) in order to effectively house his study Table 25 Table 26.

	Philosophical framework				
	Positivism	**Postpositivism**	**Constructivism**	**Pragmatism**	**Postmodernism**
Ontology: What is reality?	Naïve realism: reality is real; facts exist and can be revealed.	Critical realism: reality is real, however, it is imperfectly and probabilistically apprehensible	Relativism: multiple realities are constructed through the lives experiences and interactions	Reality is what is useful, is practical and works.	Participative reality: subjective-objective reality is created by mind and surrounding cosmos. There no single reality, but rather, there are multiple and/ or interpretations
Epistemology: How reality is known?	Dualist/ Objectivist: findings true; the reality is seen through a "one-way mirror"	Modified dualist/ Objectivist; findings probably true: triangulation is required.	Transactional/ subjectivist; created findings: The knowledge is based on social construction assumptions.	Either or both objective and subjective meanings can produce accepted knowledge.	Inter- subjectivist[1]; co-creat findings with multiple way knowing.
Methodology: What is the model behind the research process	Main attention is paid for testing of theories. Therefore the research methods used, in principal, are quantitative, such as: questionnaire, verification of hypotheses and experiments.	critical multiplism; falsification of hypotheses; mainly quantitative methods but it may include qualitative methods	Main attention is paid for generating of theory. Therefore the research methods used, in principal, are qualitative, such as: In-depth unstructured interviews, grounded theory research and participant observation	Quantitative and qualitative (mixed or multi-methods design)	There is no single best meth for obtaining knowledge. Range of data types, typica qualitative methods of analysis.
Axiology: Role of values in research	Value-free and etic: Research must (and presumably can) be conducted in a way that is value free. the researcher is independent of the data and maintains an objective stance	Value-laden and etic: Research is value laden; the researcher is biased by world views, cultural experiences and upbringing	Value-bond and emic: Research is value bond, the researcher is part of what is being researched, cannot be separated and so will be subjective	Value-bond and etic-emic: Values play a large role in interpreting the results, the researcher adopting both objective and subjective points of view	Value-constituted research: researcher and research embedded in power relation Some research narratives ar repressed and silenced at th expenses of others. Researc radically reflexive.

[10]Table 25 - Comparison Between Five Philosophical Frameworks (Source: Aldawod & Day, 2017)

Ontology (nature of reality or being)	Epistemology (what constitutes acceptable knowledge)	Axiology (role of values)	Typical methods
Positivism			
Real, external, independent One true reality (universalism) Granular (things) Ordered	Scientific method Observable and measurable facts Law-like generalisations Numbers Causal explanation and prediction as contribution	Value-free research Researcher is detached, neutral and independent of what is researched Researcher maintains objective stance	Typically deductive, highly structured, large samples, measurement, typically quantitative methods of analysis, but a range of data can be analysed
Critical realism			
Stratified/layered (the empirical, the actual and the real) External, independent Intransient Objective structures Causal mechanisms	Epistemological relativism Knowledge historically situated and transient Facts are social constructions Historical causal explanation as contribution	Value-laden research Researcher acknowledges bias by world views, cultural experience and upbringing Researcher tries to minimise bias and errors Researcher is as objective as possible	Retroductive, in-depth historically situated analysis of pre-existing structures and emerging agency. Range of methods and data types to fit subject matter
Interpretivism			
Complex, rich Socially constructed through culture and language Multiple meanings, interpretations, realities Flux of processes, experiences, practices	Theories and concepts too simplistic Focus on narratives, stories, perceptions and interpretations New understandings and worldviews as contribution	Value-bound research Researchers are part of what is researched, subjective Researcher interpretations key to contribution Researcher reflexive	Typically inductive. Small samples, in-depth investigations, qualitative methods of analysis, but a range of data can be interpreted

Ontology (nature of reality or being)	Epistemology (what constitutes acceptable knowledge)	Axiology (role of values)	Typical methods
Postmodernism			
Nominal Complex, rich Socially constructed through power relations Some meanings, interpretations, realities are dominated and silenced by others Flux of processes, experiences, practices	What counts as 'truth' and 'knowledge' is decided by dominant ideologies Focus on absences, silences and oppressed/ repressed meanings, interpretations and voices Exposure of power relations and challenge of dominant views as contribution	Value-constituted research Researcher and research embedded in power relations Some research narratives are repressed and silenced at the expense of others Researcher radically reflexive	Typically deconstructive – reading texts and realities against themselves In-depth investigations of anomalies, silences and absences Range of data types, typically qualitative methods of analysis
Pragmatism			
Complex, rich, external 'Reality' is the practical consequences of ideas Flux of processes, experiences and practices	Practical meaning of knowledge in specific contexts 'True' theories and knowledge are those that enable successful action Focus on problems, practices and relevance Problem solving and informed future practice as contribution	Value-driven research Research initiated and sustained by researcher's doubts and beliefs Researcher reflexive	Following research problem and research question Range of methods: mixed, multiple, qualitative, quantitative, action research Emphasis on practical solutions and outcomes

[11]Table 26 - Comparison Between Five Philosophical Frameworks (Source: Saunders et.al., 2019)

[10] Aldawod, A., & Day, J. (2017). A Critical Reflection upon the Postmodernist Philosophical Positions and Issues Relevant to Entrepreneurship Research.
[11] Saunders, M. N. K., Lewis, P., & Thornhill, A. (2019). Research Methods for Business Students (8th ed.). Pearson.

To locate this research within a research philosophy and tradition, the researcher created Table 27 to provide his justifications. Some aspects of this table will use 'the first person' due to the personal nature of the philosophical choices.

Positivism				
	Ontology	**Epistemology**	**Axiology**	**Typical Method**
Saunders, Lewis & Thornhill Definition	Real, external, independent One true reality (universalism) Granular (things) Ordered	Scientific method Observable and measurable facts Law-like generalisations Numbers Causal explanation and prediction as contribution	Value-free research Researcher is detached, neutral and independent of what is researched Researcher maintains objective stance	Typically deductive, highly structured, large samples, measurement, typically quantitative methods of analysis, but a range of data can be analysed
Marc Penny Analysis	Research focus on Human Factors and culture is likely to be constrained if viewed through the ontology or one true reality or assuming an ordered environment	My research is likely to be a mixture of clearly observable and measurable facts however the very nature of researching Human Factors and culture means that what constitutes acceptable knowledge cannot be constrained by the definition of positivism	I am not detached from my Research and have a direct accountability for the field being researched within my organisation	The field of VBHC, its cultural and Human factors is not a large area where large samples can be obtained nor is the research likely to deliver unambiguous knowledge. My own thinking and the topic of research means that I believe Positivism is unlikely to be an appropriate or useful research philosophy.
Critical Realism				
	Ontology	**Epistemology**	**Axiology**	**Typical Method**
Saunders, Lewis & Thornhill Definition	Stratified/layered (the empirical, the actual and the real) External, independent Intransient Objective structures Causal mechanisms	Epistemological relativism Knowledge historically situated and transient Facts are social constructions Historical causal explanation as contribution	Value-laden research Researcher acknowledges bias by world views, cultural experience and upbringing Researcher tries to minimise bias and errors Researcher is as objective as possible	Retroductive, in-depth historically situated analysis of pre-existing structures and emerging agency. Range of methods and data types to fit subject matter
Marc Penny Analysis	Human factors and cultural elements influencing or not the success of VBHC can be seen as viewing the success in the context of underlying structures that help shape the success or failure of what we may observe. However critical realism doesn't see knowledge derived directly from observation which I don't believe fits with my research focus as part of this will be observing the cultural deliverables of organisations although there are likely to be a number of causal mechanisms at play	Although some of the facts within my research area could be construed as social constructs other elements of the data and research are more aligned to being observable and measurable	I am likely to have some element of bias towards my research given it is an area I am not only interested in but also have a direct accountability for its delivery within my organisation, meaning I will need to consider and try to minimise any bias. It is also likely that the elements of research will be biased by external views and influences.	Elements of my research do focus on a backwards look into causality, looking to understand a positive outcome in VBHC and the human factor and cultural events that took place prior impacting on its success. A range of methods and data types are likely to be needed, however it is unlikely that there is currently depth of data for an in-depth historically focus analysis to take place
Interpretivism				
	Ontology	**Epistemology**	**Axiology**	**Typical Method**
Saunders, Lewis & Thornhill Definition	Complex, rich Socially constructed through culture and language Multiple meanings, interpretations, realities Flux of processes, experiences, practices	Theories and concepts too simplistic Focus on narratives, stories, perceptions and interpretations New understandings and worldviews as contribution	Value-bound research Researchers are part of what is researched, subjective Researcher interpretations key to contribution Researcher reflexive	Typically, inductive. Small samples, indepth investigations, qualitative methods of analysis, but a range of data can be interpreted
Marc Penny Analysis	Research focused on human and cultural elements are likely to be influenced and viewed through the lens of social constructs	Although a focus will be on some perceptions via interview and potentially exaction research other elements will be more quantitative in nature, however there may be a	I am not only interested in but also have a direct accountability for its delivery within my organisation, meaning I will need to consider and try to minimise any bias. It is also likely that the elements	My research is likely to require a range of methods such as mixed qualitative and quantitative as well as some case study.

		connection with driving a richer understanding in my area of research such as culture elements within VBHC	of research will be biased by external views and influences	
Postmodernism				
	Ontology	**Epistemology**	**Axiology**	**Typical Method**
Saunders, Lewis & Thornhill Definition	Nominal Complex, rich Socially constructed through power relations Some meanings, interpretations, realities are dominated and silenced by others Flux of processes, experiences, practices	What counts as 'truth' and 'knowledge' is decided by dominant ideologies Focus on absences, silences and oppressed/ repressed meanings, interpretations and voices Exposure of power relations and challenge of dominant views as contribution	Value-constituted research Researcher and research embedded in power relations Some research narratives are repressed and silenced at the expense of others Researcher radically reflexive	Typically, deconstructive – reading texts and realities against themselves In-depth investigations of anomalies, silences and absences Range of data types, typically qualitative methods of analysis
Marc Penny Analysis	By its very nature Human factors and culture are socially constructed ideals. What affects these are multiple including process, experiences and practice	Although accounting for potential gaps and absences the research is more likely to focus on existing observable information. It is not likely to be focused on deconstructing existing understandings but focusing on current accepted theories and their understanding and application in a different environment	Although I may have some bias towards my research it is less likely that my values and beliefs will significantly inform or impact on my research. The research will not necessarily be radically reflective	My research is likely to require a range of methods such as mixed qualitative and quantitative as well as some case study. A range of data types is likely to be required to start to draw inference and conclusion. It is also not reviewing or critiquing existing grand theories but more looking for causal relationships between existing thinking
Pragmatism				
	Ontology	**Epistemology**	**Axiology**	**Typical Method**
Saunders, Lewis & Thornhill Definition	Complex, rich, external 'Reality' is the practical consequences of ideas Flux of processes, experiences and practices	Practical meaning of knowledge in specific contexts 'True' theories and knowledge are those that enable successful action Focus on problems, practices and relevance Problem solving and informed future practice as contribution	Value-driven research Research initiated and sustained by researcher's doubts and beliefs Researcher reflexive	Following research problem and research question Range of methods: mixed, multiple, qualitative, quantitative, action research Emphasis on practical solutions and outcomes
Marc Penny Analysis	The reality of the field is a practice implemented strategy, aligning to 'Reality' is the practice	My research will focus on the practical elements which can be applied into practice using both historical and informed future practice.	My own values which are people centric and human empowerment are likely to play a role in my research and likely to influence my outlook on the research. Although I will need to be mindful of these believes my research will focus on mine and others doubts and beliefs in the impact of Human Factors and culture	My research is likely to require a range of methods such as mixed qualitative and quantitative as well as some case study. The outcome of the research is very much embedded in practical solutions, findings and actionable solutions

Table 27 - Authors Critical Evaluation of Philosophical Positions (Source: The Researcher - Marc Penny 2025)

The above summary of reasoning naturally gravitates to a philosophical tradition of Pragmatism as the most suitable housing of this study given the aims of the research question and immaturity of the subject. This philosophy aligns to the author's natural tendency of pragmatism and need for contextual richness in the qualitative account of reality.

Additionally, the author has undertaken the HARP (Heightening your Awareness of your Research Philosophy) course by Bristow and Sunders (2014) which also indicates a research methodology of Pragmatism, closely followed by Critical Realism which aligns to the author's philosophy review and

evaluation (Appendix A – Philosophical Appraisal HARP), which supports the researchers philosophical position.

Pragmatism was chosen after critically assessing the other philosophical positions, including positivism, critical realism, interpretivism and postmodernism; determining that these others did not align well with the research objectives and researchers motivation. Action research was discounted by the researcher as this type of research would be completely biased, it would test the researchers ability to implement VBHC within a definition of their own. As already declared the focus of this research for the researcher is its practical use within their organisation and wider healthcare systems and isn't about the researchers ability to implement change or VBHC. The author also rejected the following philosophical positions on the following grounds.

Positivism

Positivism focuses on observable, measurable facts and a value-free detached researcher stance was deemed restrictive for exploring human factors and cultural elements in the field of VBHC. The author acknowledged that although some aspects of the study might involve measurable data a purely positivist approach would not accommodate the complex interactions within VBHC.

Critical Realism

While critical realism's layered view of reality and acknowledgment of causal mechanisms seemed somewhat suitable the researcher ultimately rejected it. The author felt that critical realism's emphasis on historically situated knowledge and indirect derivation of knowledge through observation would limit the study which seeks to observe current cultural practices and their impacts directly.

Interpretivism

Interpretivism's focus on subjective interpretations and socially constructed realities was partly relevant for studying human and cultural factors. However, the researcher felt that the study required a balanced approach that could incorporate quantitative elements and address practical actionable outcomes, something interpretivism alone could not sufficiently support.

Postmodernism

Postmodernism with its focus on power relations, silenced narratives and deconstruction was found unsuitable. Although cultural constructs are relevant to the research the study aims to work within existing theories and accepted practices rather than deconstructing dominant narratives.

Pragmatism offers superior support for improved professional practice and the production of actionable insights and solutions. Pragmatism allows for methodological pluralism and flexibility incorporating both qualitative and quantitative methods and emphasises practical outcomes. Such a design is most suitable for researching complex human systems and professional cultures and the emergent VBHC framework.

3.5. Theory Building and Development

Pragmatism has been long associated with theory building research and for settings where the subject is immature and poorly researched (Wills & Lake, 2021). To understand the approach to theory development deductive, inductive and abductive approaches will now be reviewed.

3.5.1. Deduction

Deduction can be considered as scientific research which looks to deduce inference from a known general truth or fact and through research prove if true; thus providing conclusive evidence (Saunders et al., 2019; Skyrms, 1975). Deduction from a generalisation perspective seeks to generalise from the general to the specific, however the ability to do this is limited by the scope of research and sample undertaken (Saunders et al., 2019), with data collected to evaluate a hypothesis or premise. Deductive reasoning starts with a general premise or hypothesis which leads to a specific conclusion or finding. Deduction ultimately helps to prove or disprove a theory. Given that the researchers field of VBHC, particularly concerning human factors and cultural influences is still emerging and lacks well-established theories, deduction would constrain the researchers ability to explore and uncover new insights. Deduction often focuses on hypothesis testing rather than theory generation which does not align with the research goal of creating practical insights. There are also no calibrated questions that have derived from previous research to test any null hypothesis.

3.5.2. Induction

Induction focuses on a specific premise, and seeks to apply that premise to the general world, delivering a general principle which can be applied (Saunders et al., 2019) and is concerned not just with the data or premise but with the wider context environment the research is taking place in. Induction in which general findings are induced through specific examples (Mingers, 2012; Saunders et al., 2019) uses data to explore and identify themes helping develop a conceptual framework. Induction can ultimately lead to new theory development.

Pragmatism, which emphasises practical outcomes and actionable insights aligns well with induction as it enables a theory to develop in response to observed phenomena without the constraints of pre-existing models. Induction supports the creation of a new theory that is grounded in the realities of the research context and shaped by both practical and empirical insights.

3.5.3. Abduction

Unlike Induction and Deduction; Abduction moves back and forth between theory and data / data and theory (Suddaby, 2006) focusing on an incomplete set of observations and through data collection and analysis builds a theory which is subsequently tested and refined (Saunders et al., 2019). Abduction can result in new theory generation or existing theory modification. Abduction was considered but not selected as it typically involves generating hypotheses from incomplete data and refining them in a way that's more iterative and exploratory. However, the author's focus is on creating a clear, structured model grounded in empirical observations making induction a potentially better fit.

After consideration the authors view is that the research is looking to build and develop a new theory or model, where data collection will be aimed at looking at the cultural and human factor phenomenon impacts on VBHC success and sustainability which can be tested through data. It is likely to be somewhat a dynamic iterative research process between research and data and existing and emerging theory. Based on this the authors view of theory development will be 'Induction' which will lead to a new conceptual model (Figure 23).

This approach lends itself to a theory building structure where the author will set out a process to refine and develop the research development where each stage will help inform, refine and develop

the next with some iterative elements depending on each stage outcomes (Shepherd & Suddaby, 2016).

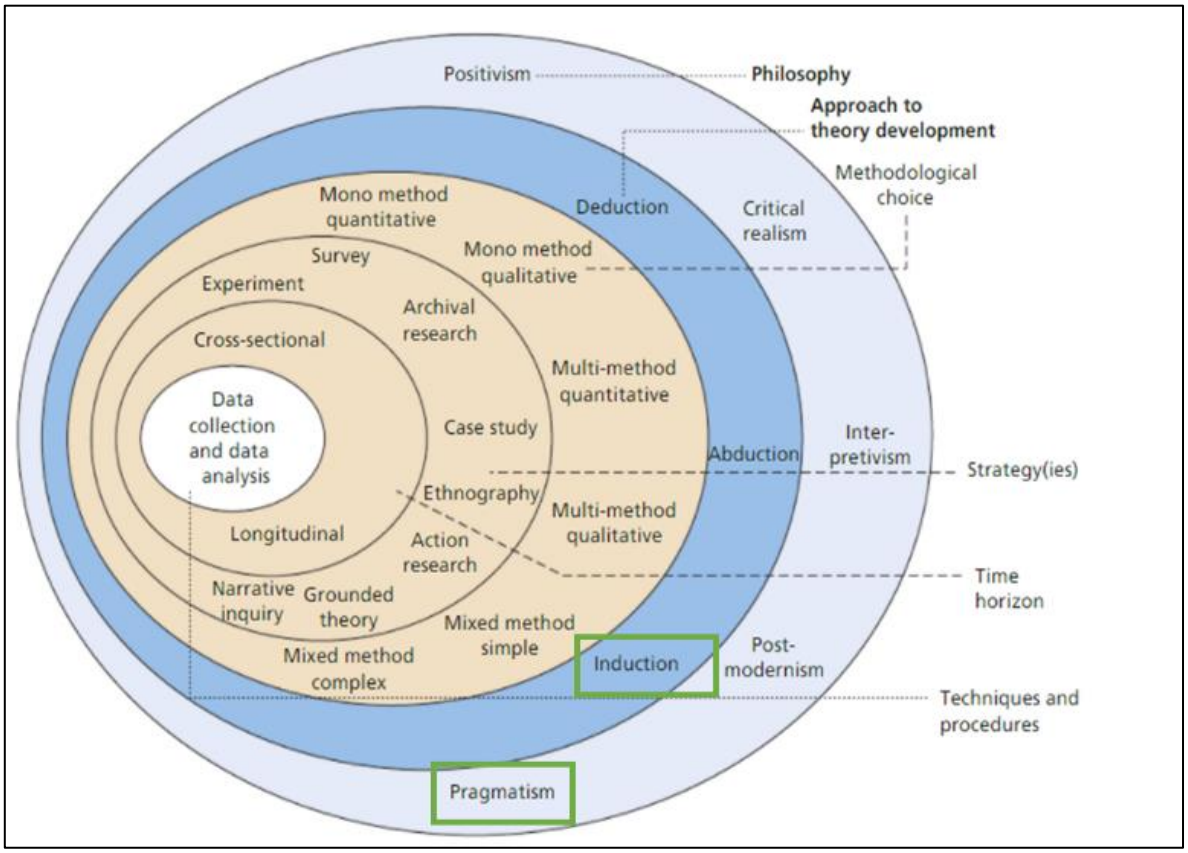


Figure 23 - Authors Research Onion Development - Approach to Theory Development (Source: Adapted from Saunders et al., 2019, p130)

Having established the tradition of this research and grounded it in pragmatic induction, the next stage of the design process is to configure the most appropriate methodology for the study.

3.6. Methodology, Research Strategies and Timelines

This section will defend the methodological data collection choice, research strategies and the time horizon for undertaking the research, collecting the data and the authors chosen position.

3.6.1. Methodological Choice

In seeking to determine the most appropriate methodological choice the author has explored the most common types of methodological positions, evaluating these against the desired aims of the research. There are considered to be 3 broad methodological choices; Quantitative, Qualitative and Mixed research design.

	Quantitative	Qualitative	Mixed
Saunders, Lewis & Thornhill Definition (M. Saunders et al., 2019)	• Numeric data • Usually associated with Deduction approach • Using numerical data to examine variables • Statistical in nature • Can be single in nature i.e. a single data collection or multiple using multiple data collection techniques • Predominantly experimental or survey research strategies	• Non-numeric data • Can be associated with Induction or Deduction approach • More interpretive than quantitative method • Often used to explore socially constructed phenomenon • Can be single in nature i.e. a single data collection or multiple using multiple data collection techniques • Meaning derived from words not numbers	• Use of both numeric and non-numeric data • Integrates Quantitative and Qualitative approaches • Often associated with pragmatism or critical realism • Considered a pluralist view – where use of anything which helps answer the research question legitimately
Edmonds & Kennedy Definition (Edmonds & Kennedy, 2017)	• Scientific method of systematic steps • Measurement reveals a relationship between variables • Validity of data is critical	• A focus on meaning • Used to explore questions such as 'How' and 'Why' • Aligned to human behaviour • Can be used to examine phenomena	• Combines various elements of qualitative and quantitative methods • Can be applied alongside Induction, Deduction and Abduction • A link exists between mixed methods and pragmatism

Table 28 - Methodological Choice Comparison (Source: Saunders et al., 2019 & Edmonds & Kennedy, 2017)

Saunders et.al (2019) suggest that, for pragmatists, the driving force in determining a research method is the research process itself and context in which it is undertaken. Similar to the authors review of Philosophical Position and Theory Development, the over-riding factor is the practical outcomes of the research and applying to the real-life world in which the author operates (Table 28). The author's view is that a mixed method simple methodology will provide the opportunity to interpret results more broadly from both a quantitative and qualitative perspective providing a more comprehensive answer to the research question posed and as a method greatly aligned to the pragmatist view point (Edmonds & Kennedy, 2017).

3.6.2. Strategies

A research strategy provides the link between philosophical position and data collection methods aligned to answering the research question posed (Denzin & Lincoln, 2018) producing a plan of action to achieve an answer to the research (Saunders et al., 2019). The author has reviewed the dominant research strategies including Experimental, Survey, Archival and Documentary, Case Study, Action Research, Narrative Enquiry and Critical Research. In selecting a research strategy(s) the author has reflected on the posed research question, the desired practical outcomes of the research and the

access to collateral (data and individuals) to undertake the research, with a summary of methods in Table 29.

RESEARCH METHOD	DESCRIPTION	POSITIVES	NEGATIVES	CHOSEN BY RESEARCHER
Experimental	A method involving manipulation of variables to observe effects on other variables.	Allows for high control over variables; can establish causality.	Often impractical in healthcare settings due to ethical concerns; may lack real-world applicability.	No
Survey	Collects data from a large sample via structured questions (e.g., questionnaires).	Efficient for gathering data from many respondents; can capture diverse perspectives on professional values.	Limited depth: relies on self-reported data, which may introduce bias or limit understanding of complex engagement.	Yes
Archival and Documentary	Uses existing documents and records for analysis (e.g., policy documents, healthcare reports).	Provides insights from historical data; useful for understanding trends in Value-Based healthcare over time.	Data may be outdated or not directly address research question; limited to available records, potentially biased.	Yes
Case Study	In-depth investigation of a single organisation or group to provide a detailed analysis.	Allows for a comprehensive understanding of engagement and values in real contexts; richly detailed insights.	Limited generalisability; can be time-consuming and may not be representative of broader healthcare settings.	No
Action Research	A collaborative approach with iterative cycles aimed at practical problem-solving, often involving participants.	Encourages participation, fostering deeper understanding of engagement in sustainable practices; actionable insights.	Can be subjective due to researcher involvement; time-intensive and may lack rigor.	No

RESEARCH METHOD	DESCRIPTION	POSITIVES	NEGATIVES	CHOSEN BY RESEARCHER
Semi-Structured Interview	Open-ended questions without a fixed sequence allowing a freer flowing conversation whilst covering key topics.	More informal allowing participants to provide rich, qualitative insights into personal values and motivations; adaptable to each interviewee's context.	Time-consuming to conduct and analyse; responses may vary widely, making cross-comparison challenging.	Yes
Narrative Inquiry	Explores experiences of individuals through their personal stories, focusing on subjective experiences.	Deep insights into professional motivations and values; captures complex engagement aspects in value-based healthcare.	Limited by subjective bias; small sample size may limit transferability across different healthcare contexts.	No
Critical Research	Challenges assumptions and power dynamics, often analysing societal structures and inequalities.	Highlights power structures that affect professional engagement; aligns well with a pragmatist approach for change.	May be seen as too theoretical or subjective; might struggle with practical applications in traditional healthcare.	No

Table 29 - Research Method Comparison (Source: The Researcher - Marc Penny 2025)

The author has discounted strategies relating to Experiment, Action Research, Narrative Enquiry and Critical Research, due to non-alignment with their philosophical foundations or approach to theory development, these have also been discounted due to the immaturity of the current research of VBHC and the focus on professionals delivering VBHC and not on the researcher. Based on this analysis the researcher has chosen ‘Survey’, ‘Semi-Structured Interview’ and ‘Archival and Documentary’ methods to capture both broad and nuanced insights on professional values and engagement within the context of sustainable VBHC - this approach aligns with the author’s evaluation of philosophical position and the chosen position of pragmatism where multiple methods may be used in gathering data. This data will be from new and existing data sets or information already held by individual organisations which will need collecting and collating into data sets.

By combining strategies, allowing the researcher to go from the general high level qualitative analysis to a detailed validation via quantitative analysis will allow the author to drill down into specific areas as necessary and validate the findings in a mixed way.

3.6.3. Timeline

The two main elements to consider when examining the timeline of research are cross sectional studies or longitudinal studies - where cross sectional studies are conducted in a moment of time whereas longitudinal studies continue over time to revisit the data at regular intervals (Saunders et al., 2019). There has been some criticism of cross sectional research especially when it comes to the validity of this approach (Rindfleisch et al., 2008) versus that of longitudinal studies, as such the author will consider carefully the elements later of credibility. The author has chosen a cross-sectional timeline for this VBHC research to capture a snapshot of current professional values and engagement within healthcare and how these factors influence sustainable VBHC delivery. This approach aligns with the practical constraints of the study, as it allows the researcher to collect data at a single point in time, facilitating a timely analysis without requiring the extended resources needed for a longitudinal study.

3.6.4. Techniques, Instruments and Data Sources

The author will use archival documentation and content analysis for the systematic review and analysis of text and literature to enable the qualitative development of a conceptual framework. Secondary data such as government reports and literature will also be used to develop the framework and help answer the research questions.

To validate the conceptual framework developed through the qualitative analysis the author will make use of purposively selected 'Expert' interviewees to validate both the methodology used for its development and the conceptual framework itself. Semi-Structured interviews will be used to take the experts through the development and actual framework to enable them to review, critique and validate it before the author then finalises the framework for qualitative validation. As part of these interviews the author will develop interview guides and protocols as well as using audio/visual recording to enable and outputs from the interviews to be captured. Chapter 3.6.5 explores the selection approach and criteria for the 'Experts'. The quantitative validation will take place through a survey which will validate the elements of the conceptual framework with a wider population and end users who experience VBHC day to day. Part of the surveys will be the use of measurement scales including Likert scale as well as an introduction and survey guide.

3.6.5. Participation Strategy

The author will select participants that included appropriate coverage and diversity of professionals to allow for overall research quality assurance and to limit bias from a single profession or group. For the validation of the conceptual framework the author will use a number of 'expert' interviewees who will be selected to ensure there is a broad range of experts who will be able to critique and assess the proposed conceptual framework. These experts will be chosen based on them being experts in their fields and cover a number of field areas:

- Experience working in the NHS
- Experience of VBHC
- Experience in academia
- Experience in transformation and change
- Experience or organisational leadership
- Contribution to academic journals

For the quantitative validation and survey element of this study, populations of targeted participants will be chosen based on the geographical regions and samples from within those populations where they will be chosen randomly and outside of the control of the researcher. Broadcast invitation to participate will be made by individual organisational VBHC leads to any member of staff they are aware of being involved in or impacted by the implementation or delivery of VBHC within their organisation. The samples are not intended to be statistically rigorous (which is the positivist tradition) but to ensure a cross section of the practice of "professionals" employed in the NHS and to allow for generalisation from the results.

3.6.6. Data Analysis

The author will use thematic analysis to identify and analyse patterns or themes in qualitative data derived from the archival documentation, content analysis and secondary data gathered as part of the literature review to develop the conceptual framework. Thematic analysis will take place via data visualisation and undertaking thematic grouping using post 'it notes and brown paper to group and theme.

Descriptive statistical analysis summarising the quantitative data gathered from the surveys will be used to compare insights.

Structured Equation modelling was not used as this required calibrated questions and answer schemas derived from previous VBHC studies or questions drawn from closely associated subject areas. Given the immaturity of research in the VBHC field, these questions were not available. The researcher instead focused on the use the context richness of each respondent. The research approach and this limitation allows future researchers to close this gap and assess variations in VBHC practice in different settings. Although structured equation modelling would give a hierarchy of basic, then intermediate and then advance practices of themes, this doesn't help answer the research objectives and questions of this research which is context-rich abductive understanding of perceptions and practice.

3.6.7. Methodology, Research Strategies and Timelines Summary

In summary, the methodological design employs a mixed-method approach combining qualitative and quantitative data to provide a comprehensive understanding of the research question aligning with a pragmatic philosophy (Edmonds & Kennedy, 2017; Saunders et al., 2019) and is summarised in Figure 24. Data will be collected using both new and existing datasets. Qualitative analysis will involve archival documentation and content analysis with validation via expert interviews. These interviews will focus on refining the conceptual framework, drawing insights from experts in fields such as the NHS, VBHC and academia. For quantitative validation a survey will be conducted using Likert scales targeting end users of VBHC. Sampling will be random ensuring diverse participation and thematic analysis will be used to identify patterns in the qualitative data while descriptive statistics will summarise the survey results, offering robust validation of the conceptual framework.

A summary of the researchers chosen research design elements and rational can be found in Table 30.

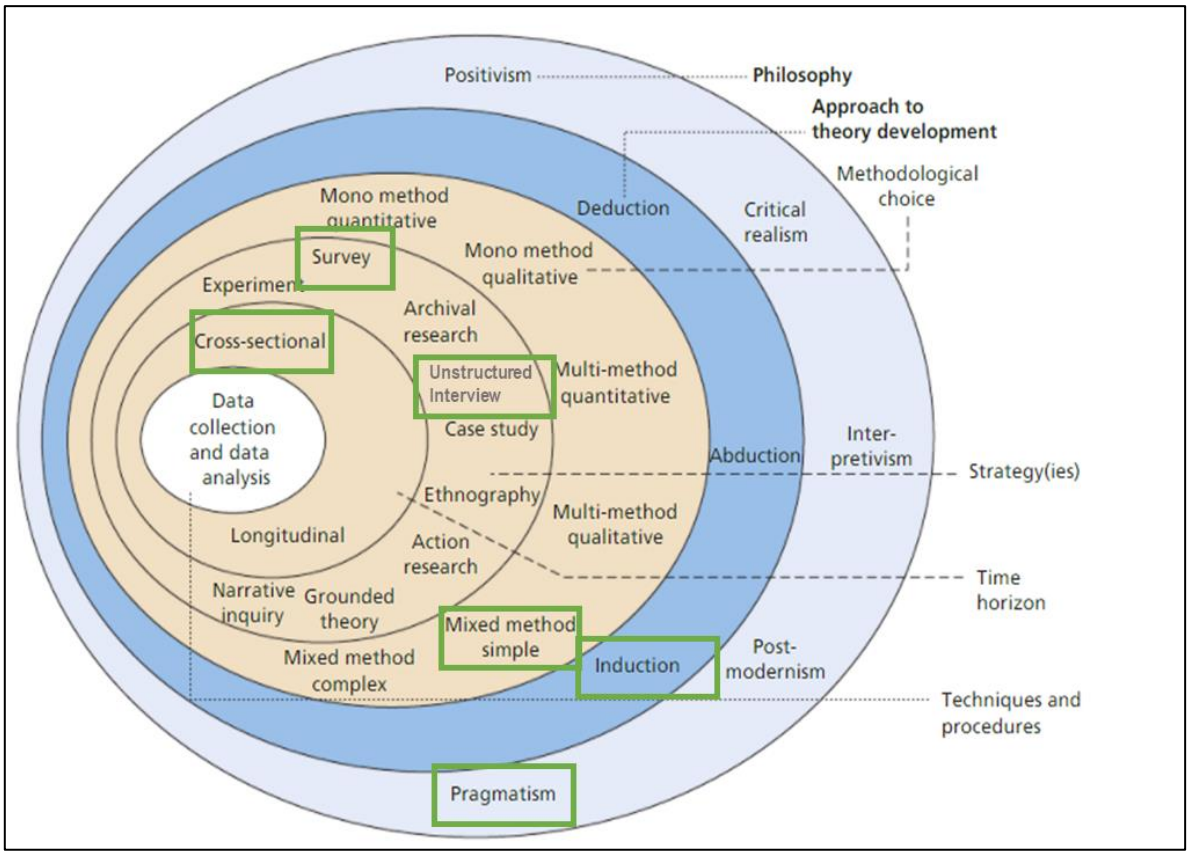


Figure 24 - Authors Research Onion Development - Methodological Choice, Strategy, Time horizon and Techniques (Source: Adapted from Saunders et al., 2019, p130)

RESEARCH DESIGN ELEMENT	ELEMENT CHOSEN	RATIONAL
Philosophy	Pragmatism	Pragmatism was selected because it supports a practical approach to knowledge aligning with the researchers aim of producing actionable insights and solutions.
Theory Development	Induction	Induction was chosen as the researcher is looking to build and develop a new theory or model, where data collection will be aimed at looking at the cultural and human factor phenomenon impacts on VBHC success and sustainability which can be tested through data.
Methodological Choice	Mixed Method Simple	Mixed method simple methodology will provide the opportunity to interpret results more broadly from both a quantitative and qualitative perspective providing a more comprehensive answer to the research question posed and as a method greatly aligned to the pragmatist viewpoint.
Research Strategy	Survey, Semi-Structured Interview & Archival Research	Methods chosen to capture both broad and nuanced insights on professional values and engagement within the context of sustainable Value-Based Healthcare.
Time Horizon	Cross Sectional	This approach aligns with the practical constraints of the study, as it allows the researcher to collect data at a single point in time, facilitating a timely analysis without requiring the extended resources needed for a longitudinal study.

Table 30 - Researchers Research Design Elements (Source: The Researcher - Marc Penny 2025)

3.7. Overall Research Framework

The author's overall research framework is grounded in a pragmatic philosophical approach focusing on practical outcomes that can be applied to real-world healthcare systems, particularly in the context of VBHC in the Welsh NHS. The framework integrates mixed methodologies employing both qualitative and quantitative data collection and analysis to explore how human factors, professional engagement and cultural elements influence the sustainable delivery of VBHC.

The research framework sets out the research questions which are around the concept of PV in sustaining VBHC and whether a distinct 'professional value' benefit domain should be included within the VBHC model. The authors research framework incorporates philosophical positions including ontology, epistemology and axiology to assess reality, knowledge and ethics within the research process while reflecting on various management philosophies. After evaluating these the author concludes that pragmatism best aligns with the research objectives supporting a methodologically flexible action-oriented approach. Theory development within the framework leans towards inductive reasoning to generate a new conceptual framework based on observed data. The research process is designed to be iterative with data collection and theory refinement occurring in parallel. The framework further breaks down into research strategies involving qualitative methods like case studies, archival analysis and expert interviews as well as quantitative approaches like surveys to validate the developed conceptual framework. The sampling strategy is designed to ensure diverse participation from professionals with varying expertise in VBHC, healthcare leadership and transformation. Data analysis will include thematic analysis for qualitative data and descriptive statistics for quantitative validation. Overall, the framework emphasises a structured, practical investigation into VBHC, aimed at delivering actionable insights for its sustainable implementation within healthcare organisations.

In conclusion the author has reviewed, assessed and where necessary critically evaluated a number of different elements which form an overall research strategy. Below is a visual diagram of the authors overall research strategy (Figure 25):

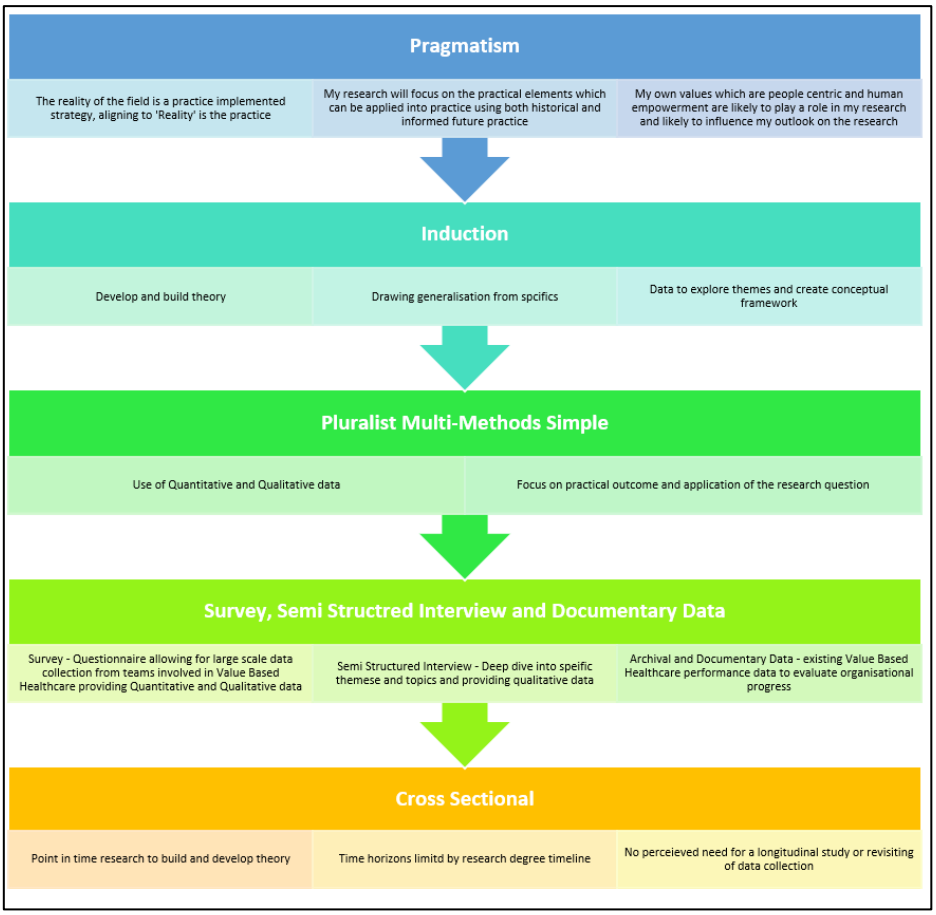


Figure 25 - Authors Overall Research Strategy Diagram (Source: The Researcher - Marc Penny 2025)

The author has explored the key elements of research design and methods of this study. There has been a clear narrative through previous chapters around the practical nature of the research and its application to real life context, thus in choosing a pragmatic philosophical position aligned with an inductive, pluralist multi-method approach the author believes this will provide the best overall strategy for answering the research question (Figure 26).

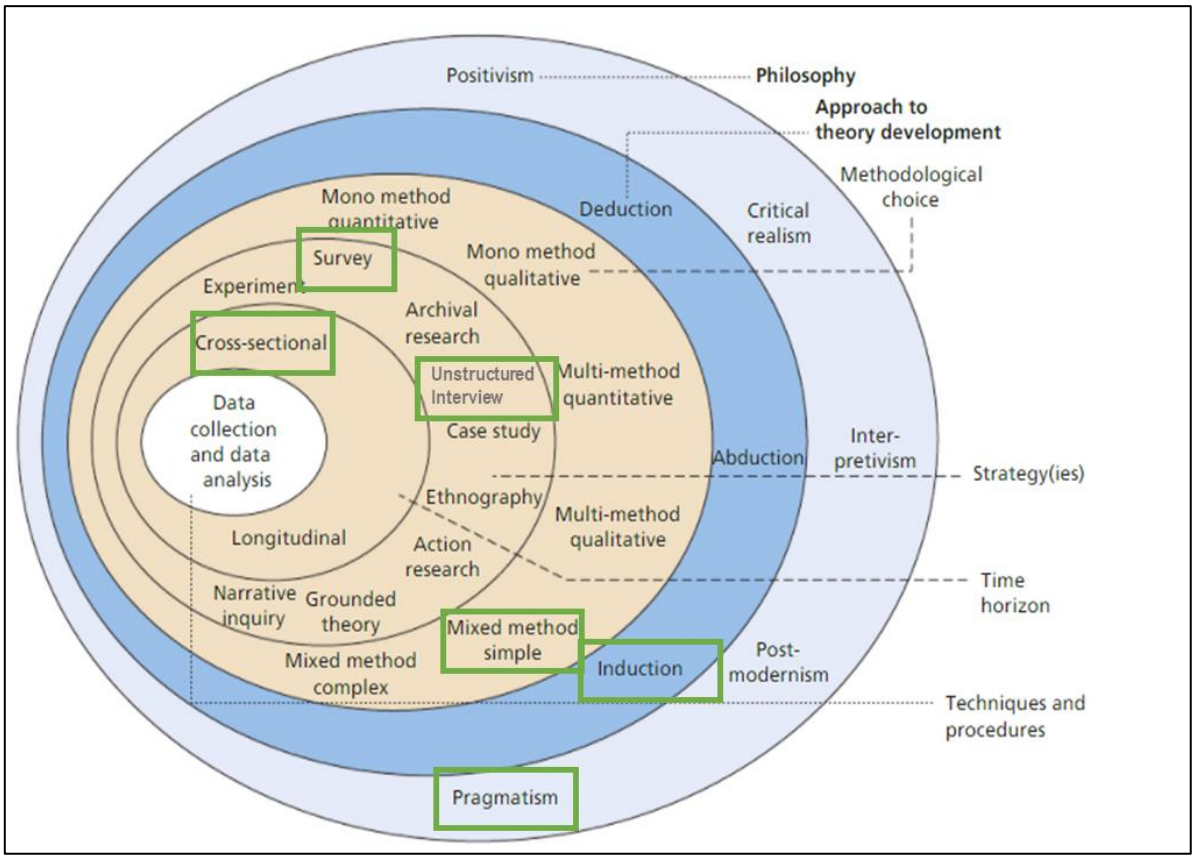


Figure 26 - Authors Research Onion Development Final (Source: Adapted from Saunders et al., 2019, p130)

3.8. Ethics and Procedures

The research is governed by both the University ethics approval process along with the Integrated Research Application System (IRAS) for approvals for health and social care / community care research in the U.K. which has been completed. Copies of the IRAS and University ethics approval can be found in Appendix B. Ethical and GDPR requirements have been reviewed and undertaken with no major issues identified.

No patient data sets will be used or developed as part of this research. All data will be anonymised prior to publication though schemas such as Organisation A, Organisation B, Organisation C etc or Individual A1, Individual A2, Individual B1 etc. Similarly, where surveys will be conducted, this will again be anonymised and evaluated at a broad population level to draw conclusions from. As part of the survey and expert interview, elements such as individuals right to withdraw or right to see what has been written will be built into the participant agreement sheet. This forms the basis of an agreement between the participant and researcher setting out what data will be collected, how the data will be used, details around data retention and destruction along with agreement for things such as recording of the interviews for data collation purposes.

3.9. Research Quality

As the author is intending to undertake a mixed method study resulting in qualitative and quantitative data then consideration must be given to both the reliability and validity of the quantitative elements as well as credibility, transparency and communicability for the quantitative elements.

3.9.1. Qualitative Trustworthiness - Credibility, Transparency and Communicability

For elements derived from qualitative data, ensuring that participants data, feedback and its interpretation are a true reflection of their meaning and match what they intended is vital when looking at ensuring credibility in research (Saunders et al., 2019). Using expert reviews help mitigate potential bias built into the data collection strategies, allowing participants to see what has been written and using confirmation with them to ensure their meaning has been interpreted as wanted and trying to avoid pre-conceived ideas or conclusions from the researcher. Ensuring truth, consistency and neutrality within the qualitative elements of the research will also help develop its wider credibility (Noble & Smith, 2015), which supports the credibility of the research.

The researcher has also taken into account the descriptive validity, interpretive validity, theoretical validity, generalisation to similar processes in similar healthcare settings and validation to provide reliability to the study (Hayashi et al., 2019).

3.9.2. Literature Review Quality, Credibility and Standing Analysis

To help assure literature quality and standing the author has compiled the amount of literature gathered and evaluated as part of this research by citation type in Table 31.

Citation Type	TOTAL	VBHC	Change Models and General Failure	Healthcare Change Failure	Healthcare General	Philosophy and Methodology	Professional Value
Book	**71**	7	24	3	7	18	12
Conference Proceedings	**1**	0	0	0	0	1	0
Electronic Article	**4**	4	0	0	0	0	0
Government Document	**1**	0	1	0	0	0	0
Journal Article	**188**	40	38	41	25	15	29
Report	**21**	12	0	1	7	0	1
Thesis	**1**	0	0	1	0	0	0
Webpage	**6**	0	0	0	4	1	1
TOTAL	**293**	**63**	**63**	**46**	**43**	**35**	**43**

Table 31 - Literature Review Sources by Type and Category (Source: The Researcher - Marc Penny 2025)

A full list of journals included in the literature review can be found in Appendix C – 'Literature Review Journal Article Scores and Ratings' detailing the number of articles from each journal and its associated AJG rating and Journal Citation Indicator (JCI) providing a view on citation quality and standing. A summary breakdown is shown in Figure 27 and Figure 28 where the count is number of articles.

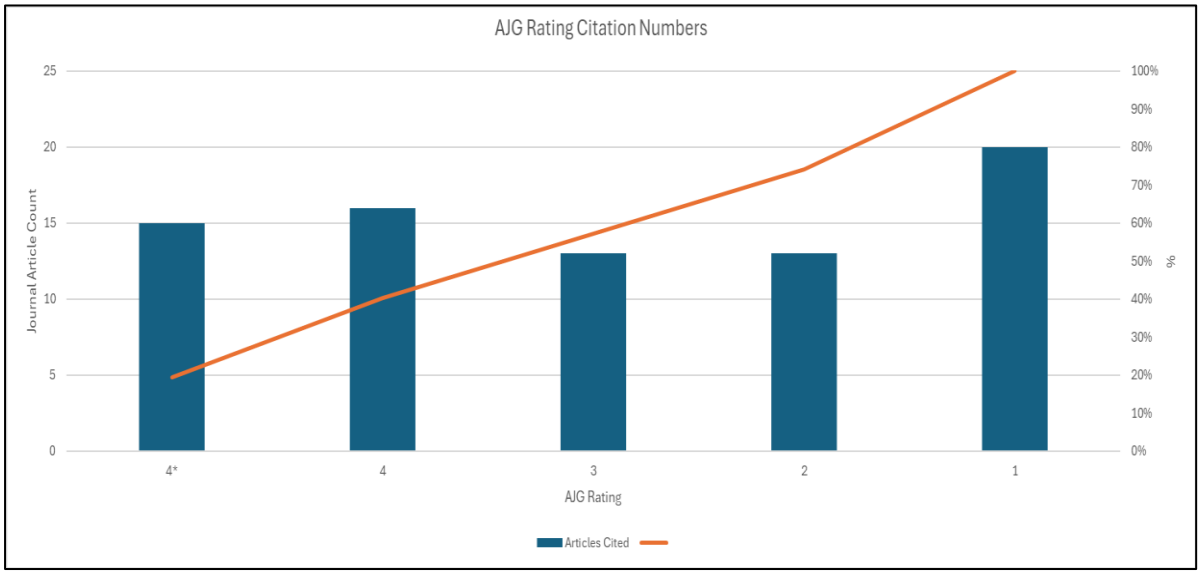


Figure 27 - AJG Rating Citation Numbers (Source: The Researcher - Marc Penny 2025)

The Academic Journal Guide (AJG) rating is a ranking system for business and management journals that helps researchers decide where to publish their work. The AJG is a guide from the Chartered Association of Business Schools (CABS) in England. The AJG ranks journals from 4* (the best) down to 1.

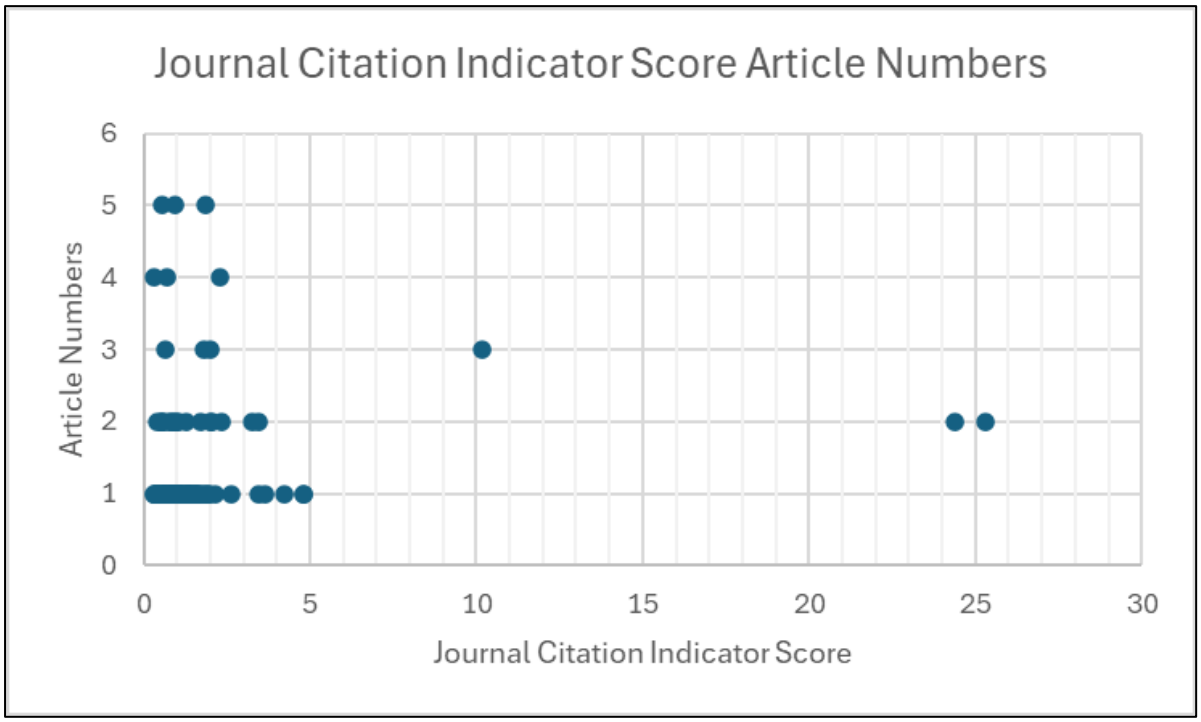


Figure 28 - Journal Citation Indicator Article Numbers (Source: The Researcher - Marc Penny 2025)

The Journal Citation Indicator is a measure of the average Category Normalised Citation Impact of citable items (articles & reviews) published by a journal over a recent three-year period. The Journal Citation Indicator (JCI) is a metric that measures a journal's citation impact relative to a global baseline:

- JCI of 1.0: The world average
- JCI higher than 1.0: Higher-than-average citation impact
- JCI lower than 1.0: Less than average citation impact

3.10. Limitations of the Study

The researcher acknowledges that all studies have limitations. The limitations of the study the author has identified are:

- Research is focused on publicly funded or majority public funded healthcare systems and does not cover those which are private insurance or out of pocket healthcare models
- The majority of the research is focused on UK healthcare systems however the author has also included one international comparison being Australia
- Generalisation will be limited to similar healthcare systems using similar process and organisational structures and using similar technology

- Generalisation will be limited to similar cultural systems and countries as cultural bias may affect generalisability
- Research taking during a period of significant challenge to all healthcare systems after emerging from COVID19 global pandemic and in the UK the result of the perceived 'austerity' in public spending since 2010 as a consequence of the financial crash

Another general limitation is associated with the researchers own potential bias and conflict due to their accountability for VBHC within their organisation. The author is likely to encountered some informant bias and such bias will b~~een~~ minimised by the design of each of the study phases.

There are a number of issues that can be associated with workplace research that the author will have to be mindful of:

- Undertaking research in the workplace as opposed to a laboratory poses a number of challenges that the author will need to address throughout the research including:
    - Less control
    - Human factors
    - Respondent interpretation
    - Respondent can be impacted by external factors
    - Respondent can be impacted by workplace factors
- The researcher may be known to the respondents which may impact positively or negatively on responses or feel influenced by the researcher
- Respondents may be within the line management or span of control of the researcher
- Respondents may fear be open and honest or feel they me be identifiable through the research
- Researchers and respondents may be mindful of professional / career impacts

Within the NHS there is a stringent ethics process so this along with the university's ethics approval helps ensure ethical standards and boundaries are maintained.

The above limitations are understood and accepted by the author although they will be considered and where suitable mitigated against as far as practical.

3.11. The Research Process

The author's philosophical position and research strategy are rooted in a pragmatic approach, emphasising the practical application of research findings to real-world healthcare settings, particularly the NHS in Wales.

The below provides an overview of the key process and phases (Figure 29) the author designed for this research:

PHASE 1A: LITERATURE REVIEW AND DESKTOP EXERCISE

- Undertake a full literature review based on the authors research spheres (Change Models - Success & Failure in Organisations, Previous Health Services changes and their sustainability and VBHC development and adoption)
- Undertake a literature review on concepts such as Professional Value and Socio-technical theory
- Undertake a key word search using iFind as the main search engine
- Review journals, books and grey literature
- Dates: From 1950s but focal literature is from year 2000s to present
- Litmaps App (Citation genealogy visualisation)

OUTPUT – Reflection and refinement of research question with links to the literature and key works. Identification of any gaps and thematic development of change failure. Identification of key themes and topics to be tested as part of the research.

PHASE 1B: CONCEPTUAL FRAMEWORK DEVELOPMENT

INPUTS – Key themes and topics derived from literature review spheres of influence, gaps and themes

- Literature gap analysis
- Qualitative thematic analysis from literature review
- Development of draft conceptual framework

OUTPUT – Thematic analysis and draft conceptual framework.

PHASE 2A: SEMI-STRUCTURED INTERVIEW EXPERT REVIEW

INPUTS – Draft conceptual framework

- Identify who to take part and selection criteria
- Identify how to recruit participants

- Interview protocols and consent
- Undertake semi-structured interviews

OUTPUT – Validated conceptual framework

PHASE 2B – PILOT QUESTIONNAIRE WITH EXPERTS

INPUTS – Conceptual framework and key themes

- Develop draft questionnaire based on literature and spheres of influence key findings and topics from the conceptual framework
- Develop draft questionnaire deployment and collection method and pilot group including selection of experts. Expert review criteria:
    - People with 5 years plus experience of NHS
    - VBHC pioneers and those accountable for its delivery within organisations
    - People with published articles on VBHC
- Gather feedback on questionnaire, data collection method, understanding and update questionnaire

OUTPUTS – Finalised questionnaire and questions

PHASE 2C: QUESTIONNAIRE WITH VBHC COMMUNITY

INPUTS – Conceptual framework and final questionnaire questions

- Identify who to take part and selection criteria i.e. local delivery teams in health organisations
- Identify how to recruit participants
- Measurement scales i.e. Likert scale questionnaire (1 to 5)
- Data tables, statistical analysis & some thematic (quantitative data with some qualitative free text)

OUTPUT – Qualitative and quantitative data and further areas for focus to include in semi-structured interview sessions

PHASE 3: RESULTS AND FINDINGS

INPUTS – Conceptual framework and all data outputs from survey questionnaires and semi-structured interviews along with literature review material. All Wales Health Boards VBHC maturity self-assessment.

- Develop final conceptual framework
- Undertake quantitative and qualitative analysis (Cross case data displays, thematic patterns and divergence points of view)

- Display of data (charts, data tables etc)
- Identification of limitations such as a focus on Wales, NHS context of COVID and austerity etc
- Generalisation, Reliability & Validity, Credibility, Transparency and Communicability

OUTPUT – Authors VBHC conceptual framework and research findings

PHASE 4: DISCUSSION AND CONCLUSIONS

INPUTS – Conceptual framework, analysis and findings along with literature review material

- Ability to have answered the research question(s) posed
- Presentation of finalised conceptual framework
- Conceptual framework viewed through socio-technical theory lens
- Other questions posed as a result of this research and identification of further areas of study
- Identification of limitations such as a focus on Wales, NHS context of COVID and austerity etc

OUTPUT – Conclusion to the research question(s) and areas for further study

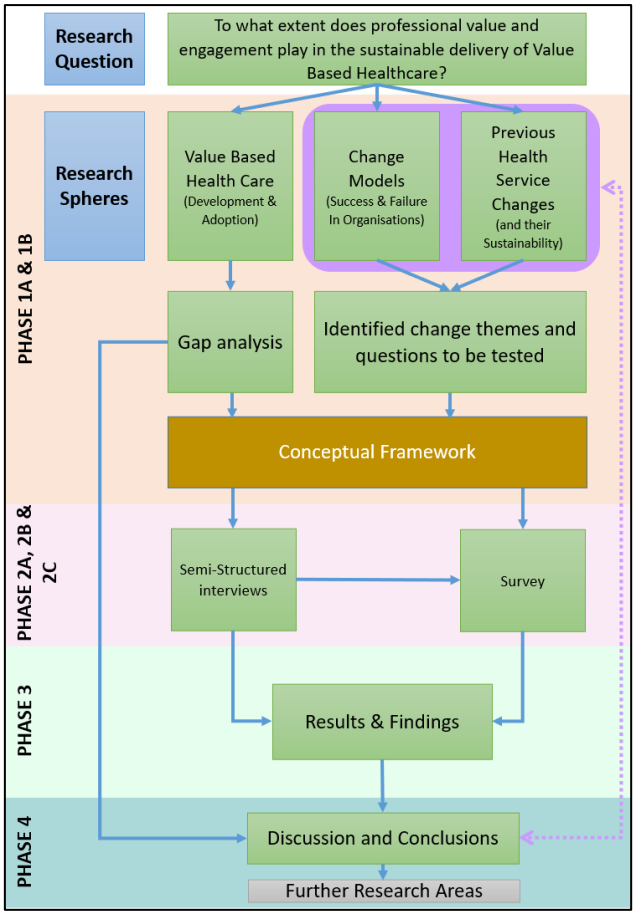


Figure 29 - Authors Research Flow and Phases (Source: The Researcher - Marc Penny 2025)

The researcher has completed phase 1a the literature review and desktop exercise and phase 1b the conceptual framework development, and delivered outputs including the key failure themes, conceptual framework and conceptual framework visualisation.

3.12. Conceptual Framework Expert Review and Refinement - Semi-Structured Interview Design

The expert interviews will help the author validate the methodology used in the authors conceptual framework development, test the logic followed and deliver the requirements for the authors research phase 2A: 'Semi-Structured Interview Expert Review', resulting in a validated conceptual framework. The interviews will provide an opportunity for the author to receive feedback from specialists with in-depth knowledge and experience in the field of VBHC, healthcare, academia and transformation, helping to ensure the robustness of the process the author has followed in the conceptual framework development. The author will use the experts to assess the logic that the author has followed in constructing the conceptual framework, identifying any weaknesses or gaps that may not have been identified.

The expert interviews also provide the ability to check the actual relationships proposed by the author, their direction and help build a consistent validation of the conceptual framework itself. The experts chosen can help assess whether the framework is comprehensive or if any elements are missing.

The expert interviews will help strengthen both the authors conceptual framework and research as a whole by providing an extra level of rigor and expert critique. This validation will help ensure that the framework is not only theoretically sound from an academic perspective but also suitable for practical use within healthcare organisations.

3.12.1. Semi-Structured Interview Experts

The experts the author has selected have a significant amount of combined experience across VBHC, academia, healthcare and transformation with a mix of leaders and non-leaders selected (Table 32).

	Professor Sally Lewis	Rhian Hamer	Professor Hamish Laing	Professor Nicholas Rich	Navjot Kalra	Doctor Tom Howson	Doctor Alice Andrews	Magda Golebiowska	Simon Mansfield
Experience of working for the NHS in the UK?	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
- How many years' experience?	30	3	38	24	9	4		7	20
Experience of Value Based Healthcare (Strategy, Policy, Research or Delivery)?	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
- How many years' experience?	11		8	6	5	4	15	2	5
Experience of working in Academia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
- How many years' experience?	6	10	9	34	5	8	25		5
Experience of working in a Transformation of Change role?	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes
- How many years' experience?	15	25	20		25	5		3	15
Leadership experience in an organisation(s)?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
- How many years' experience?	8	15	20	7	10	3	15	10	27
Named as an author, joint author or contributor to any journal articles or books with a focus on Value Based Healthcare?	Yes	No	Yes	Yes	No	No	Yes	No	No
Named as an author, joint author or contributor to any journal articles or books with a focus on People or Change?	No	Yes	No	Yes	No	Yes	Yes	No	No

[12]

Table 32 - Conceptual Framework Expert Interview Credentials (Source: The Researcher - Marc Penny 2025)

These experts have combined experience of over 135 years working in the NHS, 56 years' experience of VBHC, 102 years working in academia and 108 years working in transformation and change. Additionally, there is substantial leadership experience and journal authors - with 4 of the experts having authored VBHC articles and 4 authoring people or changed focused articles. Full biographies of the experts can be found in Appendix D – Conceptual Framework Expert Reviewers Personal Biographies.

3.12.2. Semi-Structured Interview Format

For the expert interviews the author will write to each interviewee individually to invite them to participate. If they agree then each participant will be sent instructions along with the research protocol, details can be found Appendix E - Qualitative Semi-Structured Interview Invite Cover Letter and Procedures. The interviews are expected to last approximately 40 - 60 minutes with all interviews recorded using an audio recording device and transcribed for analysis, these recordings and transcriptions will be destroyed once they have been used for the purposes of this research

[12] The researcher has included in their expert interviewees Professor Nicholas Rich who is the researchers' academic supervisor for this work. They were included as the number of experts in this field is limited and their contribution showed no bias or outlier data as a result. It was important to keep this data to add value to the thesis as an expert in the field.

The identity of participants will be kept confidential to the extent provided by law. Each participant will be assigned a code number. The list connecting the participants name to this number will be kept in a secure file, on a secure server. When the study is completed and the data has been analysed, the list will be destroyed (within 6 months of project closure).

Each expert will be asked to agree to providing their name and a short bio to be included in the research to help 'qualify' the experts used. Participation in the study is completely voluntary and there will be no penalty for not participating. In addition, during the interview, participants will have the right to waive any question they do not want to answer and have the right to withdraw up until the point of research publication.

The author has produced a presentation pack to aid with the interview and to ensure a flow to them and that the key aspects are covered, Appendix F – Qualitative Semi-Structured Interview Pack. The author will introduce the expert to the research and research questions, cover the research spheres of influence and the key literature gaps identified. The author will then talk through the development of the failure themes, conceptual framework themes and how the conceptual framework was developed. During the interview the author will check for the following from the expert participants:

- Their understanding of the methodology the author has used to develop their research and development of the conceptual framework
- That they understand the logic the author has used in its development and agreement that the logic is sounds
- Any areas the experts feel hasn't been covered or any steps missed in the conceptual framework development

These questions will help assure the validity of the framework in both its method of development and relational dimensions. The author will also during the interview ask the expert to validate the VOXI analysis, given the size of the VOXI each expert will be asked to validate different sections of the VOXI, with all relationships being individually validated by at least 3 experts.

At the completion of this research phase the author hopes to have validated the development of and the content of their conceptual framework.

3.12.3. Conceptual Framework Expert Review and Refinement Semi-Structured Interview Design Section Conclusion

The experts selected by the author have a collective experience of over 135 years in various aspects of healthcare and academia and will provide a rigorous review to ensure that the authors framework is validated. The expert interviews serve a key role in refining the author's conceptual framework by providing specialised knowledge and validating its development and practical applicability in healthcare. Using their extensive combined experience the research will benefit from enhanced credibility and robustness ensuring that the framework is both theoretically sound and practically viable. Once the semi-structured interviews have been undertaken the findings will be provided in chapter 4 and discussed in chapter 50, completing the authors research phase 2A: Semi-Structured Interview Expert Review, and provide an output of a validated conceptual framework.

3.13. Questionnaire Design

This section will develop the authors research phase 2B – Pilot Questionnaire with Experts, and after undertaking a pilot of the questionnaire with a group of experts deliver a finalised questionnaire and question set for the quantitative analysis. The questionnaire will provide primarily quantitative data with a small amount of qualitative insight and will be designed to test the authors conceptual framework developed out of the qualitative analysis from the literature review. In designing the survey and questionnaire element the author has started with investigating what makes a good questionnaire design to enable the right data to be collected from the right people in the right format to be able to undertake analysis (*06 Writing and Effective Questionnaire*, 2018).

3.13.1. Questionnaire Areas to Provide Insight into Conceptual Framework & Links to Literature Themes

To further validate the authors conceptual framework and help answer the authors research questions it will be important to demonstrate a clear link between the literature review 'failure themes' and 'conceptual themes' within the framework, the authors conceptual framework and the questions asked as part of the survey questionnaire, showing they are clearly linked and aligned. The failure themes and conceptual framework themes developed by the author have been used to develop specific questions which will test these themes in relation to VBHC, the authors conceptual framework and the research question (Table 33).

The author has developed the survey question set for the questionnaire by initially drafting key questions that would be needed to test each failure theme. The author then used the *'Handbook of Metrics for Research in Operations Management: Multi-item Measurement Scales and Objectives Items'* to identify well-established and rigorously tested questions, and associated scales that will enhance the reliability and validity of data collection as part of the authors research (Roth, 2008). The author used this resource to identify comparable questions aligned to their draft questions to help ensure that the questions and measures provide consistency across studies, thus aiding reliability & validity. The researcher tailored the questions to the context of VBHC and Table 33 shows the original handbook question and the contextualised authors question. Taking this approach will help improve the credibility and trustworthiness of the authors research findings as the use of questions and validated scales reduces potential bias and error for the author.

Where there are no comparable questions within the '*Handbook of Metrics for Research in Operations Management: Multi-item Measurement Scales and Objectives Items*' the author has developed their own questions. These are a mix of individual questions along with a number of multi-theme questions. Again to help improve reliability the author has aimed to ask at least 2 questions per failure theme to aid triangulation and validity.

Conceptual Framework Theme		**Failure Themes**		**QUESTIONS**		
				Multi Theme Question **Q -** Does being involved in delivering and or supporting Value Based Healthcare provide you with: **Q -** Should being involved in delivering and or supporting Value Based Healthcare provide you with:	**Handbook of Metrics for Research in Operations Management: Multi-item Measurement Scales and Objective Items**	**Authors Own Questions**
CFT1	Engagement	FT1	Not feeling part of a movement	-	-	Q - Using any number from 0 to 10, where 0 is not at all and 10 is fully, how much do you feel a part of a movement or community of Value Based Healthcare?

Conceptual Framework Theme		Failure Themes		QUESTIONS		
				Multi Theme Question **Q -** Does being involved in delivering and or supporting Value Based Healthcare provide you with: **Q -** Should being involved in delivering and or supporting Value Based Healthcare provide you with:	**Handbook of Metrics for Research in Operations Management: Multi-item Measurement Scales and Objective Items**	**Authors Own Questions**
CFT1	Engagement	FT2	Lack of direct engagement with change	-	Handbook of metrics for research in operations management: Hays and Hill Q 4: Our employees feel a strong sense of accountability and ownership for service quality. (7-point likert scale) **Research Contextual Revised Question -** Employees feel a strong sense of accountability and ownership for Value Based Healthcare	Q - My organisation values my opinion on delivering Value Based Healthcare
CFT1	Engagement	FT3	Lack of recognition or reward	Motivation to do my job?	-	Q - I am recognised for my work and contribution to delivering Value Based Healthcare Q - I am rewarded for my work and contribution to delivering Value Based Healthcare Q - I am not recognised for the work and effort I put into delivering Value Based healthcare
CFT1	Engagement	FT4	Poor / Top-down communications	-	Handbook of metrics for research in operations management: Escrig-Tena and Bou-Llusar Q 18: Internal communication is totally open and transparent. (7-point likert scale) **Research Contextual Revised Question -** Internal Value Based healthcare communication is totally open and transparent	Q - I receive regular communications in relation to Value Based Healthcare
CFT1	Engagement	FT5	Poor leadership	-	Handbook of metrics for research in operations management: Anderson, Rungtusanatham, Schroeder, and Devaraj Q 3: Out top management strongly encourages employee involvement in the production process. (5-point likert scale) **Research Contextual Revised Question -** Leadership strongly encourages involvement in Value Based Healthcare	Q - There is clear Value Based Healthcare leadership in my organisation

Conceptual Framework Theme		Failure Themes		QUESTIONS		
				Multi Theme Question **Q -** Does being involved in delivering and or supporting Value Based Healthcare provide you with: **Q -** Should being involved in delivering and or supporting Value Based Healthcare provide you with:	**Handbook of Metrics for Research in Operations Management: Multi-item Measurement Scales and Objective Items**	**Authors Own Questions**
CFT1	Engagement	FT6	No visible leadership	-	Handbook of metrics for research in operations management: Cua, McKone, and Schroeder Q 6: Plant management is personally involved in quality improvement projects. (Likert scale) **Research Contextual Revised Question -** Managers are personally involved in Value based Healthcare	-
CFT2	Individual Consequence	FT7	Poor career opportunities	Career development?	-	Q - The skills and knowledge I have gained through Value Based Healthcare will benefit me in career progression Q - There are no opportunities to progress my career within Value Based Healthcare
CFT2	Individual Consequence	FT8	Poor job satisfaction	Improved job satisfaction?	-	Q - Delivering Value Based Healthcare adds stress to my job Q - Delivering Value Based healthcare activities take me away from the important aspects of my job
CFT2	Individual Consequence	FT9	Poor personal satisfaction	Personal satisfaction?	-	Q - I feel a sense of pride in delivering Value Based Healthcare Q - I feel a sense of accomplishment when delivering Value Based Healthcare work

Conceptual Framework Theme		Failure Themes		QUESTIONS		
				Multi Theme Question **Q -** Does being involved in delivering and or supporting Value Based Healthcare provide you with: **Q -** Should being involved in delivering and or supporting Value Based Healthcare provide you with:	**Handbook of Metrics for Research in Operations Management: Multi-item Measurement Scales and Objective Items**	**Authors Own Questions**
CFT2	Individual Consequence	FT10	Poor working environment	Improved working environment?	-	Q - My working conditions and environment make it difficult to deliver what's expected of me Q - My working environment enables me to deliver at my best
CFT3	Ownership	FT11	Not integral to the role	-	-	Q - Do you see Value Based Healthcare as part of your job and integral or separate and an additional activity? Q - Is the delivery of Value Based healthcare built into your day-to-day job? Q - I am provided with specific objectives relating to Value Based Healthcare
CFT3	Ownership	FT12	Loss of control	Control over your work?	-	Q - I feel I have control and input into the delivery of Value Based Healthcare within my area. Q - I don't feel involved with Value Based healthcare activities which affect me.
CFT3	Ownership	FT13	Not being allowed to make mistakes and learn from them	-	-	Q - I am allowed to make mistakes and learn from them Q - My manager encourages me / my team to learn from past experiences Q - I can provide feedback on Value Based Healthcare activities
CFT3	Ownership	FT14	Not involved in decision making	Empowerment to make decisions?	-	Q - I am involved in decisions relating to Value Based Healthcare activities which affect me Q - I have no ability to input into decisions relating to Value Based Healthcare and my areas of work

Conceptual Framework Theme		Failure Themes		QUESTIONS		
				Multi Theme Question **Q -** Does being involved in delivering and or supporting Value Based Healthcare provide you with: **Q -** Should being involved in delivering and or supporting Value Based Healthcare provide you with:	**Handbook of Metrics for Research in Operations Management: Multi-item Measurement Scales and Objective Items**	**Authors Own Questions**
CFT4	Shared Aims	FT15	Lack of vision, context and certainty	-	Handbook of metrics for research in operations management: Ahmad and Schroeder (2003); and Anderson, Rungtusanatham, Schroeder, and Devaraj Q 44 and Q 7: In our plant, goals, objectives, and strategies are communicated to me. (5-point likert scale). **Research Contextual Revised Question -** In our organisation Value Based Healthcare goals, objectives, and strategies are communicated to me	Q - I understand why we are undertaking Value Based Healthcare activities
CFT4	Shared Aims	FT16	Poor or unclear expectations	-	Handbook of metrics for research in operations management: Escrig-Tena and Bou-Llusar Q 6: All the members of the firm have a clear idea about what is expected of them, making their contribution to the company as beneficial as possible (7 point likert scale) **Research Contextual Revised Question -** All the members of the team have a clear idea of what is expected of them in relation to Value Based Healthcare, making their contribution to the organisation as beneficial as possible	Q - I understand my role in supporting delivery of the organisations Value Based Healthcare vision

Conceptual Framework Theme		Failure Themes		QUESTIONS		
				Multi Theme Question **Q -** Does being involved in delivering and or supporting Value Based Healthcare provide you with: **Q -** Should being involved in delivering and or supporting Value Based Healthcare provide you with:	**Handbook of Metrics for Research in Operations Management: Multi-item Measurement Scales and Objective Items**	**Authors Own Questions**
CFT4	Shared Aims	FT17	Unclear benefits or aims	-	-	Q - Rank the below Value Based Healthcare benefit areas in order of how you see their importance? - Allocative Value - Technical Value - Personal Value - Societal Value Q - Rank the below Value Based Healthcare benefit areas in order of how you believe your organisation see's their importance? - Allocative Value - Technical Value - Personal Value - Societal Value Q - What words would you use to describe what Value Based Healthcare means to you?
CFT5	Skills & Capacity	FT18	Lack of training or skills	Skills development?	Handbook of metrics for research in operations management: Anderson, Rungtusanatham, Schroeder, and Devaraj Q 17: Employees receive training to perform multiple tasks. (5-point likert scale). **Research Contextual Revised Question -** Employees receive training to perform Value Based Healthcare activities	-
CFT5	Skills & Capacity	FT19	Not enough time or resources	-	Handbook of metrics for research in operations management: Gilgeous Q 30: Lack of resources is a major source of plan/project failure. (6-point likert scale) **Research Contextual Revised Question -** Lack of resource is a major source of Value Based Healthcare failure	Q - I am given the time to undertake Value Based Healthcare activities

Conceptual Framework Theme		Failure Themes		QUESTIONS		
				Multi Theme Question **Q -** Does being involved in delivering and or supporting Value Based Healthcare provide you with: **Q -** Should being involved in delivering and or supporting Value Based Healthcare provide you with:	**Handbook of Metrics for Research in Operations Management: Multi-item Measurement Scales and Objective Items**	**Authors Own Questions**
CFT5	Skills & Capacity	FT20	Not understanding terminology or shared language	-	-	Q - I understand the language used and its terminology in Value Based Healthcare Q - People in the organisation understand what is meant by Value Based Healthcare Q - I understand the language used in meetings and discussion around Value Based Healthcare

Table 33 - Pilot Questionnaire Mapped to Change Failure Themes (Source: The Researcher - Marc Penny 2025)

In addition to the mapped questions in Table 33 to individual failure themes the author also believes it is important to understand if people see VBHC as a one-off activity and if they believe VBHC provides value to themselves, building on the concept of 'professional value'. The author proposes asking two additional questions:

- Please describe what value you believe being involved in Value Based Healthcare gives you (if any), describe in a few sentences or provide some reflective words.
- Do you believe Value Based Healthcare work is a one-off project activity or something which will be continuously delivered within your role?

3.13.2. Questionnaire Design and Accessibility

The author has undertaken research and reading to ensure elements such as language, look & feel and style as well as question design, answer schemas and accessibility issues are addressed (Clark et al., 2021; Saunders et al., 2019) and as discussed in section 3.13.1 validated where possible with established questions and scales (Roth, 2008). To assist with the survey questionnaire design the author has made use of a professional online survey tools 'SurveyMonkey', making use of the tools support functions which provide standard and recognised question formatting, answer schemas, statistical analysis and data outputs. The use of this tool also supports with the elements of reliability and validity along with helping with data quality and accessibility. Designing out and taking account of elements such as participant error, participant bias and researcher error has been considered by the

author. Participant error is where the participant potentially misunderstands the question being asked or the answer schema being used, to mitigate this the author will pilot the survey first to help reduce any potential error. Participant bias can arise when respondents provide answers, they believe are acceptable or that they think the researcher or their organisation wants to hear. To help mitigate this the author will ensure anonymity and ask respondents to answer honestly. Additionally, the author will test each failure theme with at least two questions to help triangulation of results. Researcher error including errors in the construction or administration of the questionnaire can potentially affect the results of the research. By using 'SurveyMonkey' and piloting the questionnaire with experts the author aims to reduce this potential error.

Question Types and Response Types

The author has considered the types of questions to be used within the pilot questionnaire and ensuring that the right questions are asked to support answering the research question and further validating the authors conceptual framework. Design considerations include:

- Avoiding phrasing questions in the negative
- Avoiding leading questions
- Avoiding double barrelled questions
- Using a mix of open and closed questions
- Using response schemas such as Likert scale, bi-polar scale (two polar opposites), ranking / rating and free

As part of the pilot of the questionnaire the author will seek cognitive testing of the questions by the expert review group prior to the questionnaire being finalised and going live the questions along with the response schemas.

The author has also included in the questionnaire, filtering or categorisation questions to allow for analysis based on a number of categories, these include:

- Organisation the participants works for
- Role within the organisation
- Whether they provide services directly to patients

Accessibility, Look & Feel

The author will seek to ensure that the questionnaire is engaging, interesting and succinct to help aid response rate and completion rates across a broad range of respondents who may have limited time to complete. Using 'SurveyMonkey', respondents will also have the ability to part complete and come back to the questionnaire later which may slightly increase full response rates. Design principles such as keeping language simple and avoiding jargon, explaining where needed any key themes or concepts, ensuring a clear presentation of the questions and clear instructions will help improve elements around completion rates, reliability and validity of responses.

The survey will be available and tailored by 'SurveyMonkey' for use on a desktop, tablet or mobile helping participants complete the questionnaire when convenient for them.

Reliability

To assist with reliability such as testing a respondents understanding of the question and providing a consistent response back as other respondents interpretation, the use of experts to review the questionnaire prior to it being finalised will support and improve reliability (Saunders et al., 2019). Supporting reliability the author will be asking a number of questions around the same 'Failure Themes' identified in a different way allowing for reliability checking (Jenn, 2006) and internal consistency checking (Clark et al., 2021; Saunders et al., 2019) along with using previously validated questions and scoring schemas.

Validity

Validity concerns itself with the ability of the survey to capture and measure what is needed to answer the research question(s) (Saunders et al., 2019) and accurately captures what is required. To assist in ensuring measurement validity the author has sort as part of the pilot to receive feedback from a range of individuals including academic and VBHC experts (Bell et al., 2022) enabling testing that the questions are phrased in a way that respondents understand (Jenn, 2006). This approach also helps with other areas of validity such as content validity by using a mix of different questions and also answer schemes to allow for evaluation and assessment of construct validity. Additionally, the author has built the 'SurveyMonkey' questionnaire to change the display order of questions and some of the answer schemas to avoid response bias by the formatting and order of questions and answers.

Credibility, Trustworthiness, Transparency and Communicability

For elements derived from qualitative data, ensuring that participants data, feedback and its interpretation are a true reflection of their meaning and match what they intended is vital when looking at ensuring credibility in research (Saunders et al., 2019). Although phase 2C: Questionnaire with VBHC Community, mainly focuses on qualitative data derived from the questionnaire survey there will be some elements of quantitative data from free text responses and as part of phase 2A: Semi-Structured Interview Expert Review. For these elements then the author will give consideration to credibility, trustworthiness, transparency and communicability (Guba & Lincoln, 1994).

The final pilot survey including its look and feel can be found in Appendix G - Quantitative Questionnaire Pilot Questions.

3.13.3. Questionnaire Participants and Expert Reviewers

For research phase 2B – Pilot Questionnaire with Experts the author has selected 8 'experts' to undertake the pilot of the questionnaire survey and provide feedback. These individuals have been drawn from a range of organisations and roles to allow for full evaluation of the pilot questionnaire and feedback to improve the final research data's validity, reliability along with its wider generalisability.

The pilot questionnaire was completed by the following 8 respondents (R1, R2, R*n*) across 2 x Welsh organisations including the Welsh National Value In health Centre and an academic institution (Table 34):

R#	Healthcare	Academic	Deliver services directly to patients	VBHC Experience	Role
R1	Yes	No	No	Yes	Admin
R2	No	Yes	No	No	Academic
R3	Yes	No	No	Yes	Finance
R4	Yes	No	Yes	Yes	Nursing
R5	Yes	No	No	Yes	Admin
R6	Yes	No	No	Yes	Project Management
R7	Yes	No	No	Yes	Admin
R8	Yes	Yes	No	Yes	Strategy / Senior Leadership

Table 34 - Pilot Questionnaire Expert Reviewers Sills and Experience (Source: The Researcher - Marc Penny 2025)

Participants were chosen to ensure a representative sample of respondents required to complete the full questionnaire as well as expert input from academia, VBHC expertise and VBHC deliver experts. These people have been accessed via existing VBHC networks within NHS Wales.

Participants were asked to complete the pilot questionnaire electronically using SurveyMonkey with instructions as part of the questionnaire introduction which also covered ethics, data protection and assumed consent to participate.

For the finalised questionnaire survey the author will produce a generic communication which will be shared amongst VBHC leads in each of the Welsh NHS organisations as well as NHS Scotland and the Australian Centre for Value Based Healthcare / wider Australian Healthcare Organisation (Appendix H - Quantitative Questionnaire Invite Cover Letter for VBHC Leads). This spread of participation across the UK geographical regions and the inclusion of Australia will provide the ability to gather insights from a range of organisations and slightly differing healthcare settings. The healthcare leads will then broadcast out participation invites to their VBHC networks. The author intends to continue with promotion and cascade of broadcast messages until response saturation is reached and no further respondents are yielded as part of broadcast communications. As the questionnaire is a voluntary survey then consent will be assumed, and at the start of the survey details on protocol and confidentiality will be provided (Appendix I - Quantitative Questionnaire Procedures).

3.13.4. Questionnaire Pilot and Refinement

As part of the pilot questionnaire each section has an additional question to gather feedback on the ease of use, understanding, functionality of the questionnaire and any additional comments for consideration. The mix of participants including experts from VBHC and Academia in the pilot has enabled a range of feedback to be collected and considered. The feedback is detailed below (Table 35) along with the authors proposed response:

FEEDBACK NUMBER	PILOT SURVEY SECTION	PILOT SURVEY FEEDBACK	RESPONSE
FB1	Section 1 - Survey introduction	Consider adding in length of service for NHS employees	Accept - Incorporate into main survey
FB2	Section 1 - Survey introduction	Provide more context for the survey	Accept - but limited. See below
FB3	Section 2 - VBHC and individuals own perspective	Provide more context for the section	Accept - but limited. See below
FB4	Section 2 - VBHC and individuals own perspective	Q5 - Instead of forcing a ranking allow to select equal ranking	Accept - Incorporate into main survey
FB5	Section 2 - VBHC and individuals own perspective	For Likert scale answers consider providing N/A for people	Accept - Incorporate into main survey
FB6	Section 3 - VBHC and the individuals perspective on the organisation	Q12 - Add in an option of 'No concept'	Accept - Incorporate into main survey
FB7	Section 3 - VBHC and the individuals perspective on the organisation	Q12 - Instead of forcing a ranking allow to select equal ranking	Accept - Incorporate into main survey
FB8	Section 3 - VBHC linked to change failure themes	Q14 - Add a sub question relating to leadership embedding VBHC	Accept - Incorporate into main survey
FB9	Section 3 - VBHC linked to change failure themes	Q17 - Ensure Likert scale goes left to right towards engagement	Accept - Incorporate into main survey
FB10	Section 3 - VBHC linked to change failure themes	Q18 - Ensure Likert scale goes left to right towards engagement	Accept - Incorporate into main survey
FB11	Section 3 - VBHC linked to change failure themes	Q21 - Provide more options and free text comment	Accept - Incorporate into main survey
FB12	Section 5 - VBHC and personal value area	Q23 - Add an 'Unsure' option and free text comment	Accept - Incorporate into main survey

Table 35 - Pilot Questionnaire Feedback and Action (Source: The Researcher - Marc Penny 2025)

For feedback FB2 & FB3 some participants requested more context to the questionnaire, its aims and purpose. The questionnaire included an introduction page which gave some very limited details of the purpose of the research and its content, but mainly focused on anonymity and data protection / privacy. This was by design by the author to try and limit any undue influence on participants responses if they knew the key context and reasons for the research. Unprompted awareness is an

issue that has been considered by the author, so the question of how much detail the author includes in the introduction to the questionnaire (*06 Writing and Effective Questionnaire*, 2018) has been a careful consideration.

- Authors Response – The author will act upon the feedback and provide some further context but will try and limit it too much detail to avoid undue bias though unprompted awareness.

Additionally, a lesson learnt by the author as part of the pilot is the need to capture a greater range of categorisation data to allow for improved granularity and analysis of experience of respondents. Additional categorisation data will be captured including:

- Healthcare Length of Experience
- VBHC Length of Experience
- Academic Length of Experience
- Leadership Length of Experience

Based on the pilot and feedback from the expert reviewers the author has updated the key questions associated with the failure themes (Table 36):

Conceptual Framework Theme		**Failure Themes**		**QUESTIONS**		
				Multi Theme Question **Q -** Does being involved in delivering and or supporting Value Based Healthcare provide you with: **Q -** Should being involved in delivering and or supporting Value Based Healthcare provide you with:	**Handbook of Metrics for Research in Operations Management: Multi-item Measurement Scales and Objective Items**	**Authors Own Questions**
CFT1	Engagement	FT1	Not feeling part of a movement	-	-	Q - Using any number from 0 to 10, where 0 is not at all and 10 is fully, how much do you feel a part of a movement or community of Value Based Healthcare?

Conceptual Framework Theme		Failure Themes		QUESTIONS		
				Multi Theme Question **Q -** Does being involved in delivering and or supporting Value Based Healthcare provide you with: **Q -** Should being involved in delivering and or supporting Value Based Healthcare provide you with:	**Handbook of Metrics for Research in Operations Management: Multi-item Measurement Scales and Objective Items**	**Authors Own Questions**
CFT1	Engagement	FT2	Lack of direct engagement with change	-	Handbook of metrics for research in operations management: Hays and Hill Q 4: Our employees feel a strong sense of accountability and ownership for service quality. (7-point likert scale) **Research Contextual Revised Question -** Employees feel a strong sense of accountability and ownership for Value Based Healthcare	Q - My organisation values my opinion on delivering Value Based Healthcare
CFT1	Engagement	FT3	Lack of recognition or reward	Motivation to do my job?	-	Q - I am recognised for my work and contribution to delivering Value Based Healthcare Q - I am rewarded for my work and contribution to delivering Value Based Healthcare Q - I am not recognised for the work and effort I put into delivering Value Based healthcare
CFT1	Engagement	FT4	Poor / Top-down communications	-	Handbook of metrics for research in operations management: Escrig-Tena and Bou-Llusar Q 18: Internal communication is totally open and transparent. (7-point likert scale) **Research Contextual Revised Question -** Internal Value Based healthcare communication is totally open and transparent	Q - I receive regular communications in relation to Value Based Healthcare
CFT1	Engagement	FT5	Poor leadership	-	Handbook of metrics for research in operations management: Anderson, Rungtusanatham, Schroeder, and Devaraj Q 3: Out top management strongly encourages employee involvement in the production process. (5-point likert scale) **Research Contextual Revised Question -** Leadership strongly encourages involvement in Value Based Healthcare	Q - There is clear Value Based Healthcare leadership in my organisation

Conceptual Framework Theme		Failure Themes		QUESTIONS		
				Multi Theme Question **Q -** Does being involved in delivering and or supporting Value Based Healthcare provide you with: **Q -** Should being involved in delivering and or supporting Value Based Healthcare provide you with:	**Handbook of Metrics for Research in Operations Management: Multi-item Measurement Scales and Objective Items**	**Authors Own Questions**
CFT1	Engagement	FT6	No visible leadership	-	Handbook of metrics for research in operations management: Cua, McKone, and Schroeder Q 2: Plant management provides personal leadership for quality products and quality improvement. (5-point likert scale) **Research Contextual Revised Question -** Managers provide personal leadership for Value Based Healthcare and Q 6: Plant management is personally involved in quality improvement projects. (Likert scale) **Research Contextual Revised Question -** Managers are personally involved in Value based Healthcare	-
CFT2	Individual Consequence	FT7	Poor career opportunities	Career development?	-	Q - The skills and knowledge I have gained through Value Based Healthcare will benefit me in career progression Q - There are no opportunities to progress my career within Value Based Healthcare
CFT2	Individual Consequence	FT8	Poor job satisfaction	Improved job satisfaction?	-	Q - Delivering Value Based Healthcare adds stress to my job Q - Delivering Value Based healthcare activities take me away from the important aspects of my job
CFT2	Individual Consequence	FT9	Poor personal satisfaction	Personal satisfaction?	-	Q - I feel a sense of pride in delivering Value Based Healthcare Q - I feel a sense of accomplishment when delivering Value Based Healthcare work

Conceptual Framework Theme		Failure Themes		QUESTIONS		
				Multi Theme Question **Q -** Does being involved in delivering and or supporting Value Based Healthcare provide you with: **Q -** Should being involved in delivering and or supporting Value Based Healthcare provide you with:	**Handbook of Metrics for Research in Operations Management: Multi-item Measurement Scales and Objective Items**	**Authors Own Questions**
CFT2	Individual Consequence	FT10	Poor working environment	Improved working environment?	-	Q - My working conditions and environment make it difficult to deliver what's expected of me Q - My working environment enables me to deliver at my best
CFT3	Ownership	FT11	Not integral to the role	-	-	Q - Do you see Value Based Healthcare as part of your job and integral or separate and an additional activity? Q - Is the delivery of Value Based healthcare built into your day-to-day job? Q - I am provided with specific objectives relating to Value Based Healthcare
CFT3	Ownership	FT12	Loss of control	Control over your work?	-	Q - I feel I have control and input into the delivery of Value Based Healthcare within my area. Q - I don't feel involved with Value Based healthcare activities which affect me.
CFT3	Ownership	FT13	Not being allowed to make mistakes and learn from them	-	-	Q - I am allowed to make mistakes and learn from them Q - My manager encourages me / my team to learn from past experiences Q - I can provide feedback on Value Based Healthcare activities
CFT3	Ownership	FT14	Not involved in decision making	Empowerment to make decisions?	-	Q - I am involved in decisions relating to Value Based Healthcare activities which affect me Q - I have no ability to input into decisions relating to Value Based Healthcare and my areas of work

Conceptual Framework Theme		Failure Themes		QUESTIONS		
				Multi Theme Question **Q -** Does being involved in delivering and or supporting Value Based Healthcare provide you with: **Q -** Should being involved in delivering and or supporting Value Based Healthcare provide you with:	**Handbook of Metrics for Research in Operations Management: Multi-item Measurement Scales and Objective Items**	**Authors Own Questions**
CFT4	Shared Aims	FT15	Lack of vision, context and certainty	-	Handbook of metrics for research in operations management: Ahmad and Schroeder (2003); and Anderson, Rungtusanatham, Schroeder, and Devaraj Q 44 and Q 7: In our plant, goals, objectives, and strategies are communicated to me. (5-point likert scale). **Research Contextual Revised Question -** In our organisation Value Based Healthcare goals, objectives, and strategies are communicated to me	Q - I understand why we are undertaking Value Based Healthcare activities
CFT4	Shared Aims	FT16	Poor or unclear expectations	-	Handbook of metrics for research in operations management: Escrig-Tena and Bou-Llusar Q 6: All the members of the firm have a clear idea about what is expected of them, making their contribution to the company as beneficial as possible (7 point likert scale) **Research Contextual Revised Question -** All the members of the team have a clear idea of what is expected of them in relation to Value Based Healthcare, making their contribution to the organisation as beneficial as possible	Q - I understand my role in supporting delivery of the organisations Value Based Healthcare vision

Conceptual Framework Theme		Failure Themes		QUESTIONS		
				Multi Theme Question **Q -** Does being involved in delivering and or supporting Value Based Healthcare provide you with: **Q -** Should being involved in delivering and or supporting Value Based Healthcare provide you with:	**Handbook of Metrics for Research in Operations Management: Multi-item Measurement Scales and Objective Items**	**Authors Own Questions**
CFT4	Shared Aims	FT17	Unclear benefits or aims	-	-	Q - Rank the below Value Based Healthcare benefit areas in order of how you see their importance? - Allocative Value - Technical Value - Personal Value - Societal Value Q - Rank the below Value Based Healthcare benefit areas in order of how you believe your organisation see's their importance? - Allocative Value - Technical Value - Personal Value - Societal Value Q - What words would you use to describe what Value Based Healthcare means to you?
CFT5	Skills & Capacity	FT18	Lack of training or skills	Skills development?	Handbook of metrics for research in operations management: Anderson, Rungtusanatham, Schroeder, and Devaraj Q 17: Employees receive training to perform multiple tasks. (5-point likert scale). **Research Contextual Revised Question -** Employees receive training to perform Value Based Healthcare activities	-
CFT5	Skills & Capacity	FT19	Not enough time or resources	-	Handbook of metrics for research in operations management: Gilgeous Q 30: Lack of resources is a major source of plan/project failure. (6-point likert scale) **Research Contextual Revised Question -** Lack of resource is a major source of Value Based Healthcare failure	Q - I am given the time to undertake Value Based Healthcare activities

Conceptual Framework Theme		Failure Themes		QUESTIONS		
				Multi Theme Question **Q -** Does being involved in delivering and or supporting Value Based Healthcare provide you with: **Q -** Should being involved in delivering and or supporting Value Based Healthcare provide you with:	**Handbook of Metrics for Research in Operations Management: Multi-item Measurement Scales and Objective Items**	**Authors Own Questions**
CFT5	Skills & Capacity	FT20	Not understanding terminology or shared language	-	-	Q - I understand the language used and its terminology in Value Based Healthcare Q - People in the organisation understand what is meant by Value Based Healthcare Q - I understand the language used in meetings and discussion around Value Based Healthcare

Table 36 - Final Questionnaire Mapped to Change Failure Themes (Source: The Researcher - Marc Penny 2025)

The finalised questionnaire survey can be found in Appendix J - Quantitative Questionnaire Final.

3.13.5. Questionnaire Section Conclusion

The author has covered in section 3.13 the methodology they have used in developing the pilot questionnaire as part of research phase 2B of the author's research, aimed at refining the questionnaire for quantitative analysis. The questionnaire is designed to validate the author's conceptual framework, which has been derived from the literature review and qualitative analysis.

Within the chapter the author has discussed the development of a question set using established questions and metrics from the '*Handbook of Metrics for Research in Operations Management'* to improve reliability and validity. The 2B pilot phase involves expert reviews and feedback of the questionnaire, ensuring the final questionnaire addresses the research questions while mitigating potential participant and researcher error while also considering how to avoid bias and ensuring clear, accessible question design to maintain credibility and transparency.

3.14. Conceptual Framework and Data/Insights Gathering Design Chapter Summary & Conclusions

In this chapter, the researcher has completed Phase 2b of their research:

Phase 2B: Pilot Questionnaire with Experts

The author developed a pilot questionnaire to test the conceptual framework quantitatively. The questionnaire was refined based on expert input pilot ensuring clarity, reliability and validity of questions. The author has used existing validated metrics from the 'Handbook of Metrics for Research in Operations Management' to improve the questionnaire's rigor and reduce potential participant and researcher error. The finalised questionnaire has been designed to gather both quantitative and qualitative data to support the research and will be tested further via phase 2c.

Further building on the foundational context established in Chapters 1 and 2, this chapter has provided a critical exploration of the philosophical and methodological underpinnings required to answer the research question: *To what extent does professional value and engagement play a role in the sustainable delivery of Value Based Healthcare?.* Chapters 1 and 2 identified the systemic and human factors influencing VBHC implementation, highlighting the need for a pragmatic, theory-building approach that integrates both organisational change theories and professional value dynamics. Chapter 3 has responded to this by grounding the study in a pragmatic research philosophy, prioritising actionable insights and methodological flexibility.

The philosophical stance of pragmatism, as discussed in this chapter, aligns with the study's focus on bridging theoretical inquiry with real-world application in healthcare systems. The development of a mixed-methods research design, combining qualitative and quantitative approaches, ensures a comprehensive exploration of VBHC's cultural, organisational and professional dimensions. The conceptual framework introduced in the previous chapter, informed by STS theory and the findings of the literature review, serves as a robust foundation for empirical validation in subsequent chapters. This framework connects the themes of professional value, engagement and organisational change, weaving a cohesive narrative through the research.

Overall the chapter highlights the importance of iterative development in research, starting with the authors theoretical foundation, validating it through expert input and refining the questionnaire to ensure they are comprehensive, reliable and valid. The authors finalised draft conceptual framework is designed to address the key barriers to VBHC sustainability, such as professional engagement,

leadership visibility and resource availability. By following this phased approach the author hopes to ensure that the framework is both academically robust and practically relevant.

In conclusion, the author's pragmatic philosophical position, combined with an inductive, mixed-method research strategy, is well-suited to the practical goals of this study. By focusing on the real-world application of VBHC in the NHS, the research aims to generate actionable insights that can inform the sustainable implementation of healthcare reforms. The flexibility of the pragmatic approach also allows the research to adapt to the complexities of human and cultural factors, ensuring that the study remains relevant to both academic and practical healthcare contexts.

CHAPTER 4 – RESULTS AND FINDINGS

4. Introduction

The Results and Findings chapter forms a key part of the research process presenting the empirical data collected as outlined in chapters 2 and 3. The researcher will systematically present the data and findings that relate to the elements of the conceptual framework (Clark et al., 2021) – see section 2.14. The author will interpret the findings data in relation to the original research questions and objectives (Clark et al., 2021) in Chapter 5, although the researcher will make some small commentary relating the findings back to literature in this chapter but the main exploration will be via the discussion chapter 5. This chapter will present phase 3 of the authors research process:

PHASE 3: RESULTS AND FINDINGS

INPUTS – Conceptual framework and all data outputs from survey questionnaires and semi-structured interviews along with literature review material. All Wales Health Boards VBHC maturity self-assessment.

- Develop final conceptual framework
- Undertake quantitative and qualitative analysis (Cross case data displays, thematic patterns and divergence points of view)
- Display of data (charts, data tables etc)

OUTPUT – Authors VBHC conceptual framework and research findings

The findings will support the author in answering their research question:

To what extent does professional value and engagement play a role in the sustainable delivery of Value Based Healthcare?

The sub-questions to explore dimensions of this main question include:

- How do professionals derive value from being involved in and delivering Value Based Healthcare?
- What features of 'Professional' value offer greatest benefits to professionals engaged in Value Based Healthcare?

And in doing so validate the authors conceptual framework and failure themes and conceptual framework themes as outlined in chapter 2.14.

The research uses both quantitative and qualitative methods to achieve triangulation of the findings (Easterby-Smith et al., 2021). This process ensures the credibility of the data by combining multiple sources and methods (triangulation) and reduces the risk of bias whist enhancing the robustness of the conclusions to this phase of research. The data presentation methods include charts, tables and thematic analysis. The chapter will conclude and then lead into the discussion chapter 5.

4.1. Presentation of Semi-Structured Interviews – Conceptual Framework

This section will cover the authors research phase 2a:

Phase 2a: semi-structured interview expert review

INPUTS – Draft conceptual framework

- Identify who to take part and selection criteria
- Identify how to recruit participants
- Interview protocols and consent
- Undertake semi-structured interviews

OUTPUT – Validated conceptual framework

Although the purposively selected expert interviewees for the semi-structured interviews have consented to providing their names and details for the purposes of reporting the findings, the responses have been anonymised. Expert Respondents will be referred to as ER1, ER2, ER#.

The expert interviews have helped the author validate the methodology used in the authors framework development and test the logic followed and deliver the requirements for the authors research phase 2A: Semi-Structured Interview Expert Review. The author has used the experts to assess the logic that the author has followed in constructing the conceptual framework, identifying any weaknesses or gaps that may not have been identified.

This validation has helped ensure that the framework is not only theoretically sound from an academic perspective but also suitable for practical use within healthcare organisations.

Although the interviews were semi-structured the author used an 'interview pack' to help with the flow of the interviews and ensure all aspects were covered (Appendix F – Qualitative Semi-Structured Interview Pack). The author also ensured that during the interview that key questions were asked to confirm methodology, logic and gaps, these questions were:

- Understanding of the methodology the author has used to develop their research and development of the conceptual framework
- That they understood the logic the author had used in its development and agreement that the logic was sound
- Any areas the experts feel hadn't been covered or any steps missed in the conceptual framework development

Interviews took approximately 1 hour per interview and Table 37 provides a breakdown of responses to the key questions asked during the semi-structured interviews.

	Does the methodology the author has used to develop their research and development of the conceptual framework make sense and do you believe it to be valid and rigorous?	Do you understand the logic the author has used in its development and agree that the logic is sound?	Are there any areas the you feel hasn't been covered or any steps missed in the conceptual framework development?
ER1	**Yes**	**Yes**	**No**
ER2	**Yes**	**Yes**	**No**
ER3	**Yes**	**Yes**	**Yes**
ER4	**Yes**	**Yes**	**No**
ER5	**Yes**	**Yes**	**No**
ER6	**Yes**	**Yes**	**Yes**
ER7	**Yes**	**Yes**	**No**
ER8	**Yes**	**Yes**	**No**
ER9	**Yes**	**Yes**	**No**

Table 37 - Qualitative Semi-Structured Interview Expert Interview Key Responces (Logic, Methedology, Gaps)

All expert respondents confirmed that they believed that the methodology the author used to develop the research and development of the conceptual framework made sense and they believed it to be valid and rigorous. Also, all expert respondents confirmed that they understood the logic the author used in the research and conceptual framework development and agreed that the logic was sound with no queries or concerns raised.

The experts chosen were also asked if there any areas they felt hadn't been covered or any steps missed in the conceptual framework development to help assess whether the framework is

comprehensive or if any elements were missing. In regard to this question two respondents felt that there were additional areas to be explored:

- 'ER3' stated that they believed the author should consider as part of the literature review research diffusion of innovations in service organisations by Greenhalgh et al. which was produced following a comprehensive systematic literature review.
- 'ER4' stated that the author should consider and explore the impacts of professional standards and Royal Colleges on professionals working in organisations and how they may affect professionals motivations and ability to deliver change.

The author has retrospectively reviewed and reflected on the above aspects of feedback from the expert interviews and has included and considered them in the previous chapter of this thesis - 2.9.2 Professional Regulation in UK Healthcare and Organisational Dissonance.

The expert interviews also provided the ability to check the actual relationships proposed by the author and their direction and help build a consistent validation of the conceptual framework itself. Due to the number of relationships interviewees were asked to validate different parts of the framework, and the author has ensured each relationship has been validated by at least 3 of the expert respondents. After all expert interviews concluded, all conceptual framework relationships have been validated and consensus on their relationship direction reached. From this element of the research there were no outliers in regard to responses.

4.1.1. Key Semi-Structured Interview – Conceptual Framework Results and Findings

All expert respondents validated the methodology and logic used by the author in the development of the conceptual framework and where additional areas to be explored were identified the author has retrospectively included as part of their research. The conceptual framework relationships have been validated by the expert participants and consensus reached. This completes the researchers phase 2a - semi-structured interview expert review and provides a validated conceptual framework.

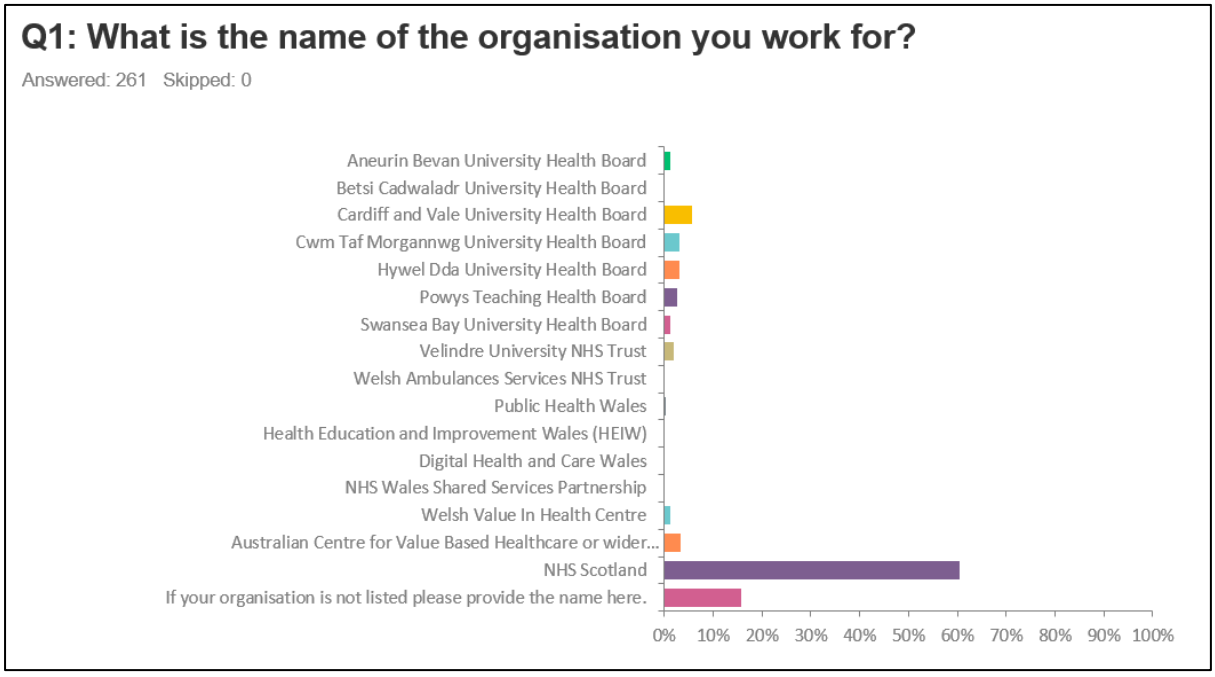
4.2. Presentation of Questionnaire Results

The following section will present the findings from the authors questionnaire survey and is structured to align with the authors overarching 'Conceptual Framework Themes'. This design covers the researchers phase 2c questionnaire with VBHC community. The data will not be presented in the order

that the questionnaires asked the questions, but all question responses are presented during this chapter. Full details of each question presented in the order they were asked including statistics for each question on minimum, maximum, median, mean and the standard variation can be found in Appendix K - Quantitative Questionnaire Data Tables and Charts.

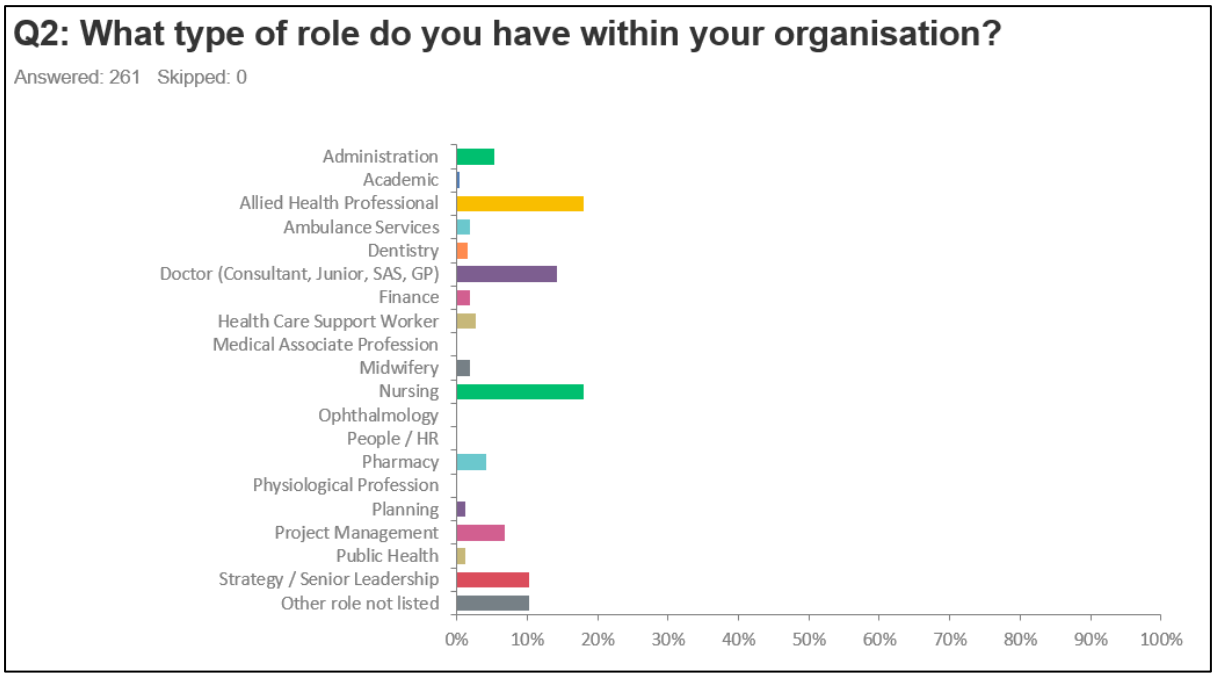
4.2.1. Questionnaire Response Rate and Demographic Information

Overall there was 261 respondents to the survey, however not all respondents fully completed the survey, and each answer provided below provides the response rate. The minimum response rate received was 133 responses. This response rate provides a confidence level of 95% with a margin of error of 8.5%, 133 responses is enough to provide general trends or exploratory analysis, making answers to the questions significant and valid from a generalisation statistical perspective. Detailed demographic information can be found in Appendix L - Quantitative Questionnaire Demographic Data.



Research Charts 1 - Questionnaire Q1 Organisation Demographic

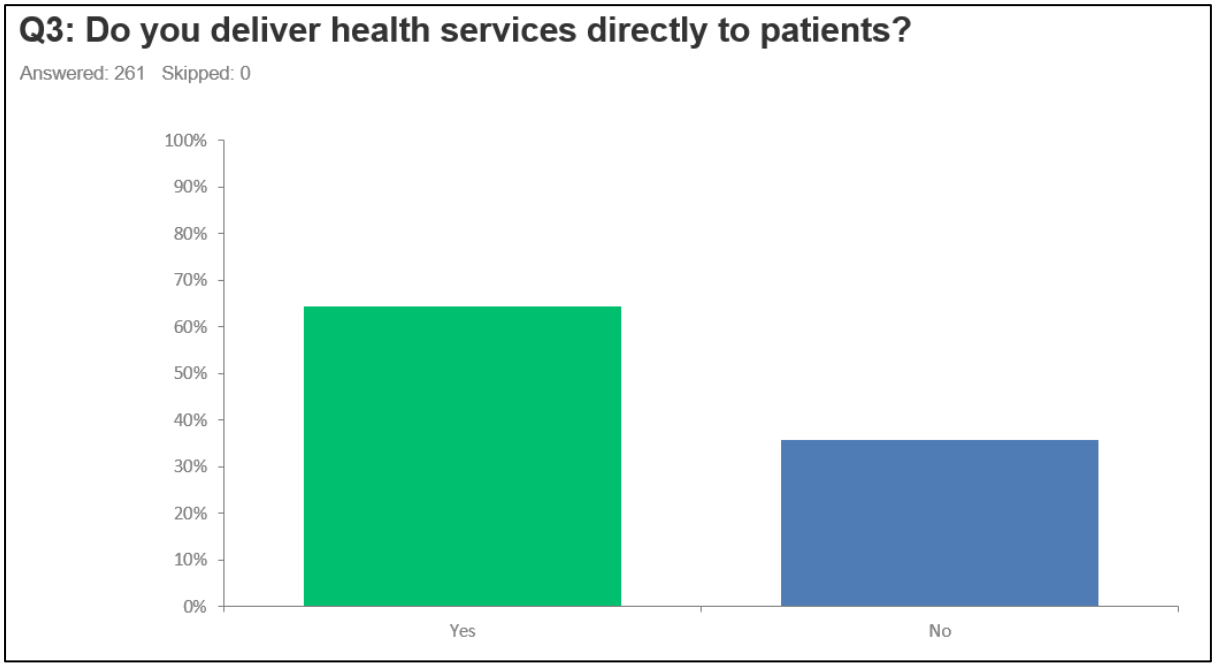
The participant counts from Australia Healthcare = 35, NHS Scotland = 172 and NHS Wales = 52. This spread gives geographical validity to the data for a generalised analysis purpose.



Research Charts 2 - Questionnaire Q2 Role Demographic

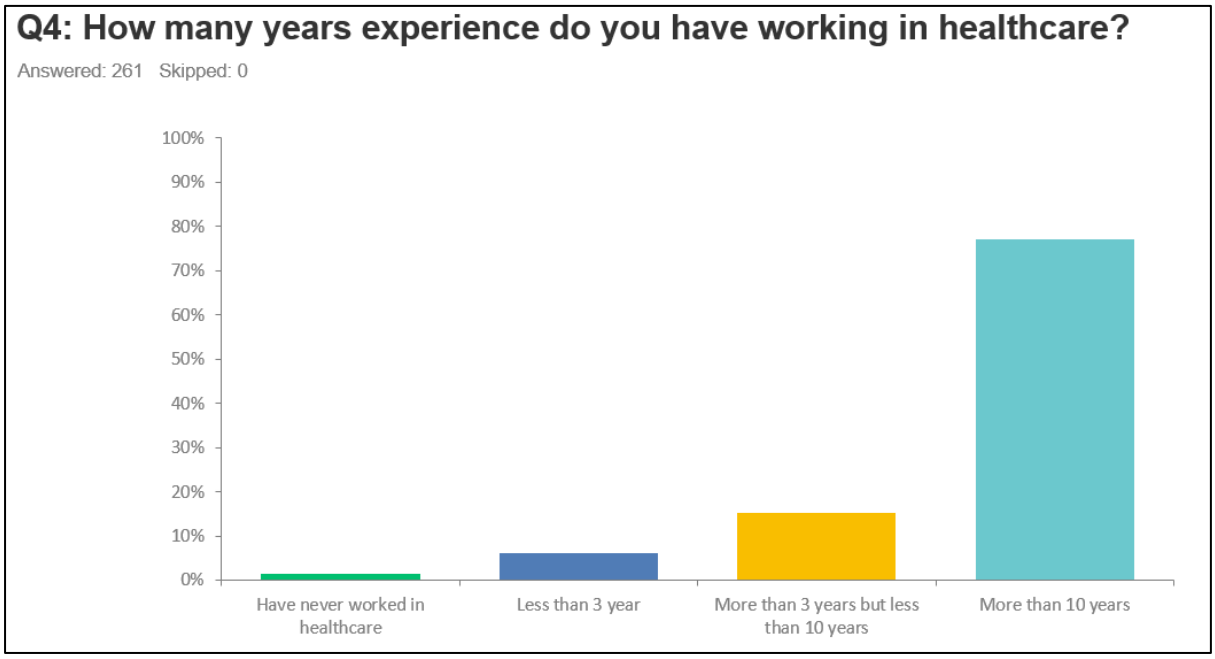
ANSWER CHOICES	RESPONSES	
Administration	5.36%	14
Academic	0.38%	1
Allied Health Professional	18.01%	47
Ambulance Services	1.92%	5
Dentistry	1.53%	4
Doctor (Consultant, Junior, SAS, GP)	14.18%	37
Finance	1.92%	5
Health Care Support Worker	2.68%	7
Medical Associate Profession	0.00%	0
Midwifery	1.92%	5
Nursing	18.01%	47
Ophthalmology	0.00%	0
People / HR	0.00%	0
Pharmacy	4.21%	11
Physiological Profession	0.00%	0
Planning	1.15%	3
Project Management	6.90%	18
Public Health	1.15%	3
Strategy / Senior Leadership	10.34%	27
Other role not listed	10.34%	27
TOTAL		261

Table 38 - Questionnaire Q2 Role Demographic



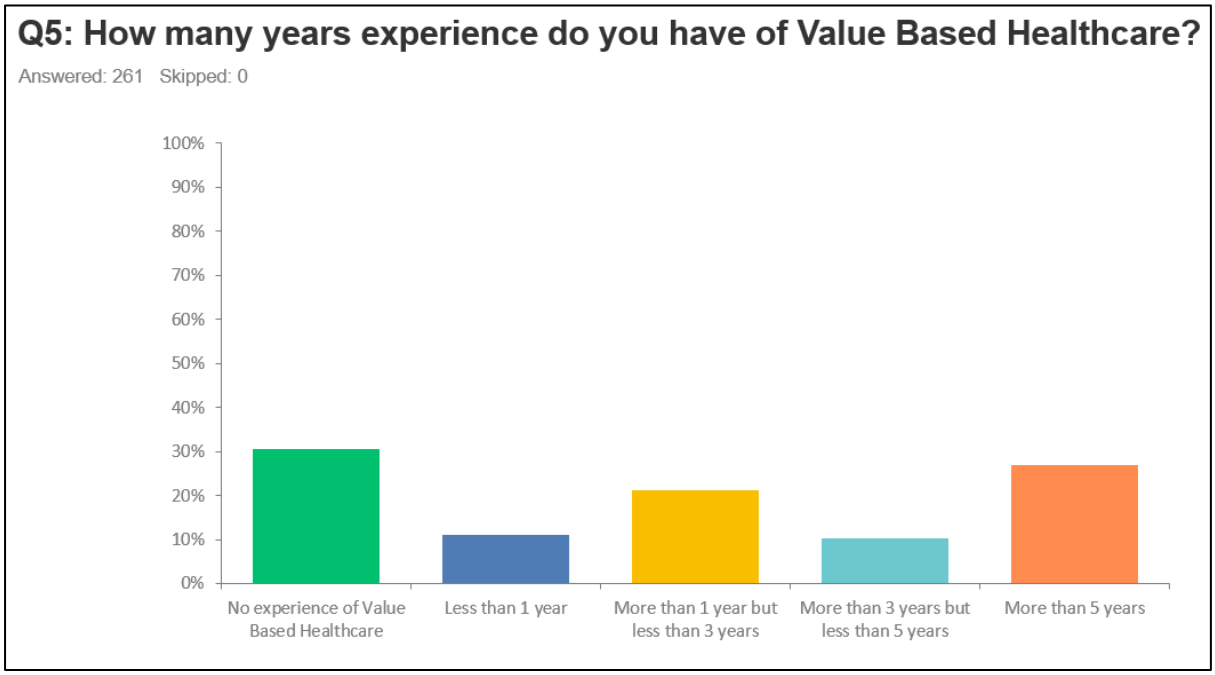
Research Charts 3 - Questionnaire Q3 Patient Facing Demographic

168 (64.3%) participants indicated they delivered services directly to patients with 93 (35.6%) indicating they did not. The results from Q1, Q2 and Q3 demonstrate good response coverage across regions, professions and whether respondents deliver front line services or not, helping ensure validity and reliability by including a broad range of views and experiences.



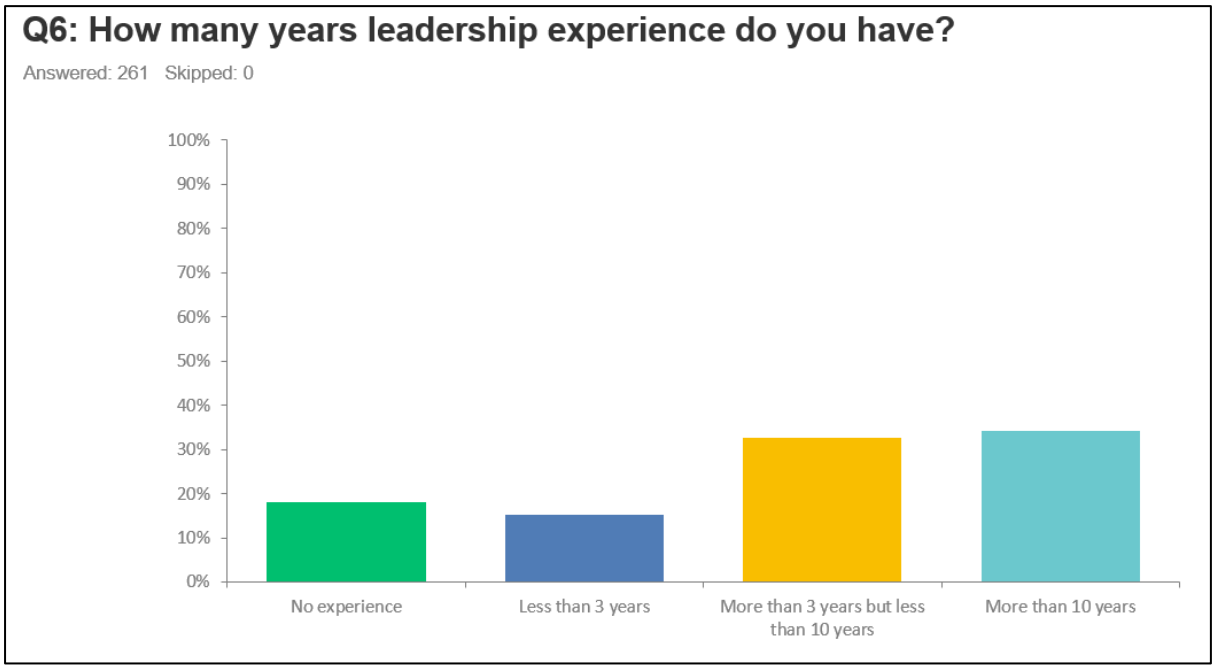
Research Charts 4 - Questionnaire Q4 Healthcare Experience Demographic

The participant count of experience working healthcare of 'More than 10 years = 201', 'More than 3 years but less than 10 years = 40', 'Less than 3 years = 16' and 'those who have never worked in healthcare = 4'. The participants demonstrate a high level of experience within the healthcare sector again supporting the research validity and reliability.



Research Charts 5 - Questionnaire Q5 VBHC Experience Demographic

The participant count of experience in VBHC of 'More than 5 years = 70', 'More than 3 years but less than 5 years = 27', 'More than 1 year but less than 3 years = 55', 'Less than 1 year = 29' and 'No experience of Value Based Healthcare = 80'. Q5 shows a broad range of experience in delivering VBHC, supporting the research validity and reliability, ensuring views of different experiences are captured and considered as part of this research.



Research Charts 6 - Questionnaire Q6 Leadership Experience Demographic

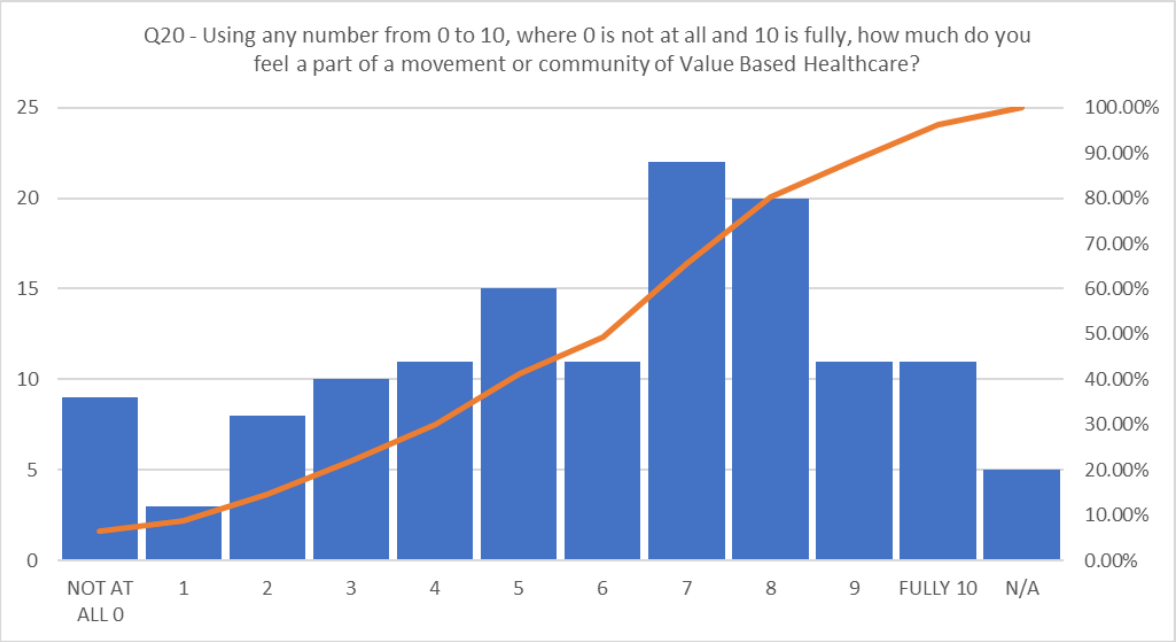
The participant count of experience in leadership of 'More than 10 years = 89', 'More than 3 years but less than 10 years = 85', 'Less than 3 years = 40' and 'No experience = 47'. Q6 shows a broad range of experience in delivering VBHC, supporting the research validity and reliability, ensuring views of different experiences are captured and considered as part of this research.

4.2.2. Results and Findings Conceptual Framework Theme 1 – Engagement

This section provides the questionnaire results associated with the questions asked for the authors conceptual framework theme 1 focused around engagement and the 6 sub Failure Themes.

Failure Themes		**Conceptual Framework Theme**	
FT1	Not feeling part of a movement	CFT1	Engagement
FT2	Lack of direct engagement with change	CFT1	Engagement
FT3	Lack of recognition or reward	CFT1	Engagement
FT4	Poor / Top down communications	CFT1	Engagement
FT5	Poor leadership	CFT1	Engagement
FT6	No visible leadership	CFT1	Engagement

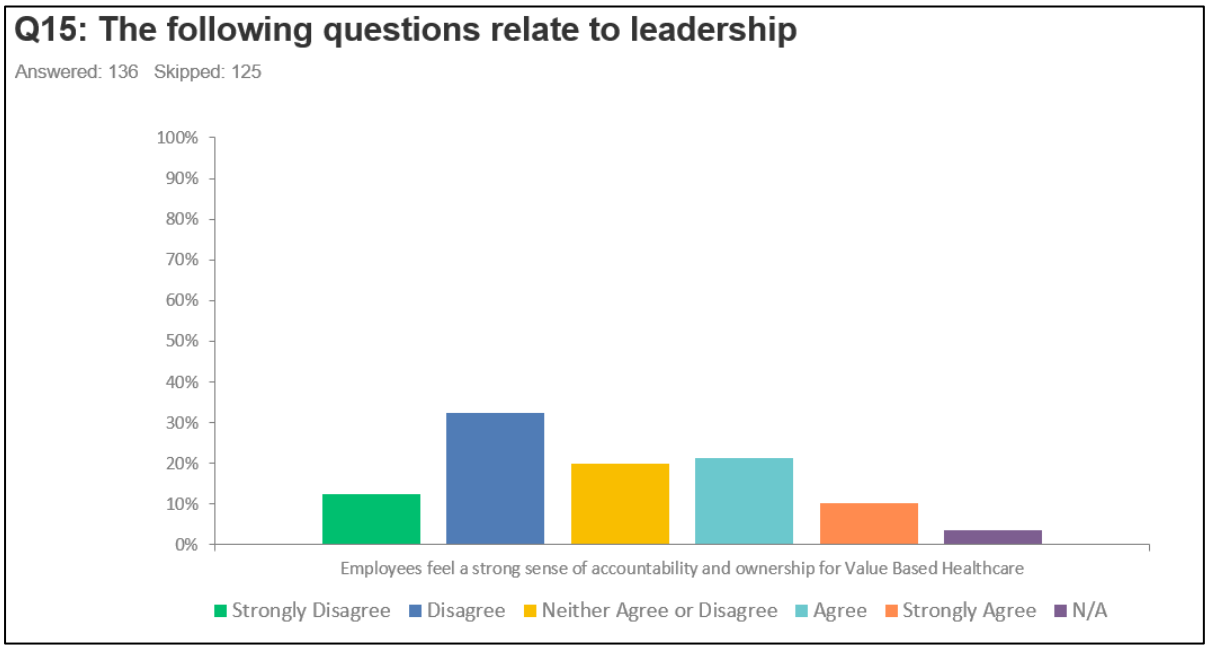
- **FT1 – Not feeling part of a movement**



Research Charts 7 - Questionnaire Q20 Feeling Part of A VBHC Movement

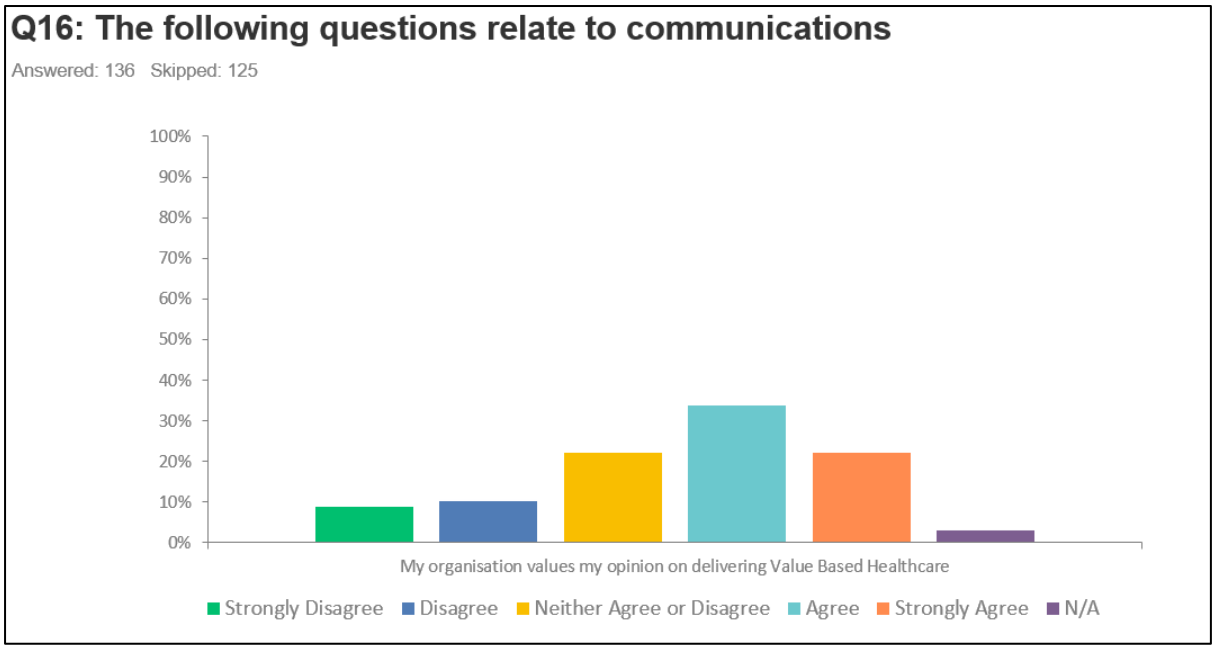
Participants responded 5 or above shows that 66.2% of people felt they were part of a VBHC movement or community and those responding 5 or below 41.2%.

- **FT2 – Lack of direct engagement with change**



Research Charts 8 - Questionnaire Q15 Employees Feel Sense of Accountability For VBHC

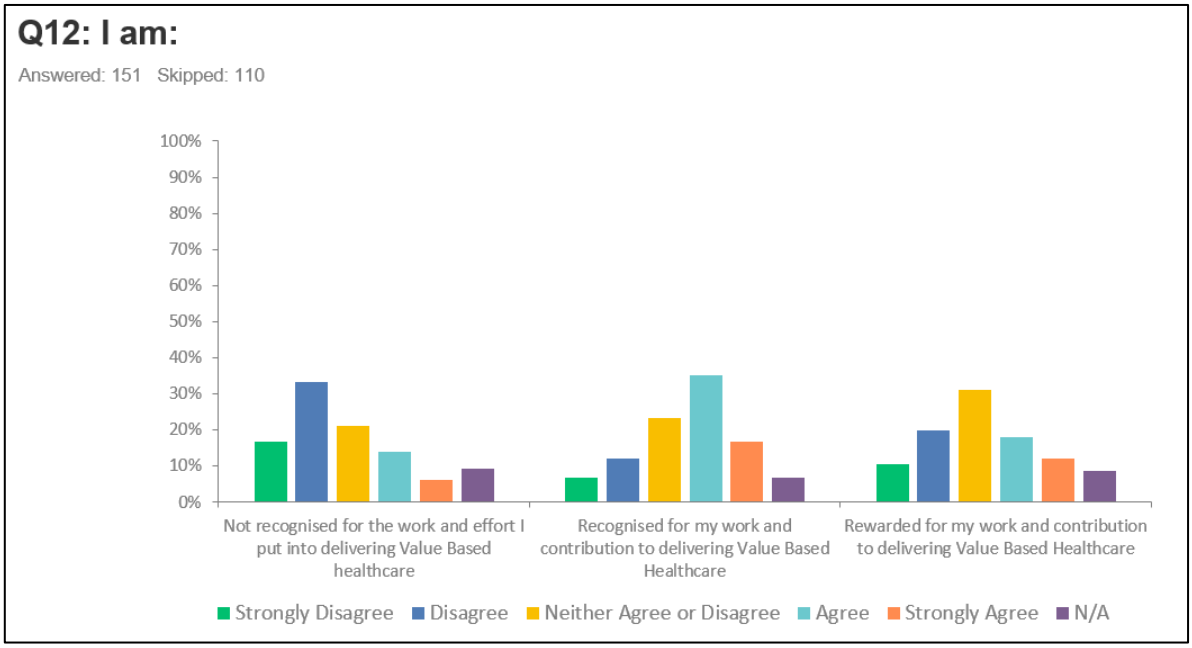
Participants responded where they felt a strong sense of accountability and ownership for VBHC with 31.6% agreeing or strongly agreeing and 44.9% disagreeing or strongly disagreeing.



Research Charts 9 - Questionnaire Q16 Values My Opinion on Delivering VBHC

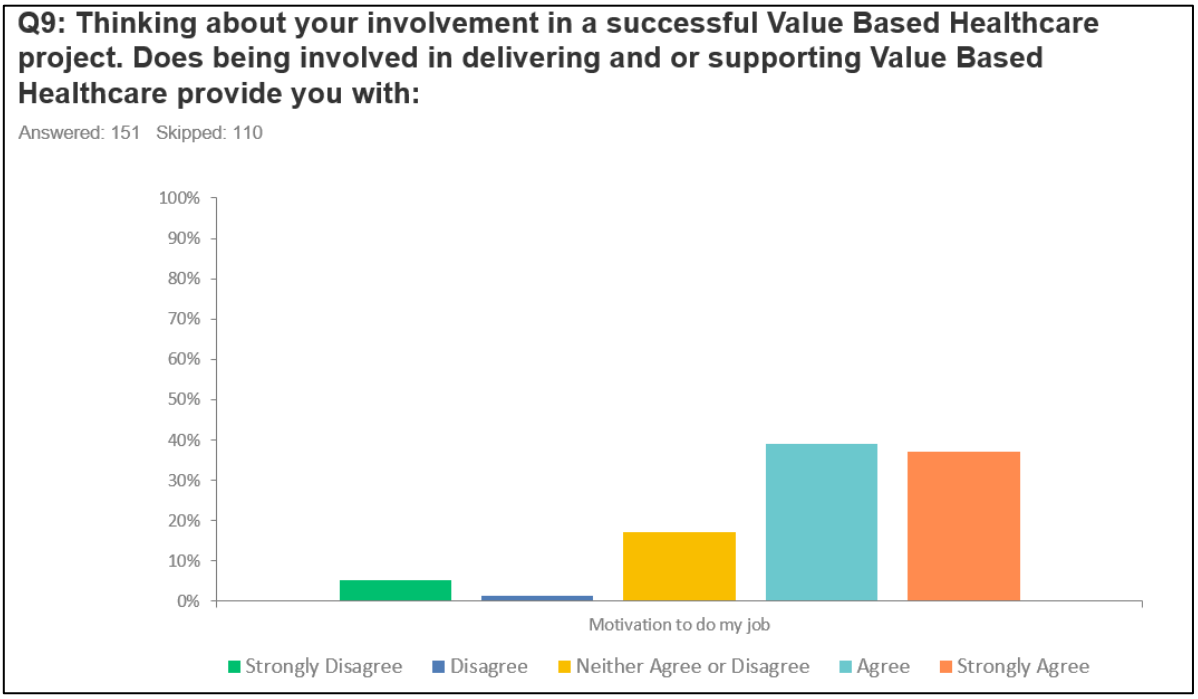
Participants responded where they felt their organisation values their option on delivering VBHC with 55.8% agreeing or strongly agreeing and 19.1% disagreeing or strongly disagreeing.

- **FT3 – Lack of recognition or reward**



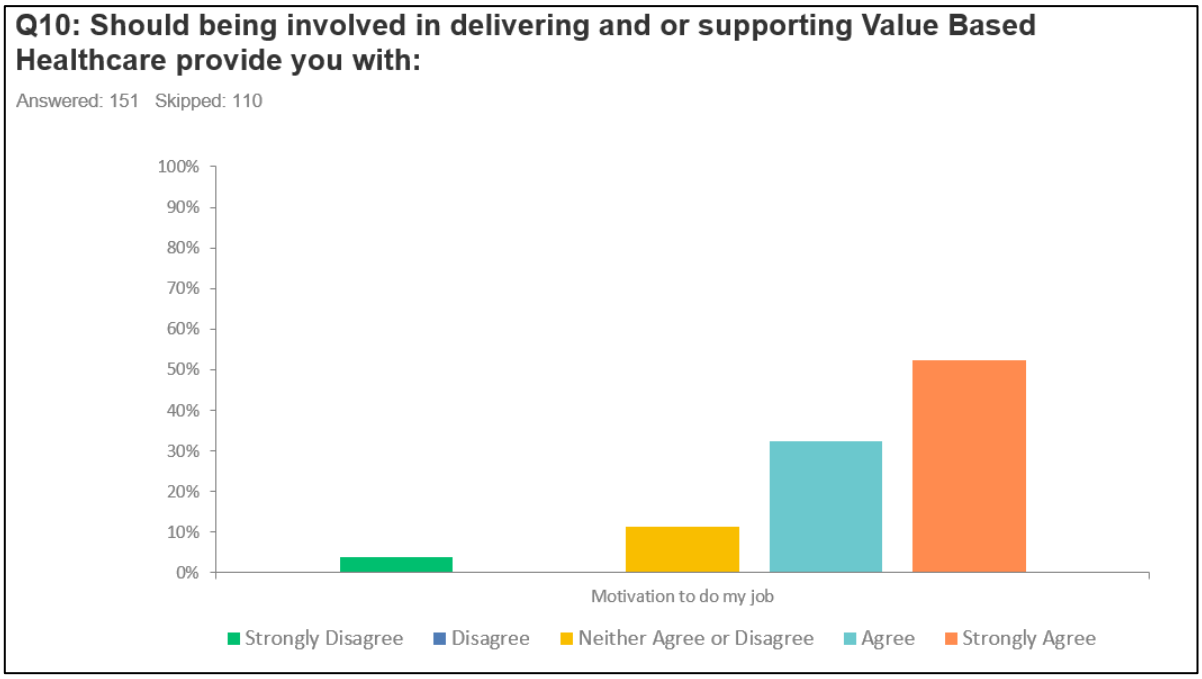
Research Charts 10 - Questionnaire Q12 Recognition and Reward

Participants responded where they felt they were not recognised for the work and effort they put into delivering VBHC with 19.9% agreeing or strongly agreeing and 49.6% disagreeing or strongly disagreeing. Participants responded where they felt they were recognised for their work and contribution to VBHC with 51.6% agreeing or strongly agreeing and 18.5% disagreeing or strongly disagreeing. Participants responded where they felt they were rewarded for their work and contribution in delivering VBHC with 29.7% agreeing or strongly agreeing and 30.4% disagreeing or strongly disagreeing.



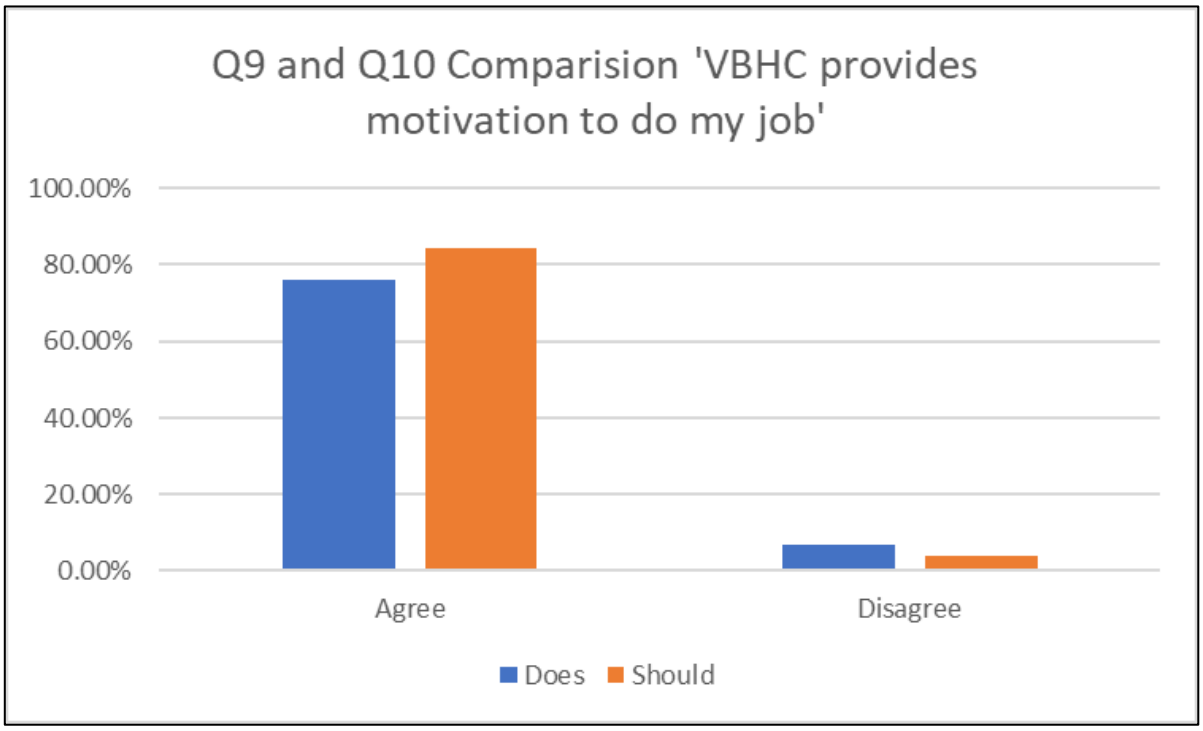
Research Charts 11 - Questionnaire Q9 Does Being Involved in VBHC Provide Motivation

Participants responded where they felt that VBHC does help provide motivation to do their jobs with 76.1% agreeing or strongly agreeing and 6.6% disagreeing or strongly disagreeing.



Research Charts 12 - Questionnaire Q10 Should Being Involved in VBHC Provide Motivation

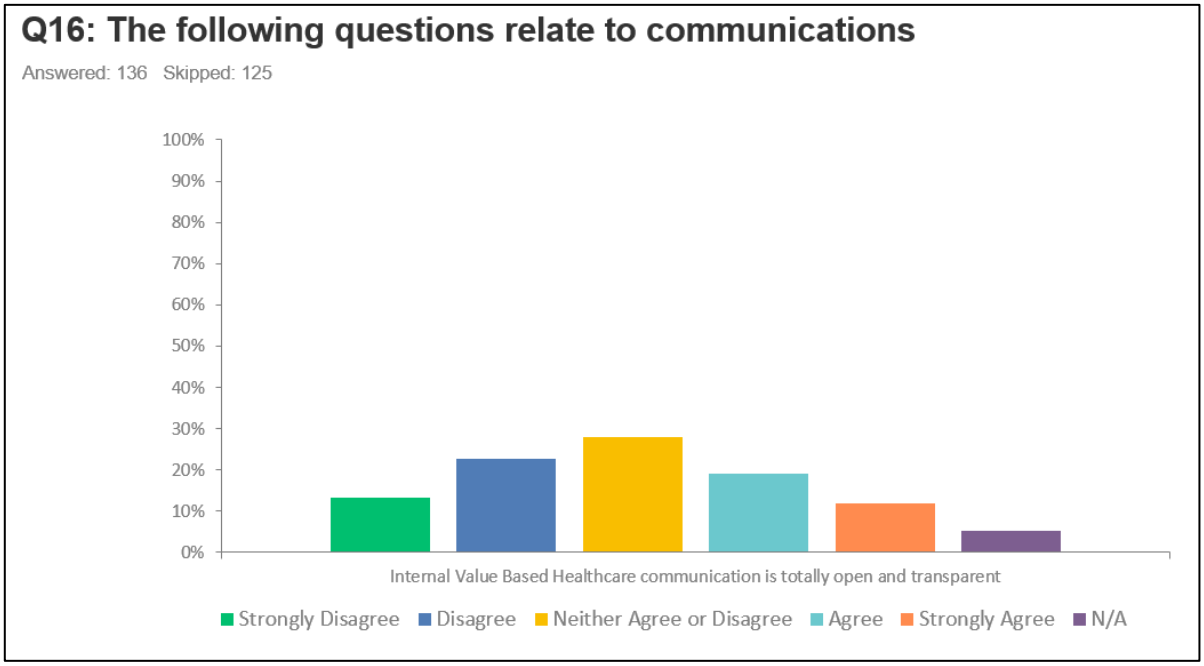
Participants responded where they felt that VBHC should help provide motivation to do their jobs with 84.4% agreeing or strongly agreeing and 3.9% disagreeing or strongly disagreeing.



Research Charts 13 - Q9 And Q10 Comparison 'VBHC Provides Motivation to Do My Job'

84.4% or respondents felt VBHC should provide motivation to do their job compared with 76.1% of respondents saying it does provide motivation to do their job.

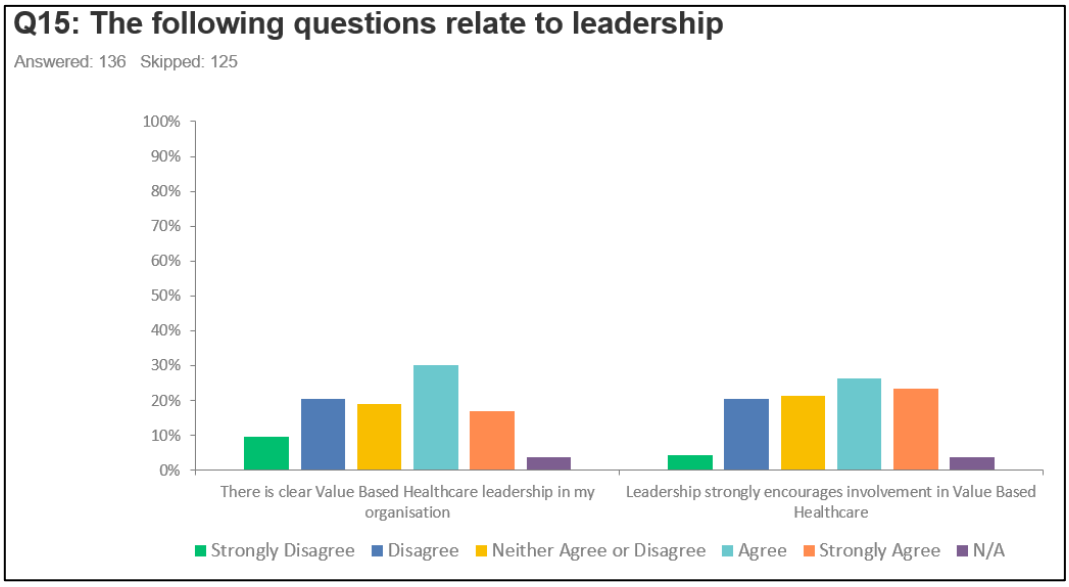
- **FT4 – Poor / Top-down communications**



Research Charts 14 - Questionnaire Q16 Internal VBHC Communications Are Open and Transparent

Participants responded where they felt internal VBHC communications were open and transparent with 30.8% agreeing or strongly agreeing and 36.0% disagreeing or strongly disagreeing.

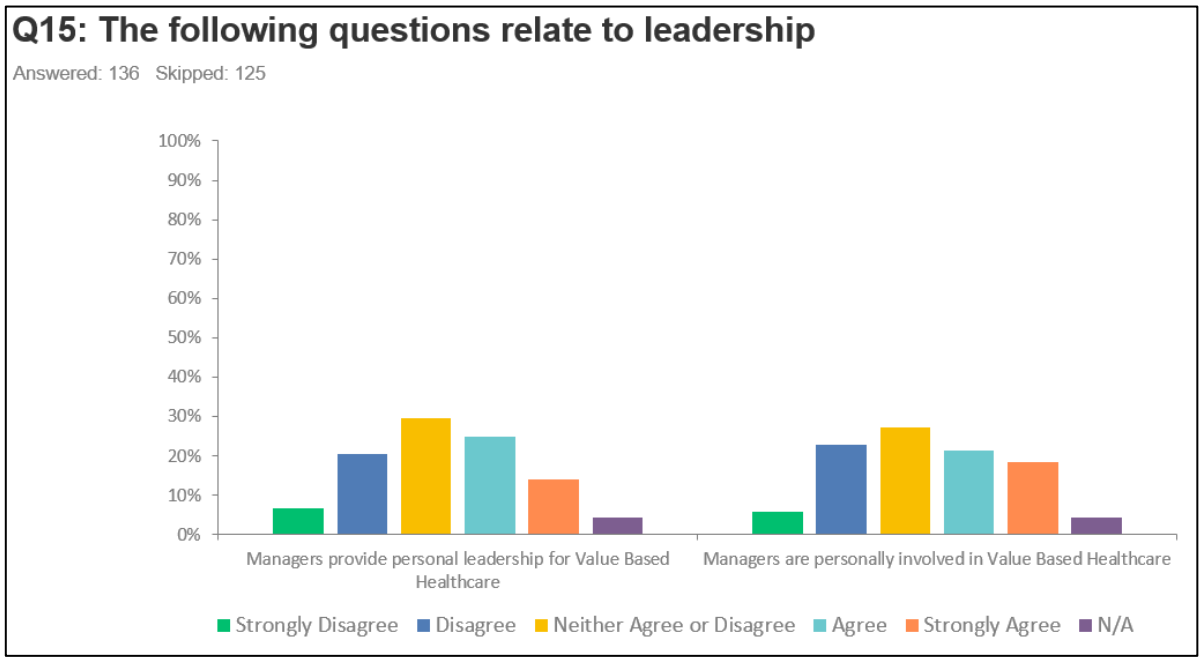
- **FT5 – Poor leadership**



Research Charts 15 - Questionnaire Q15 Leadership and Encouragement

Participants responded where they felt there is clear VBHC leadership in their organisation with 47.1% agreeing or strongly agreeing and 30.2% disagreeing or strongly disagreeing. Participants responded where they felt leadership strongly encourages involvement in VBHC with 50.0% agreeing or strongly agreeing and 25.0% disagreeing or strongly disagreeing.

FT6 – No visible leadership



Research Charts 16 - Questionnaire Q15 Management Leadership and Involvement

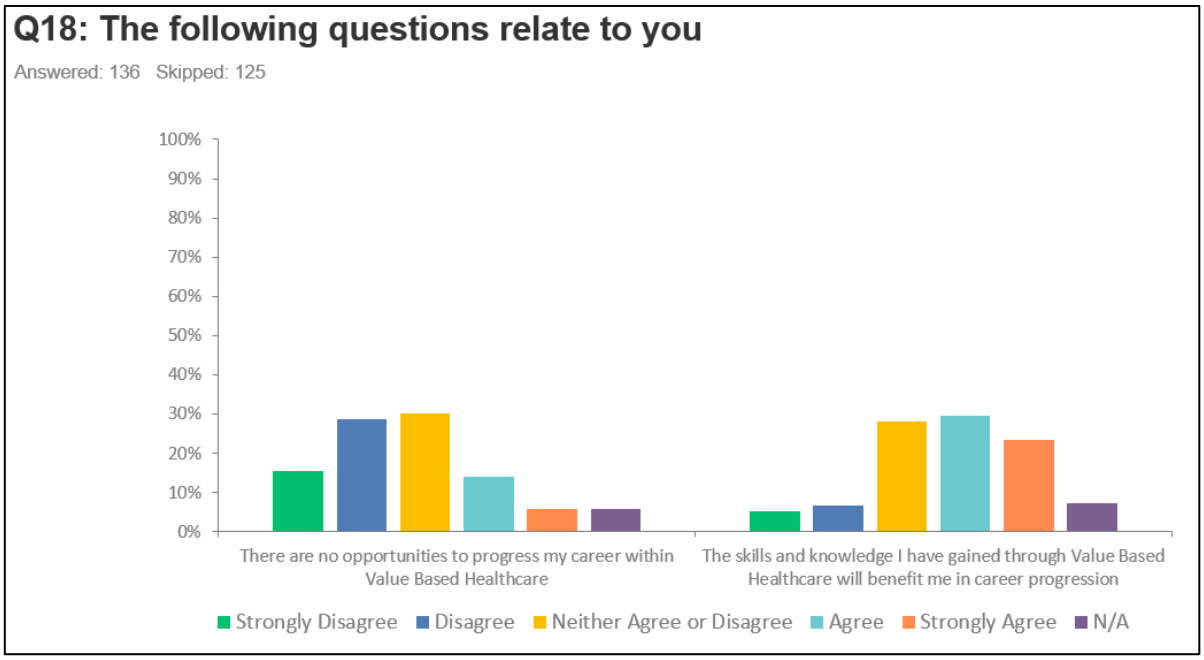
Participants responded where they felt managers provided personal leadership for VBHC with 39.7% agreeing or strongly agreeing and 27.2% disagreeing or strongly disagreeing. Participants responded where they felt managers were personally involved in VBHC with 39.7% agreeing or strongly agreeing and 28.7% disagreeing or strongly disagreeing.

4.2.3. Results and Findings Conceptual Framework Theme 2 – Individual Consequence

This section provides the questionnaire results associated with the questions asked for the authors conceptual framework theme 2 focused around individual consequence and the 4 sub Failure Themes.

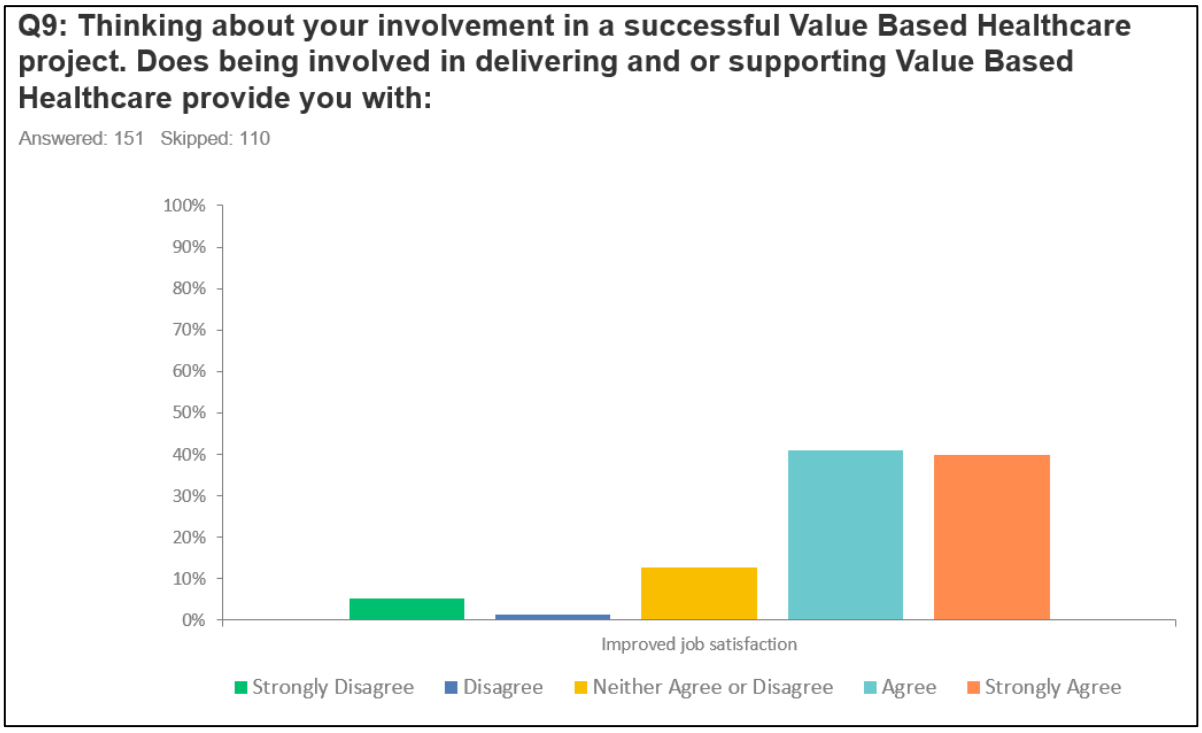
Failure Themes		Conceptual Framework Theme	
FT7	Poor career opportunities	CFT2	Individual Consequence
FT8	Poor job satisfaction	CFT2	Individual Consequence
FT9	Poor personal satisfaction	CFT2	Individual Consequence
FT10	Poor working environment	CFT2	Individual Consequence

- **FT7 – Poor career opportunities**



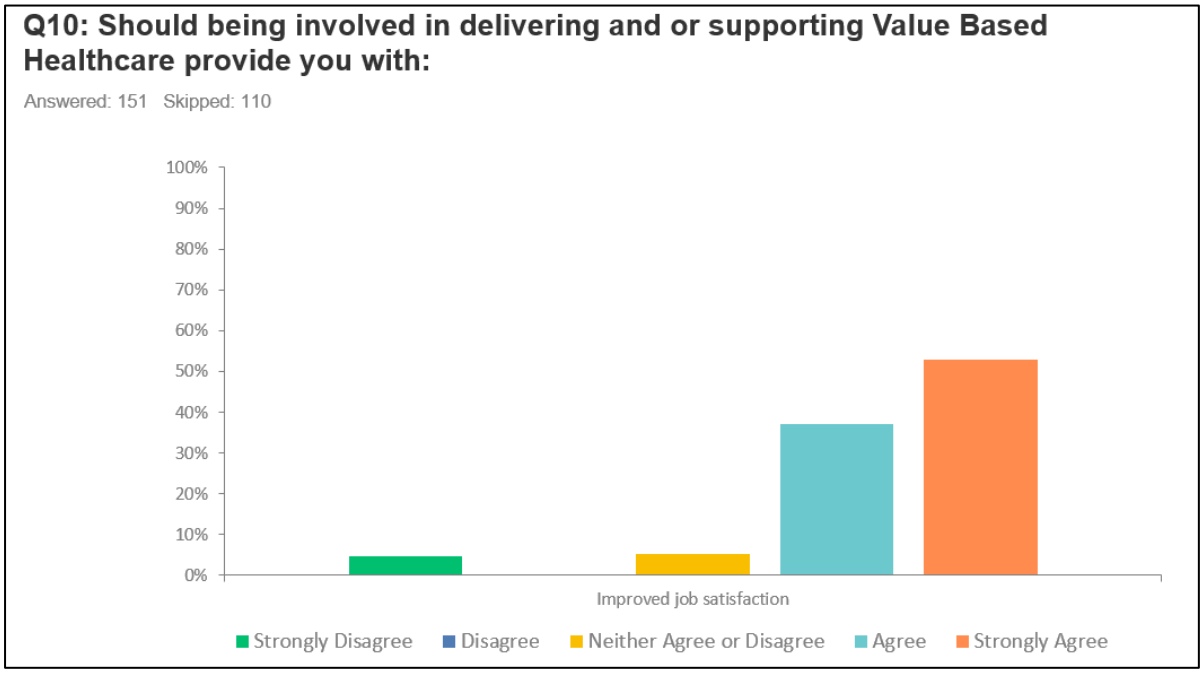
Research Charts 17 - Questionnaire Q18 Knowledge and Career Progression

Participants responded where they felt there were no opportunities to progress their career within VBHC with 19.7% agreeing or strongly agreeing and 44.0% disagreeing or strongly disagreeing. Participants responded where they felt that the skills and knowledge, they had gained through VBHC would help their career progression with 52.9% agreeing or strongly agreeing and 11.7% disagreeing or strongly disagreeing.



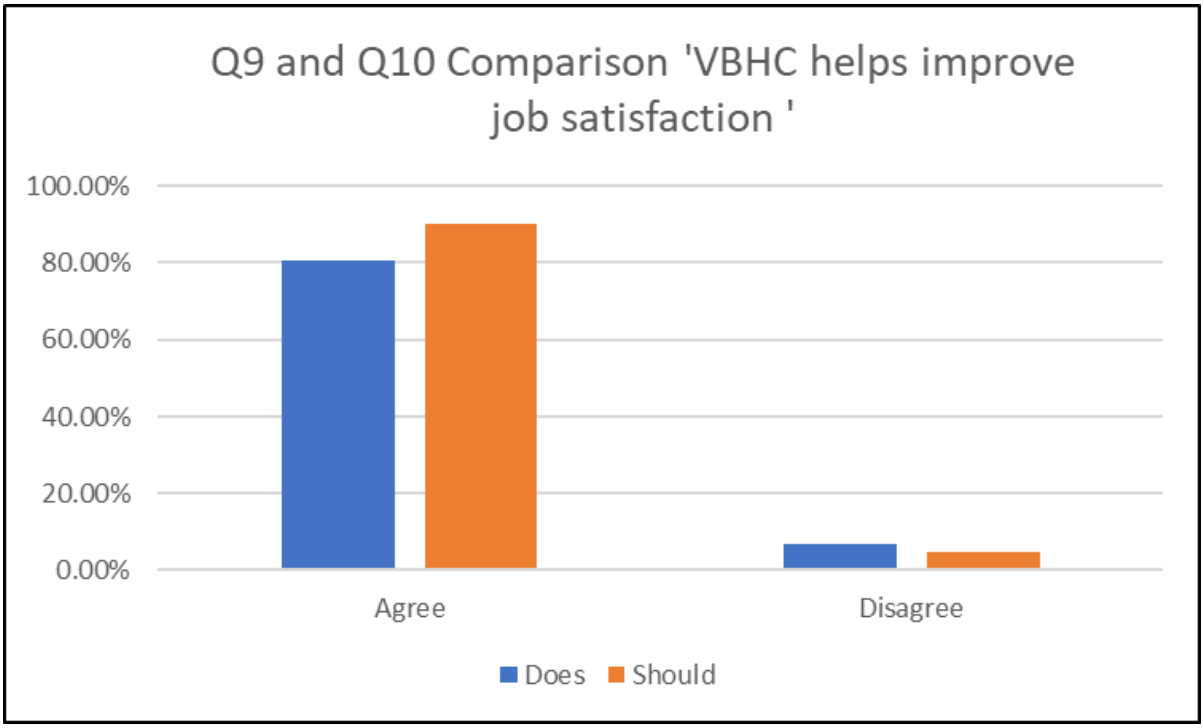
Research Charts 18 - Questionnaire Q9 Does Being Involved in VBHC Provide Improved Job Satisfaction

Participants responded where they felt that VBHC does help improve job satisfaction with 80.8% agreeing or strongly agreeing and 6.6% disagreeing or strongly disagreeing.



Research Charts 19 - Questionnaire Q10 Should Being Involved in VBHC Provide Improved Job Satisfaction

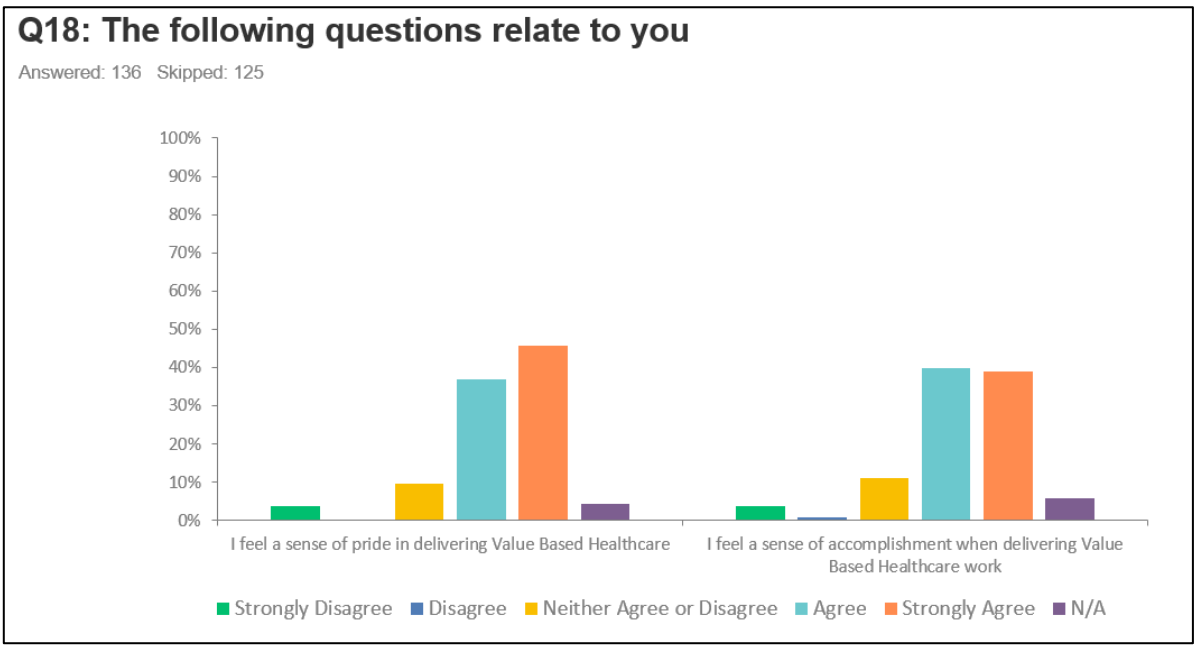
Participants responded where they felt that VBHC should help improve job satisfaction with 90.1% agreeing or strongly agreeing and 4.6% disagreeing or strongly disagreeing.



Research Charts 20 - Q9 And Q10 Comparison 'VBHC Helps Improve Job Satisfaction'

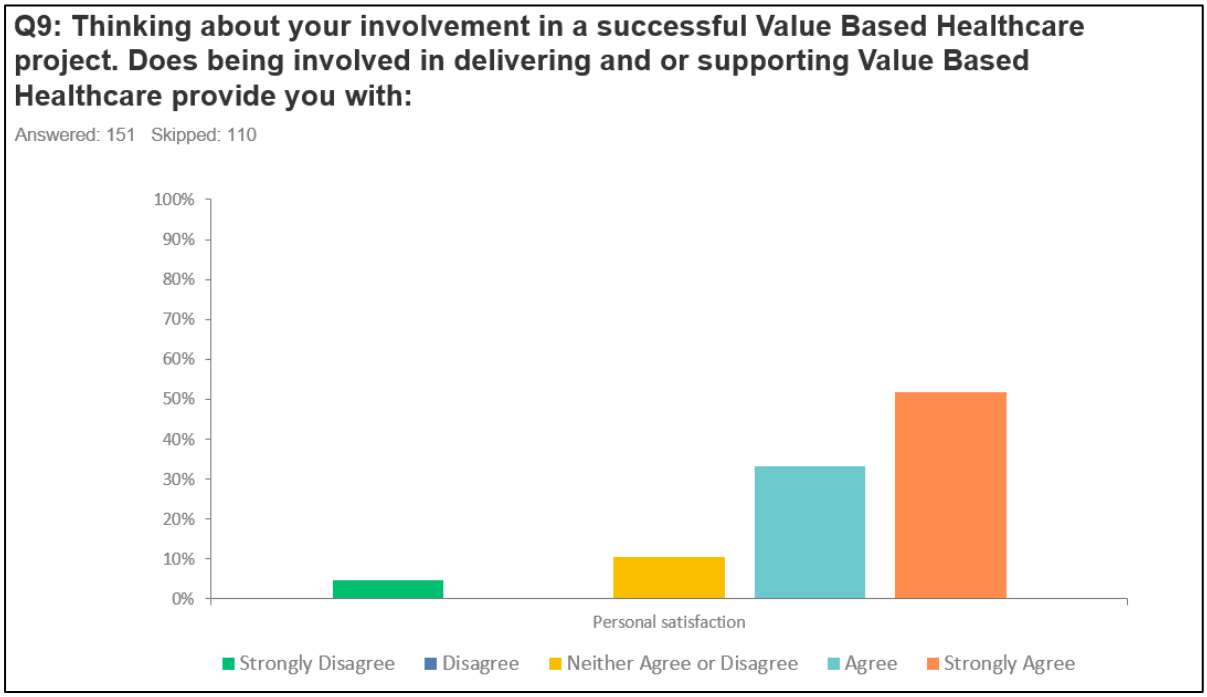
90.1% or respondents felt VBHC should help improve job satisfaction with 80.8% of respondents saying it does help improve job satisfaction.

- **FT8 – Poor job satisfaction**



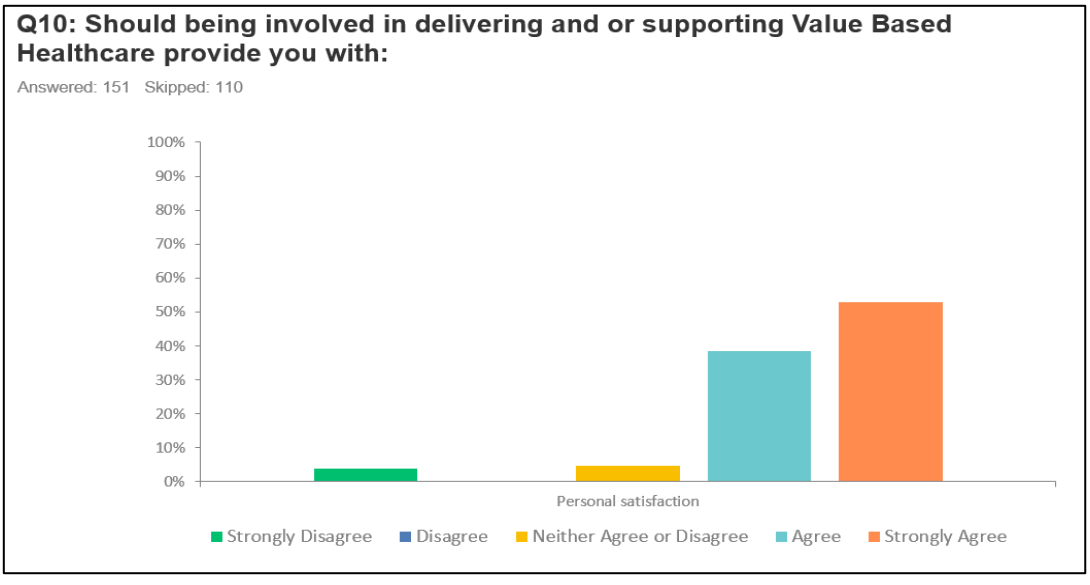
Research Charts 21 - Questionnaire Q18 Feeling Pride and Accomplishment When Delivering VBHC

Participants responded where they felt a sense of pride in delivering VBHC with 82.4% agreeing or strongly agreeing and 3.68% disagreeing or strongly disagreeing. Participants responded where they felt a sense of accomplishment when delivering VBHC with 78.7% agreeing or strongly agreeing and 4.4% disagreeing or strongly disagreeing.



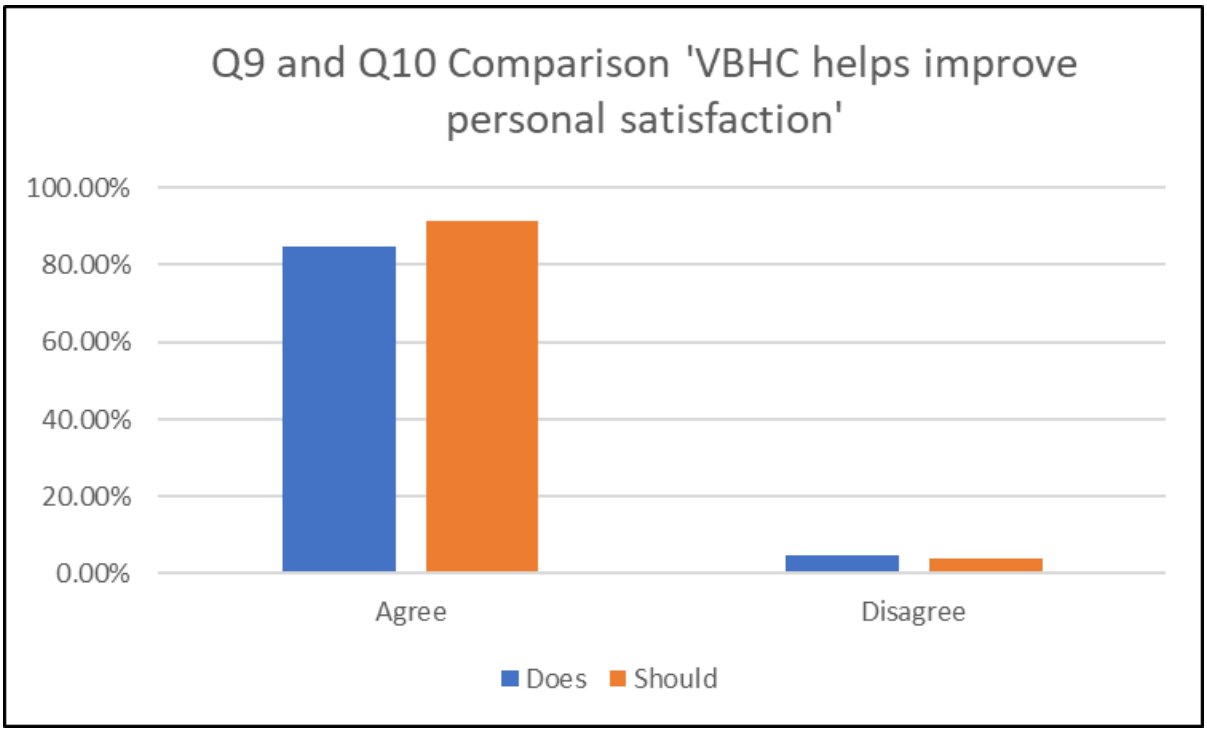
Research Charts 22 - Questionnaire Q9 Does Being Involved in VBHC Provide Personal Satisfaction

Participants responded where they felt that VBHC does provide personal satisfaction with 84.7% agreeing or strongly agreeing and 4.6% disagreeing or strongly disagreeing.



Research Charts 23 - Questionnaire Q9 Should Being Involved in VBHC Provide Personal Satisfaction

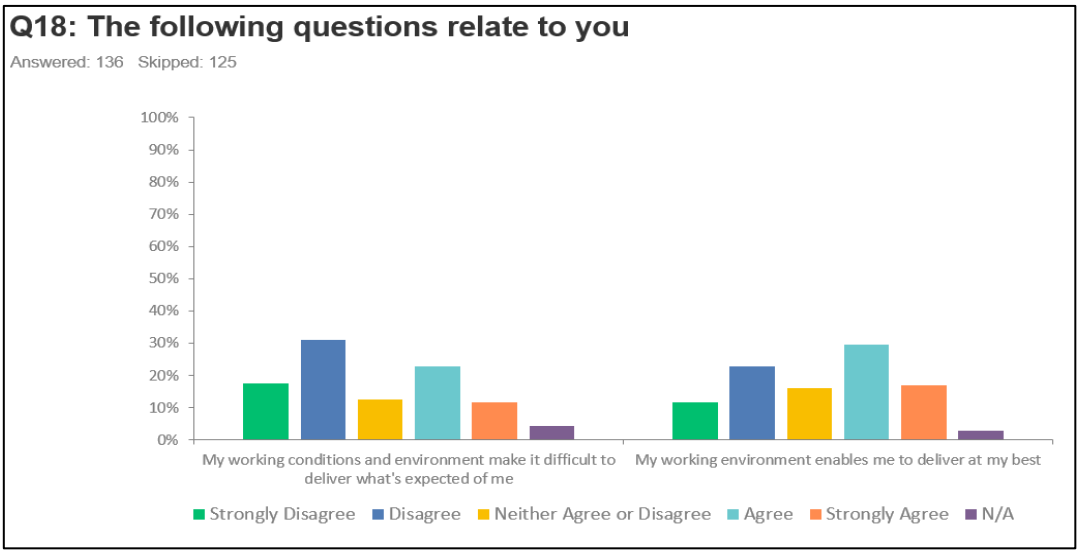
Participants responded where they felt that VBHC should provide personal satisfaction with 91.4% agreeing or strongly agreeing and 4.0% disagreeing or strongly disagreeing.



Research Charts 24 - Q9 And Q10 Comparison 'VBHC Helps Improve Personal Satisfaction'

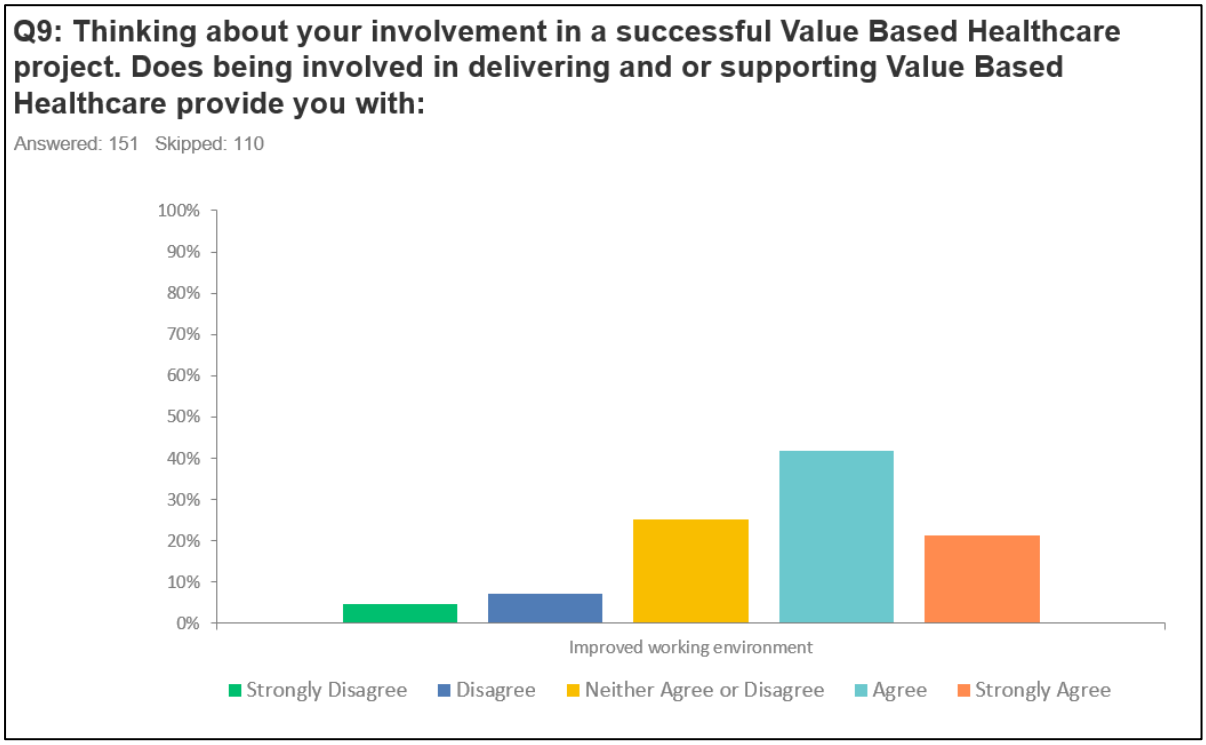
91.4% or respondents felt VBHC should help improve personal satisfaction with 84.7% of respondents saying it does help improve job satisfaction.

- **FT9 – Poor working environment**



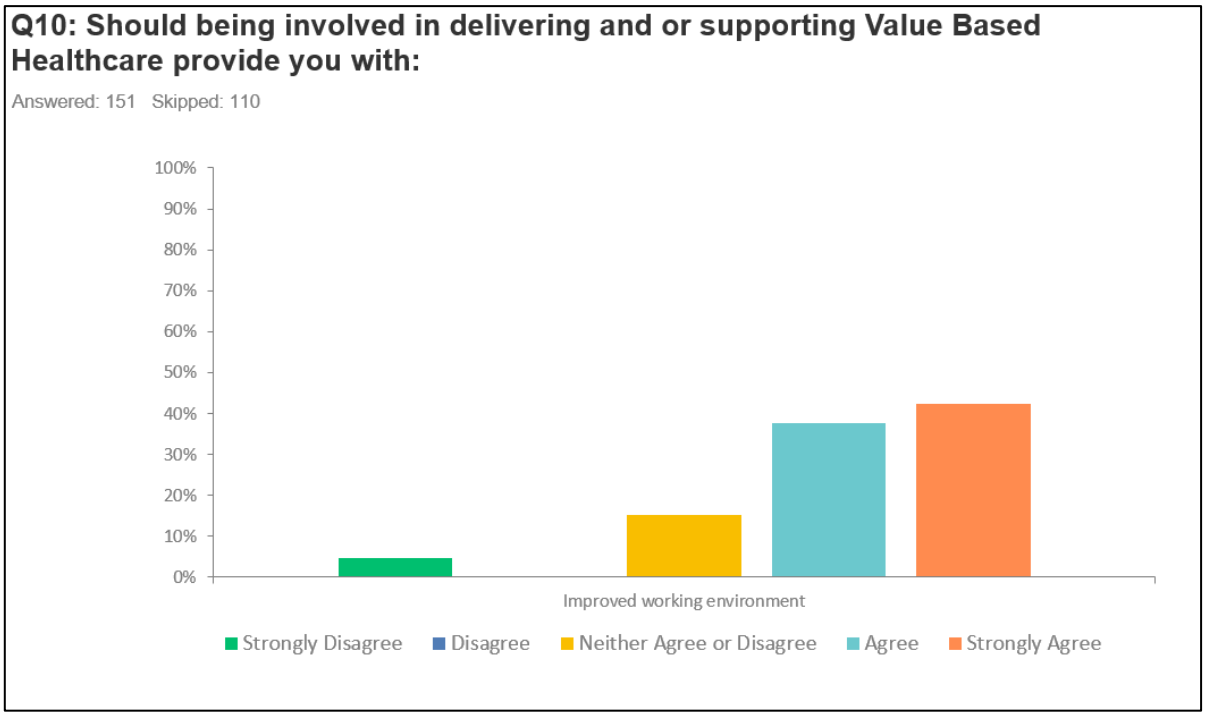
Research Charts 25 - Questionnaire Q18 Working Conditions and Environment

Participants responded where they felt their working conditions and environment made it difficult to deliver what was expected of them with 34.6% agreeing or strongly agreeing and 48.5% disagreeing or strongly disagreeing. Participants responded where they felt their working environment helped them deliver their best with 46.32% agreeing or strongly agreeing and 34.6% disagreeing or strongly disagreeing.



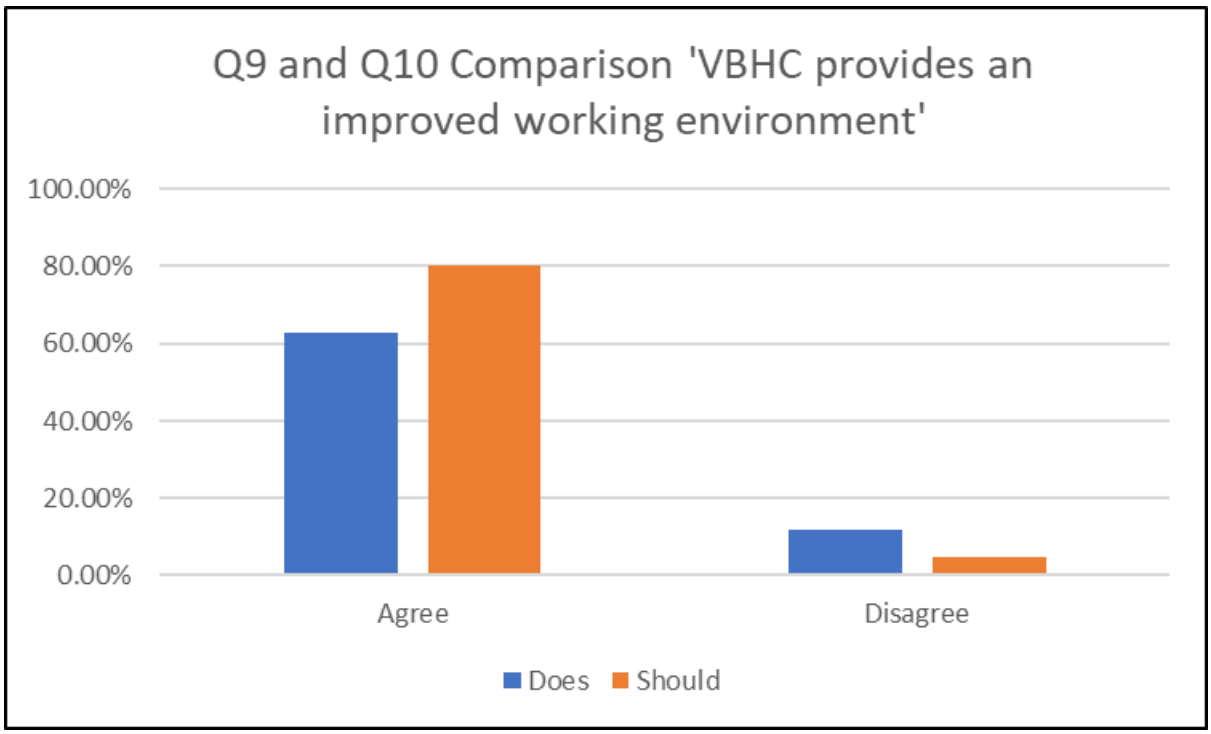
Research Charts 26 - Questionnaire Q9 Does Being Involved in VBHC Provides an Improved Working Environment

Participants responded where they felt that VBHC does provide an improved working environment with 62.9% agreeing or strongly agreeing and 11.9% disagreeing or strongly disagreeing.



Research Charts 27 - Questionnaire Q10 Should Being Involved in VBHC Provides an Improved Working Environment

Participants responded where they felt that VBHC should provide an improved working environment with 80.1% agreeing or strongly agreeing and 4.6% disagreeing or strongly disagreeing.



Research Charts 28 - Q9 And Q10 Comparison 'VBHC Helps Improve the Working Environment'

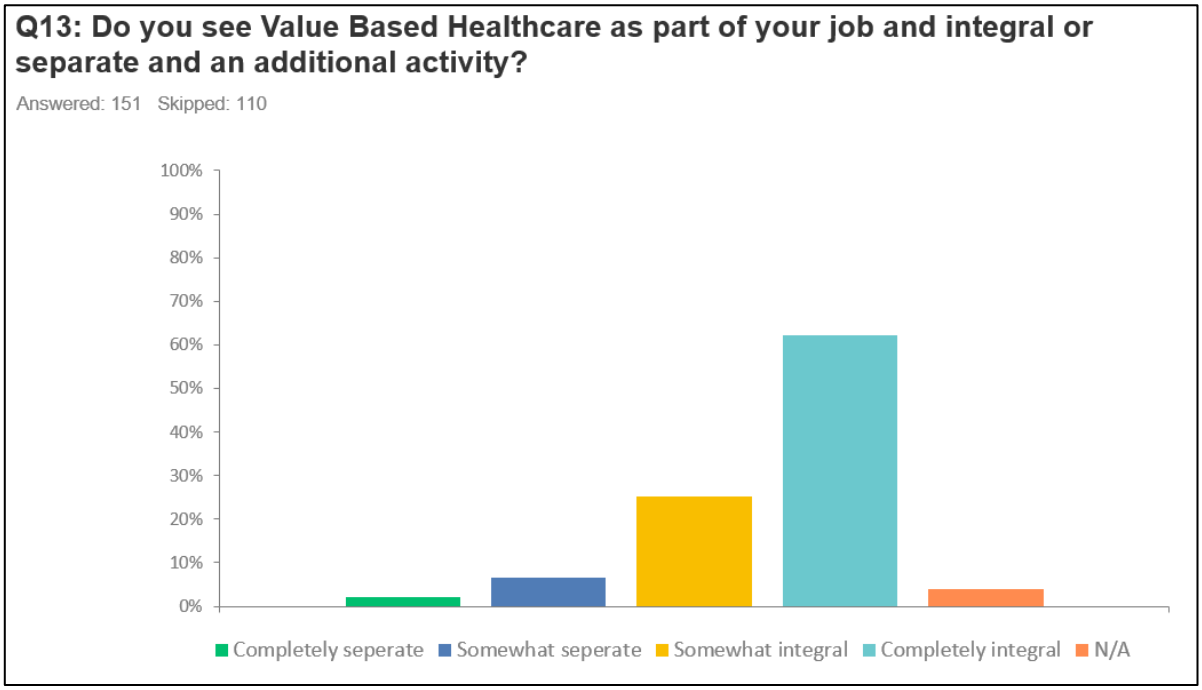
80.1% or respondents felt VBHC should help provide an improved working environment with 62.9% of respondents saying it does help provide an improved working environment.

4.2.4. Results and Findings Conceptual Framework Theme 3 – Ownership

This section provides the questionnaire results associated with the questions asked for the authors conceptual framework theme 3 focused around ownership and the 4 sub Failure Themes.

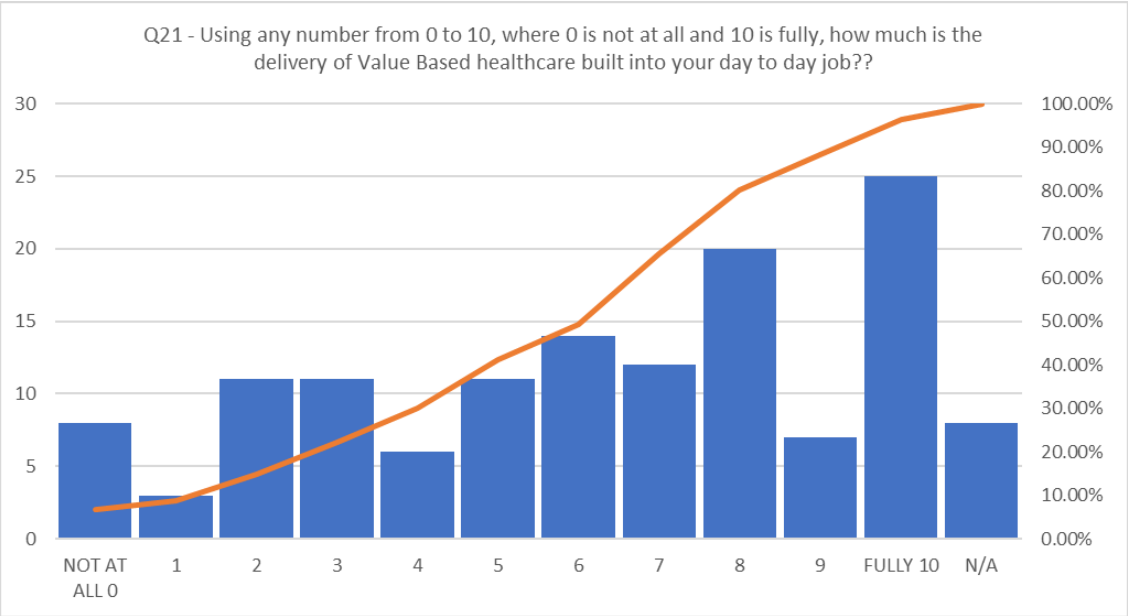
Failure Themes		Conceptual Framework Theme	
FT11	Not integral to the role	CFT3	Ownership
FT12	Loss of control	CFT3	Ownership
FT13	Not being allowed to make mistakes and learn from them	CFT3	Ownership
FT14	Not involved in decision making	CFT3	Ownership

- **FT11 – Not integral to the role**



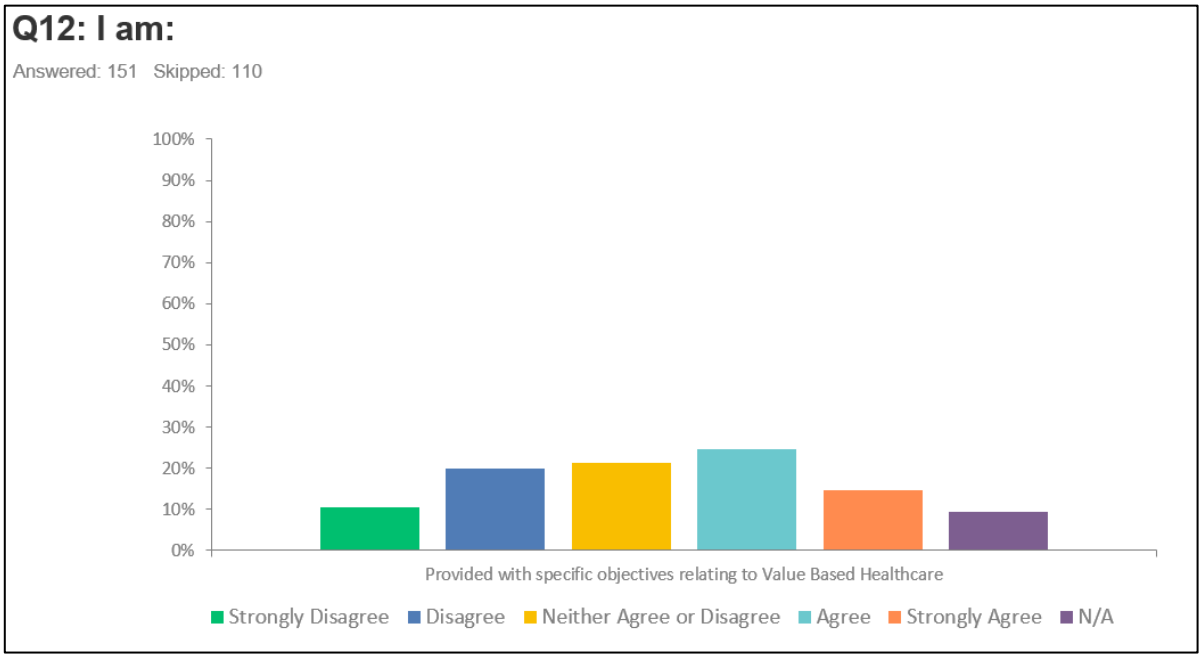
Research Charts 29 - Questionnaire Q13 Is VBHC Integral to or a Separate Part of Your Job

Participants responded where they saw VBHC as an integral part of their job or completely separate with 2% Completely Separate, 6.6% Somewhat Separate, 25.2% Somewhat Integral and 62.3% as Completely Integral. Overall 87.4% saw it as Integral and 8.6% Separate.



Research Charts 30 - Questionnaire Q21 How Much Is the Delivery of VBHC Built into Your Day Job

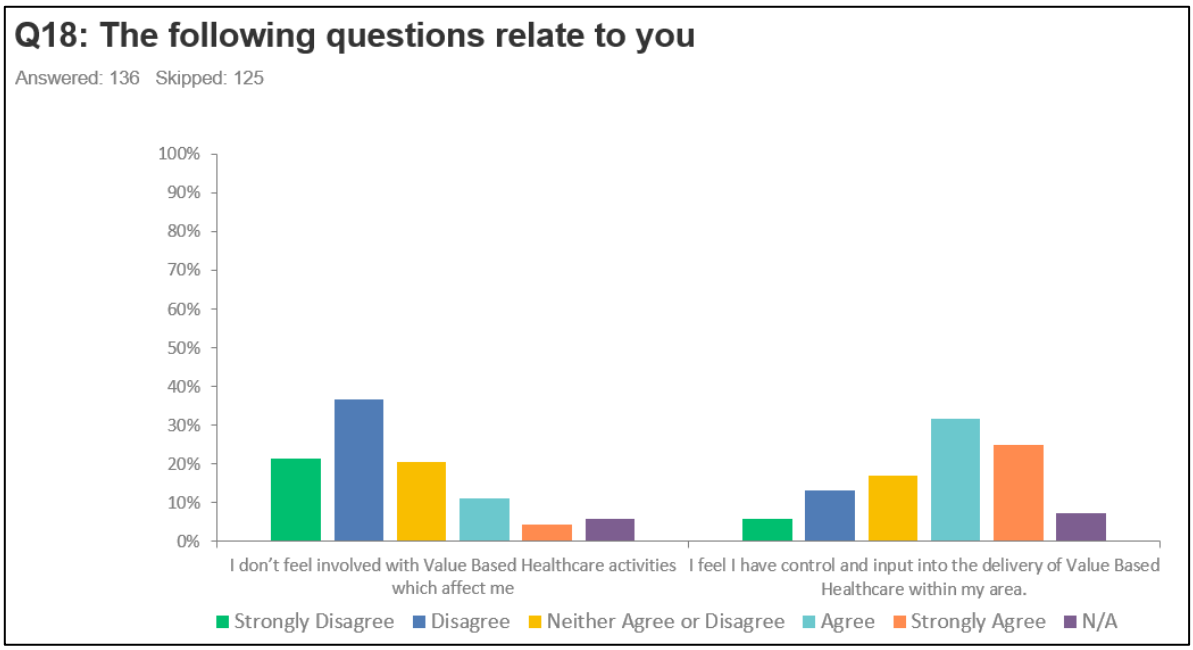
Participants responded 5 or above shows that 66.2% of people felt VBHC delivery was built into their day jobs and those responding 5 or below 41.2%.



Research Charts 31 - Questionnaire Q12 Specific Objectives Relating To VBHC

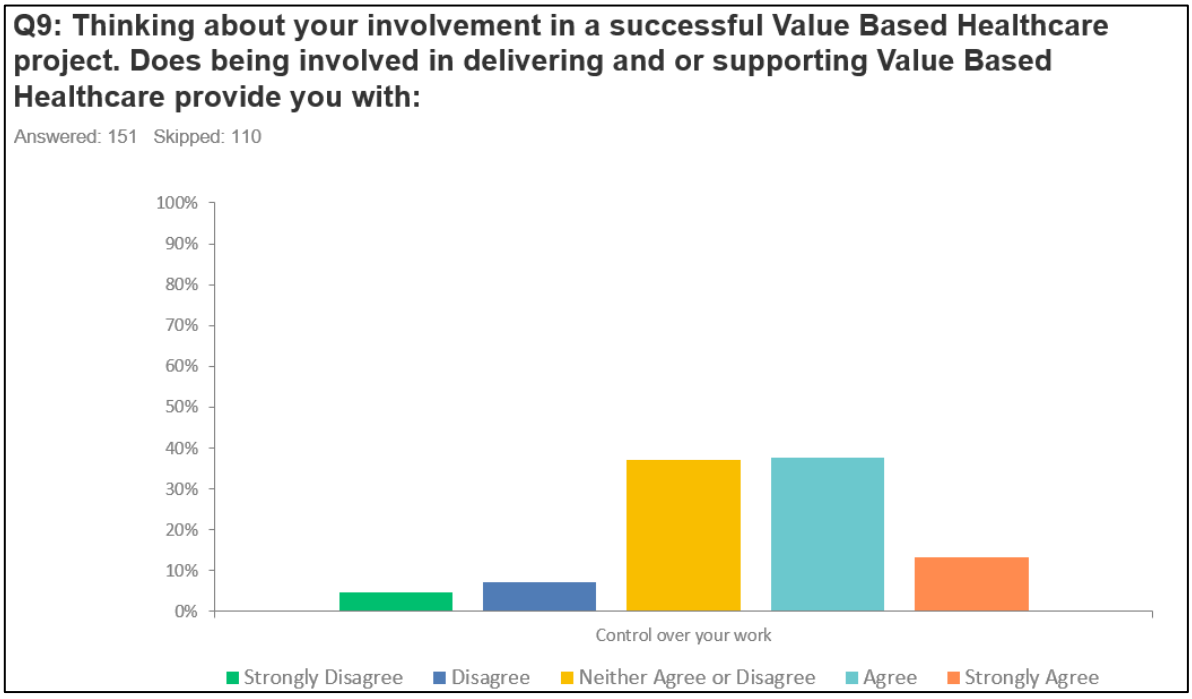
Participants responded where they had been provided with specific VBHC objectives with 39.1% agreeing or strongly agreeing and 30.5% disagreeing or strongly disagreeing.

- **FT12 – Loss of control**



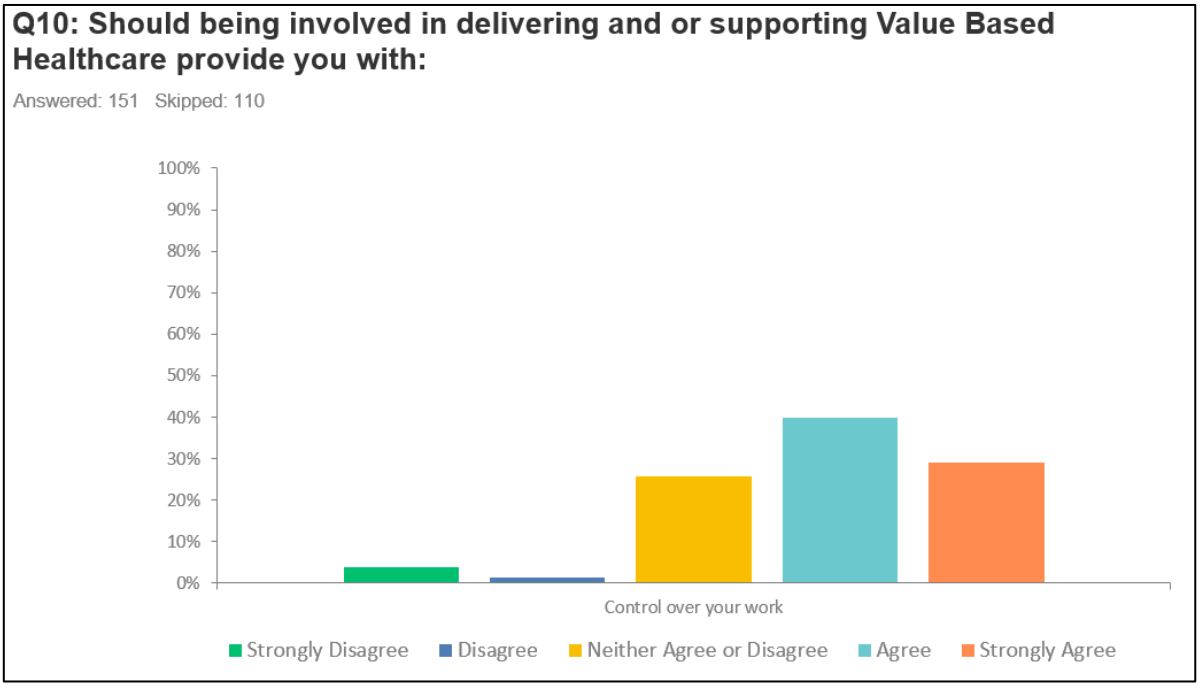
Research Charts 32 - Questionnaire Q18 Involvement and Control Over VBHC

Participants responded where they didn't feel involved with VBHC activities which affect them with 15.4% agreeing or strongly agreeing and 58.1% disagreeing or strongly disagreeing. Participants responded where felt they did have control and input into the delivery of VBHC with 56.6% agreeing or strongly agreeing and 19.1% disagreeing or strongly disagreeing.



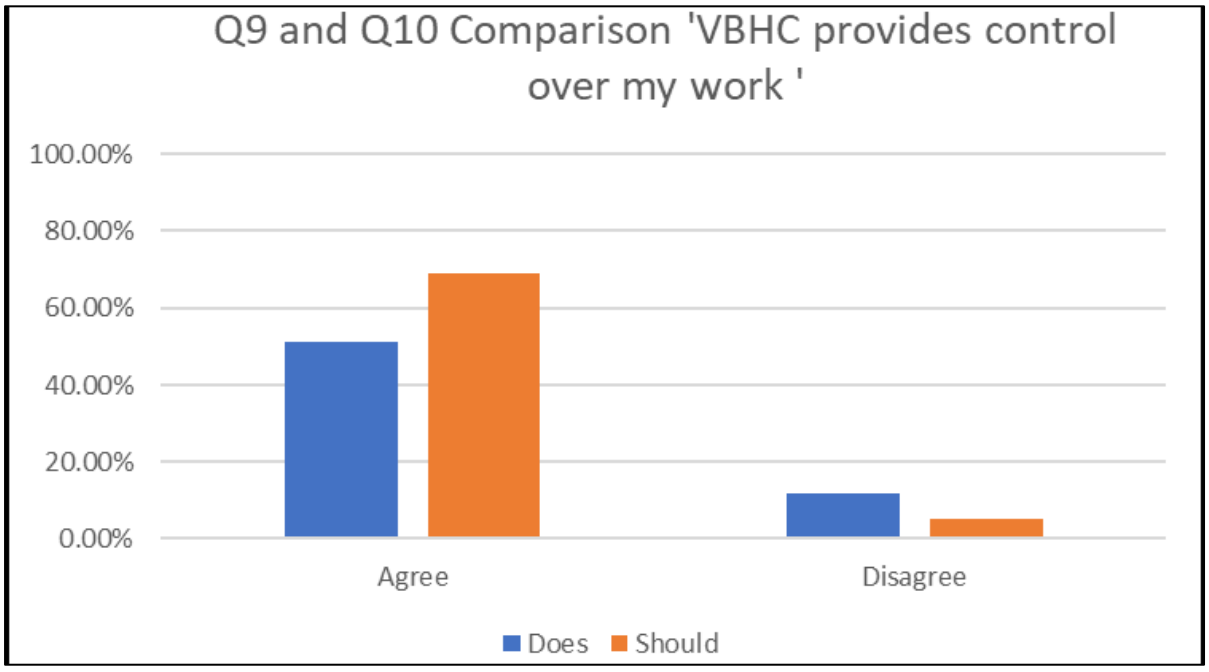
Research Charts 33 - Questionnaire Q9 Does Being Involved in VBHC Provide Control Over Your Work

Participants responded where they felt that VBHC does provide control over their work with 51.0% agreeing or strongly agreeing and 11.9% disagreeing or strongly disagreeing.



Research Charts 34 - Questionnaire Q9 Should Being Involved in VBHC Provide Control Over Your Work

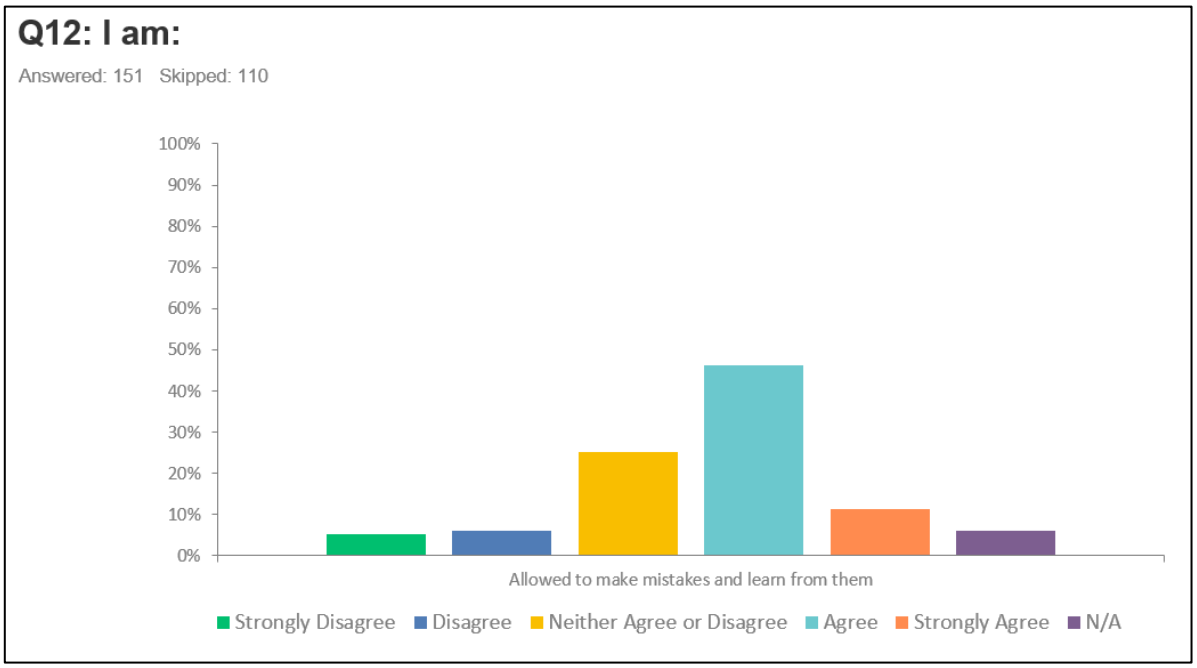
Participants responded where they felt that VBHC should provide control over their work with 68.9% agreeing or strongly agreeing and 5.3% disagreeing or strongly disagreeing.



Research Charts 35 - Q9 And Q10 Comparison 'VBHC Provides Control Over My Work'

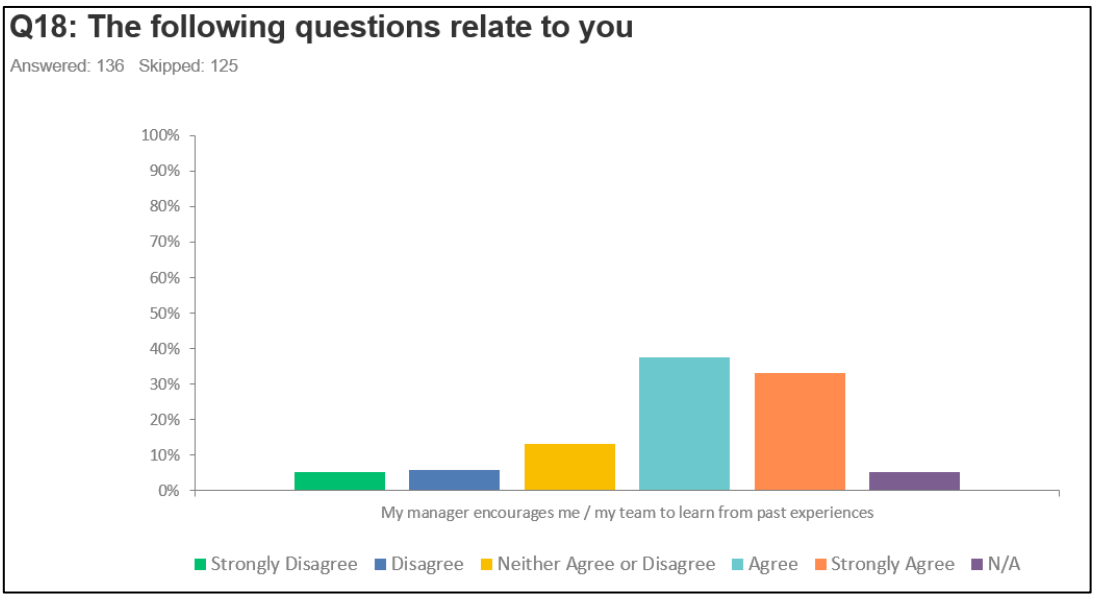
68.9% or respondents felt VBHC should provide control over their work with 51.0% of respondents saying it does help provide an improved working environment.

- **FT13 – Not being allowed to make mistakes and learn from them**



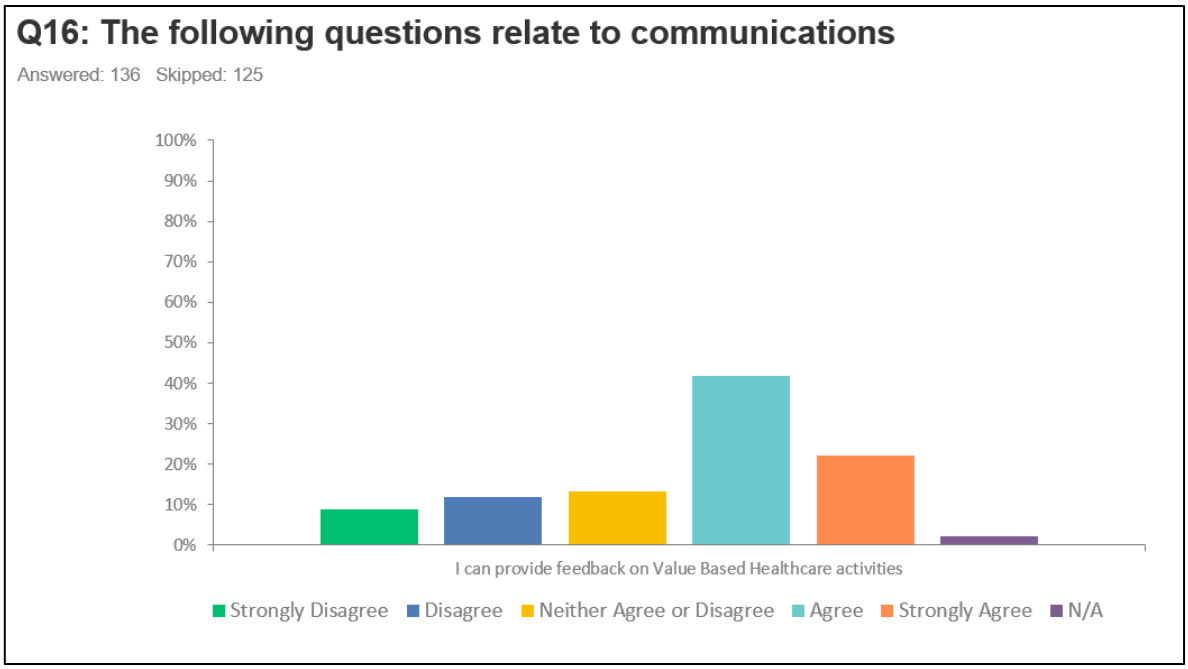
Research Charts 36 - Questionnaire Q12 Being Allowed to Make Mistakes and Learn from Them

Participants responded where they allowed to make mistakes and learn from them with 57.6% agreeing or strongly agreeing and 11.3% disagreeing or strongly disagreeing.



Research Charts 37 - Questionnaire Q18 My Manager Encourages Learning from Mistakes

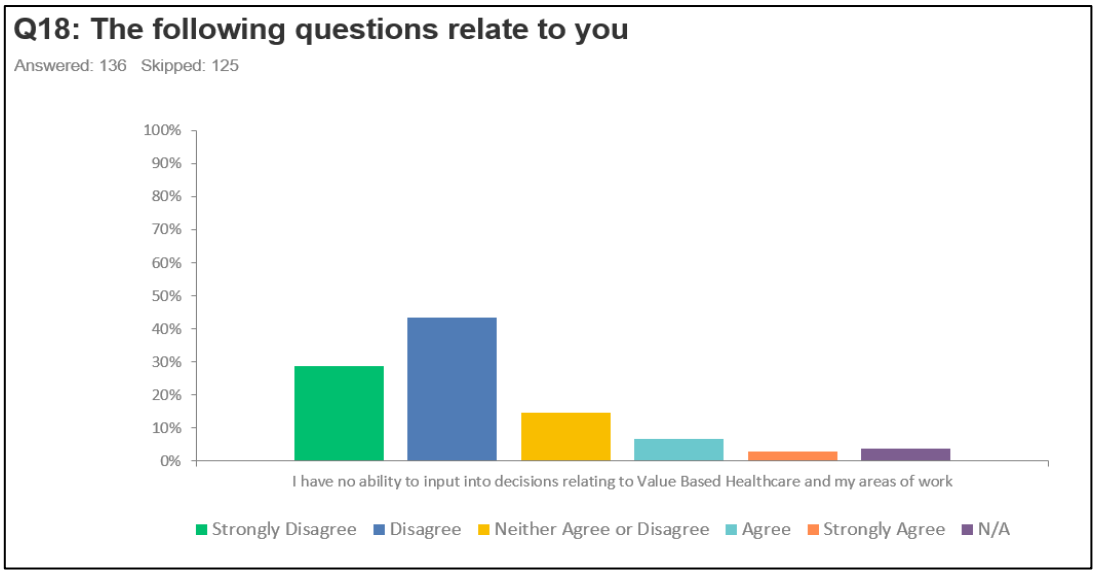
Participants responded where they or their team were encouraged by their to learn from past mistakes with 7.6% agreeing or strongly agreeing and 11.1% disagreeing or strongly disagreeing.



Research Charts 38 - Questionnaire Q16 Providing Feedback on VBHC Activities

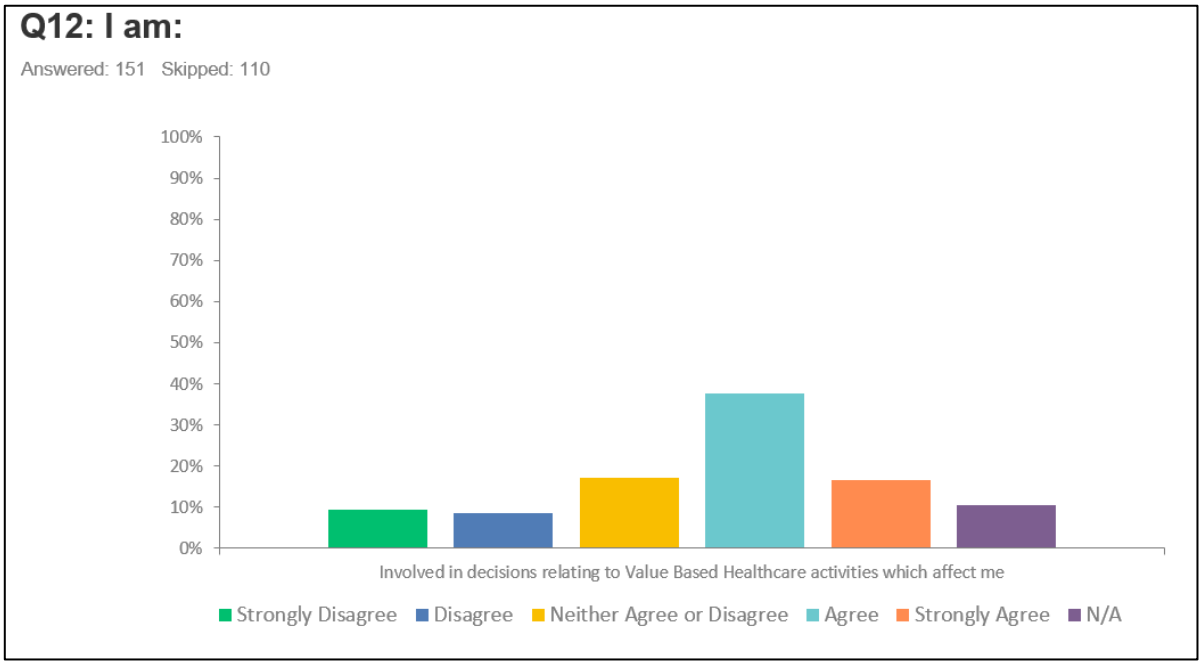
Participants responded where they could provide feedback on VBHC activities with 64.0% agreeing or strongly agreeing and 20.6% disagreeing or strongly disagreeing.

- **FT14 – Not involved in decision making**



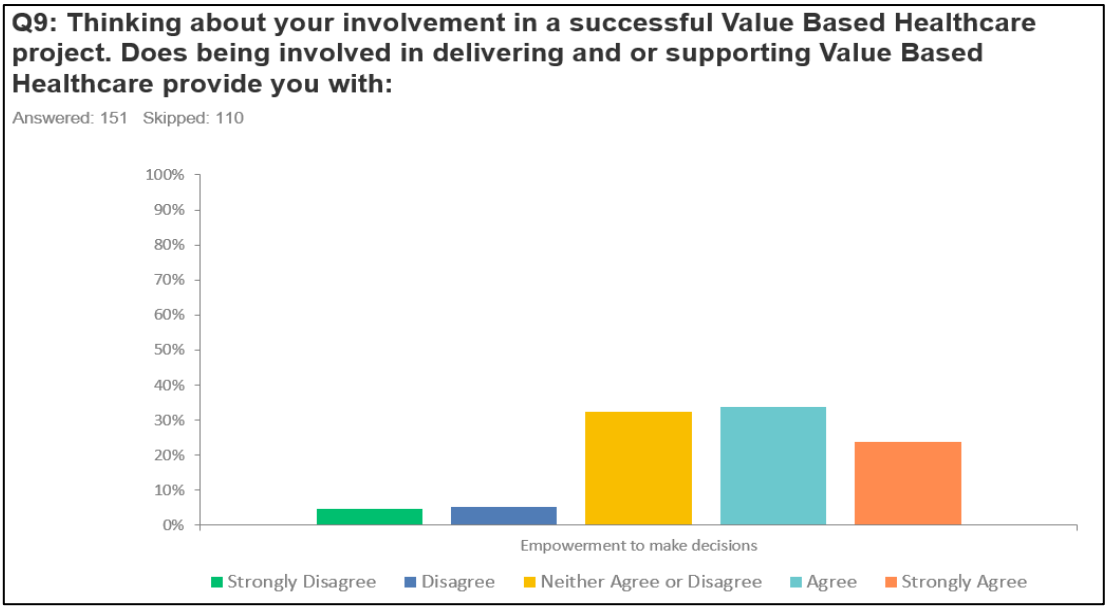
Research Charts 39 - Questionnaire Q18 Having No Ability to Input into Decisions Relating to VBHC

Participants responded where they felt they didn't have the ability to input into decisions relating to VBHC and their areas of work with 9.6% agreeing or strongly agreeing and 72.1% disagreeing or strongly disagreeing.



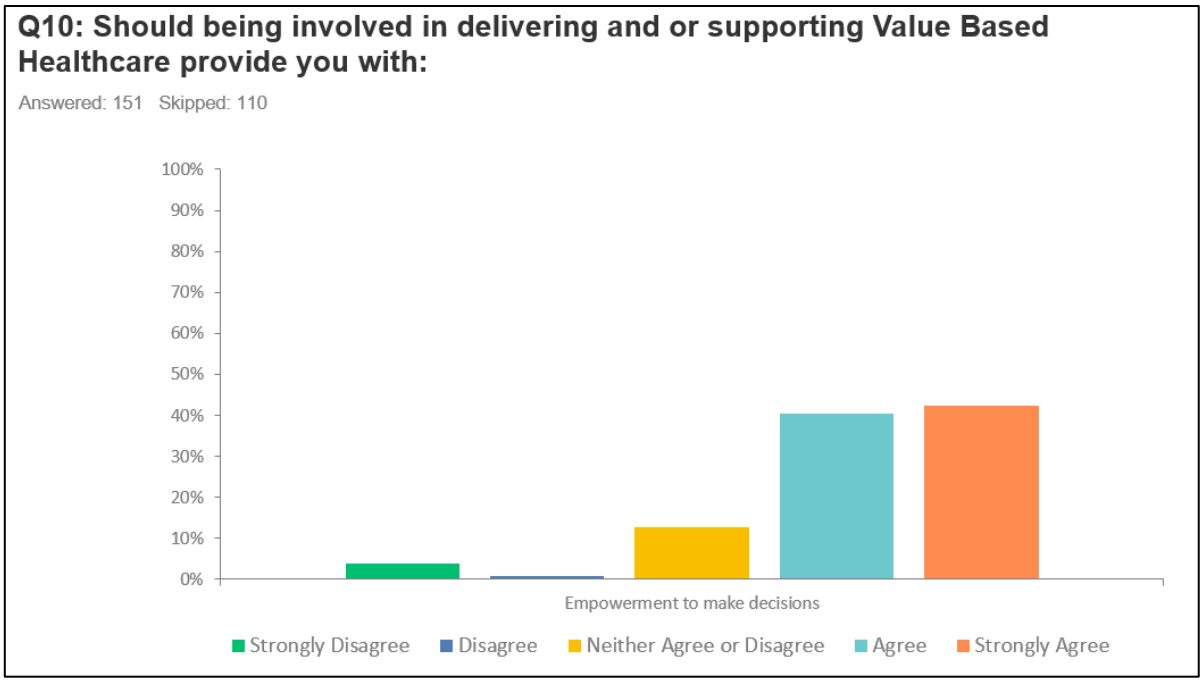
Research Charts 40 - Questionnaire Q12 Involvement in Decisions Regarding VBHC

Participants responded where they felt they were involved in decisions relating to VBHC that affected them with 54.3% agreeing or strongly agreeing and 18.9% disagreeing or strongly disagreeing.



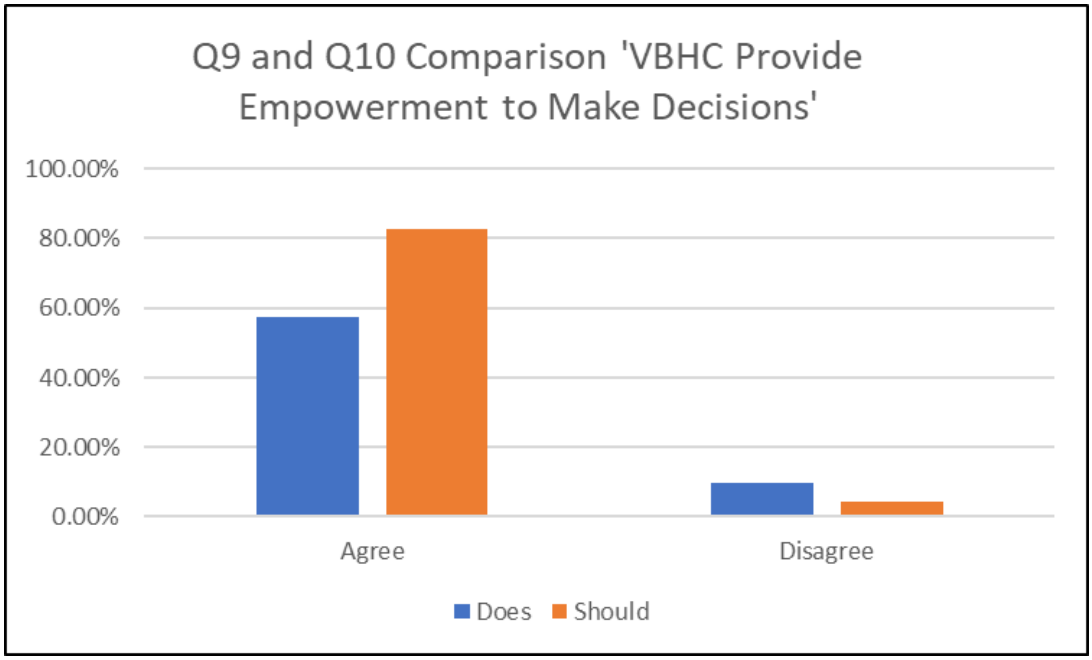
Research Charts 41 - Questionnaire Q9 Does Being Involved in VBHC Provide Empowerment to Make Decisions

Participants responded where they felt that being involved in VBHC does empower them to make decisions with 57.5% agreeing or strongly agreeing and 9.9% disagreeing or strongly disagreeing.



Research Charts 42 - Questionnaire Q10 Should Being Involved in VBHC Provide Empowerment to Make Decisions

Participants responded where they felt that being involved in VBHC should empower them to make decisions with 82.8% agreeing or strongly agreeing and 4.3% disagreeing or strongly disagreeing.



Research Charts 43 - Q9 And Q10 Comparison 'VBHC Provides Empowerment to Make Decisions'

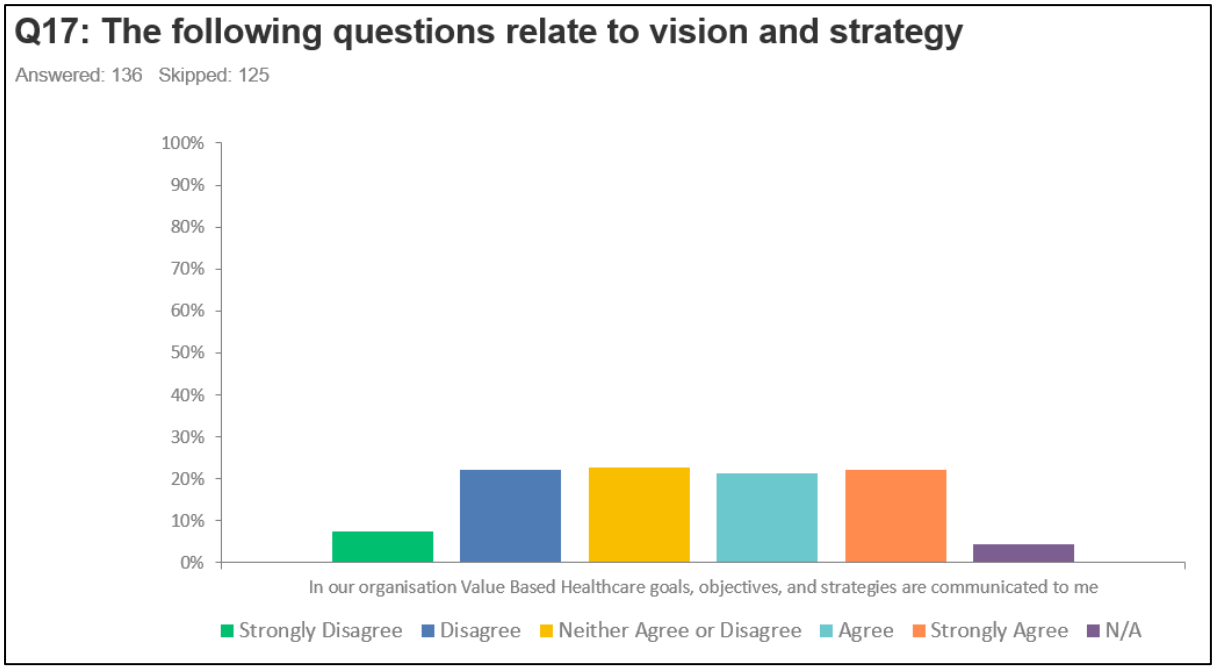
82.8% or respondents felt VBHC provide empowerment to make decisions with 57.5% of respondents saying it does help provide an improved working environment.

4.2.5. Results and Findings Conceptual Framework Theme 4 – Shared Aims

This section provides the questionnaire results associated with the questions asked for the authors conceptual framework theme 4 focused around shared aims and the 3 sub Failure Themes.

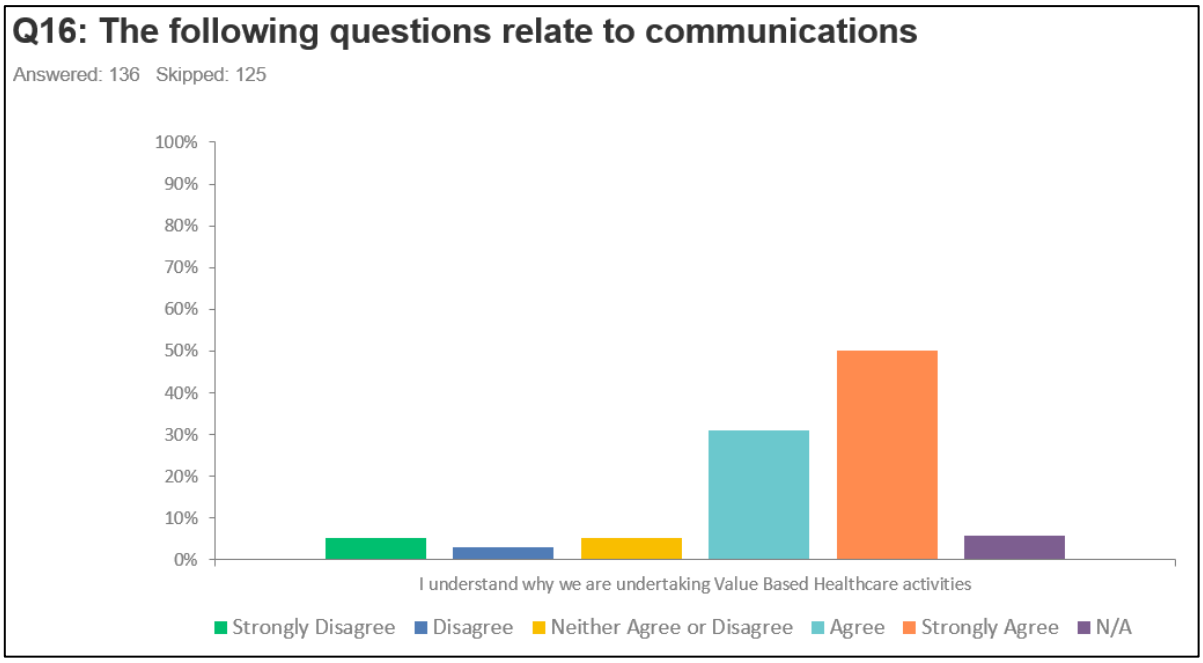
Failure Themes		Conceptual Framework Theme	
FT15	Lack of vision, context and certainty	CFT4	Shared Aims
FT16	Poor or unclear expectations	CFT4	Shared Aims
FT17	Unclear benefits or aims	CFT4	Shared Aims

- **FT15 – Lack of vision, context and certainty**



Research Charts 44 - Questionnaire Q17 VBHC Goals, Objectives and Strategies Are Communicated

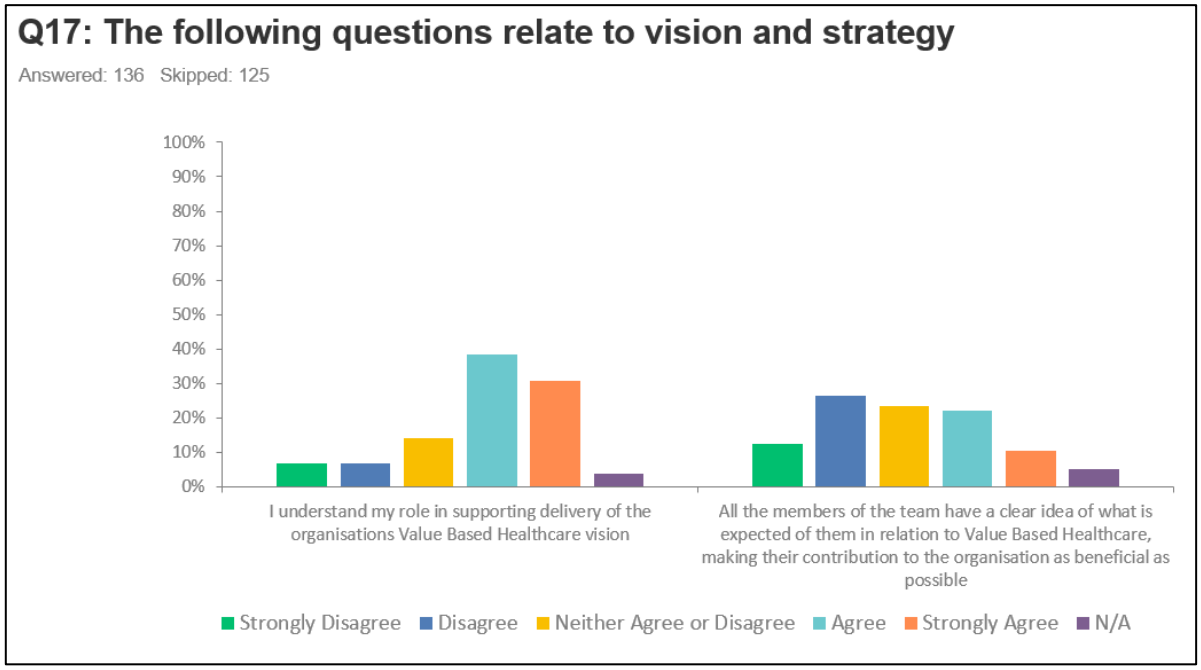
Participants responded where they felt VBHC goals, objectives and strategies were communicated to them with 43.3% agreeing or strongly agreeing and 29.4% disagreeing or strongly disagreeing.



Research Charts 45 - Questionnaire Q16 Understanding of Why VBHC Is Being Undertaken

Participants responded where they felt they understood why VBHC activities were being undertaken with 80.9% agreeing or strongly agreeing and 8.1% disagreeing or strongly disagreeing.

- **FT16 – Poor or unclear expectations**



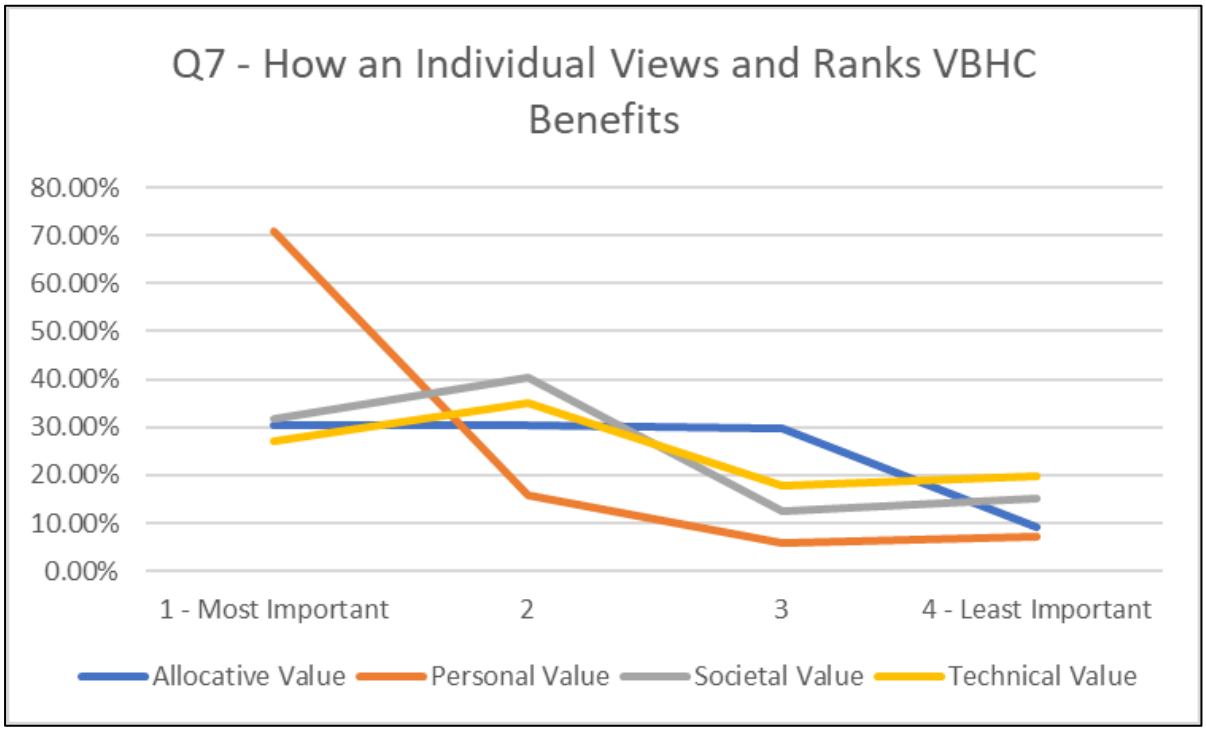
Research Charts 46 - Questionnaire Q17 Understanding My Along with My Teams Role in Delivering VBHC

Participants responded where they felt they understood their role in supporting delivery of the organisations VBHC vision with 69.1% agreeing or strongly agreeing and 13.2% disagreeing or strongly

disagreeing. Participants responded where they felt all members of their team had a clear understanding of what was expected of them in delivering VBHC with 32.4% agreeing or strongly agreeing and 41.0% disagreeing or strongly disagreeing.

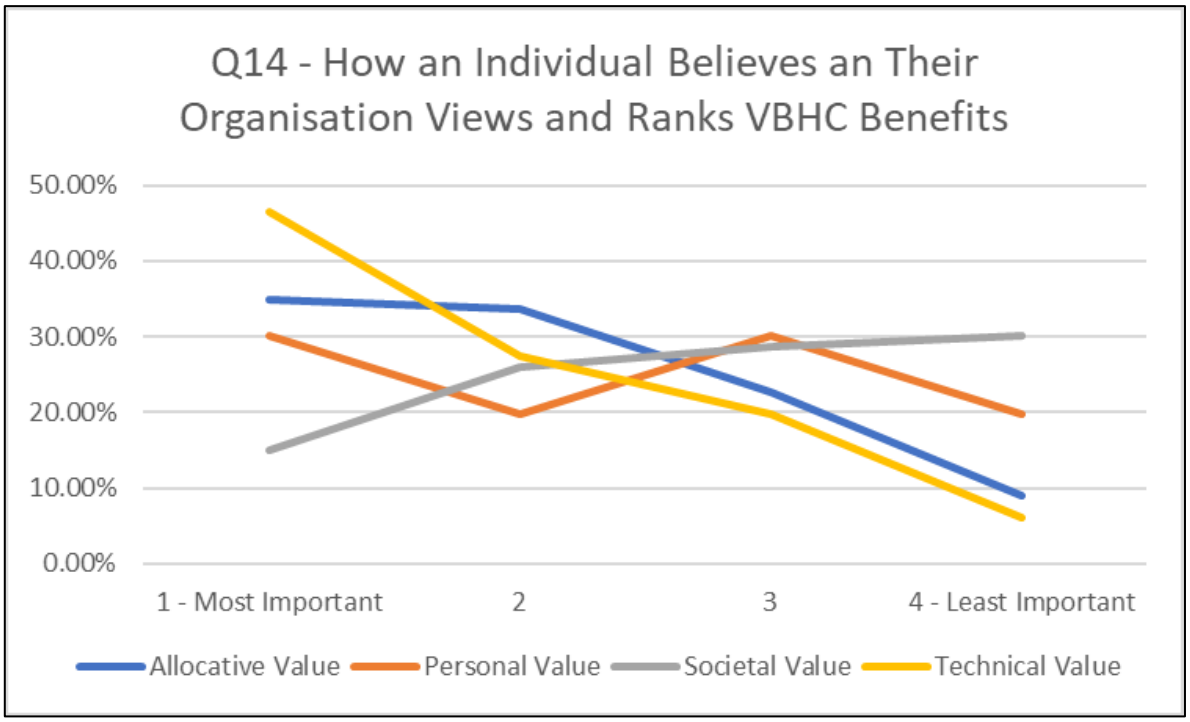
- **FT17 – Unclear benefits or aims**

Question 7 asked respondents to rank the Value Based Healthcare benefit areas in order of how **they** saw their importance with 1 being most important and 4 being least important? Similarly question 14 asked respondents to rank the Value Based Healthcare benefit areas in order of how they believed **their organisation** saw their importance with 1 being most important and 4 being least important?



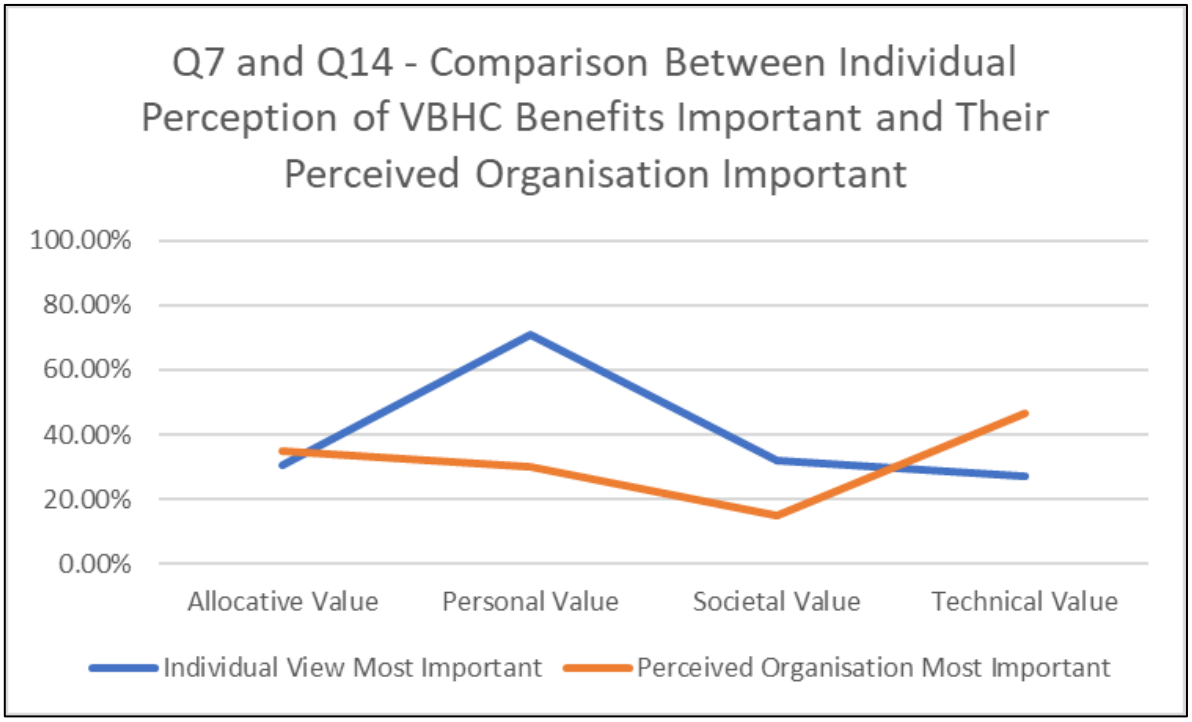
Research Charts 47 - Questionnaire Q7 How Respondents Rank VBHC Benefit Areas from Their Perspective

Participants clearly showed **they saw** VBHC 'Personal Value' as most important with 70.9% ranking it most important followed by 'Societal Value' at 31.8% and 'Allocative Value at 30.5%. 27.2% ranked 'Technical Value' as most important.



Research Charts 48 - Questionnaire Q14 How Respondents Believe Their Organisation Ranks VBHC Benefit Areas

When asked to rank VBHC benefit areas in order of how they **believed their organisation** saw their importance 46.6% of respondents believed their organisation saw 'Technical Value' as most important, followed by 'Allocative Value' at 34.9%, 'Personal Value' at 30.1% and 'Societal Value' at 15.0%.



Research Charts 49 - Q7 and Q14 - Comparison Between 'Individual Perception of VBHC Benefits Important and Their Perceived Organisation Important'

Respondents roughly viewed their view and their organisations view of allocative value benefit as being equal, with a large difference seen between views of personal value.

Q8 - What SINGLE words would you use to describe what Value Based Healthcare means to YOU?

Figure 30 - Words Cloud from Respondents Relating To VBHC

A thematic analysis for question 8 has been undertaken using NVIVO software and is shown in Figure 31 and Table 39.

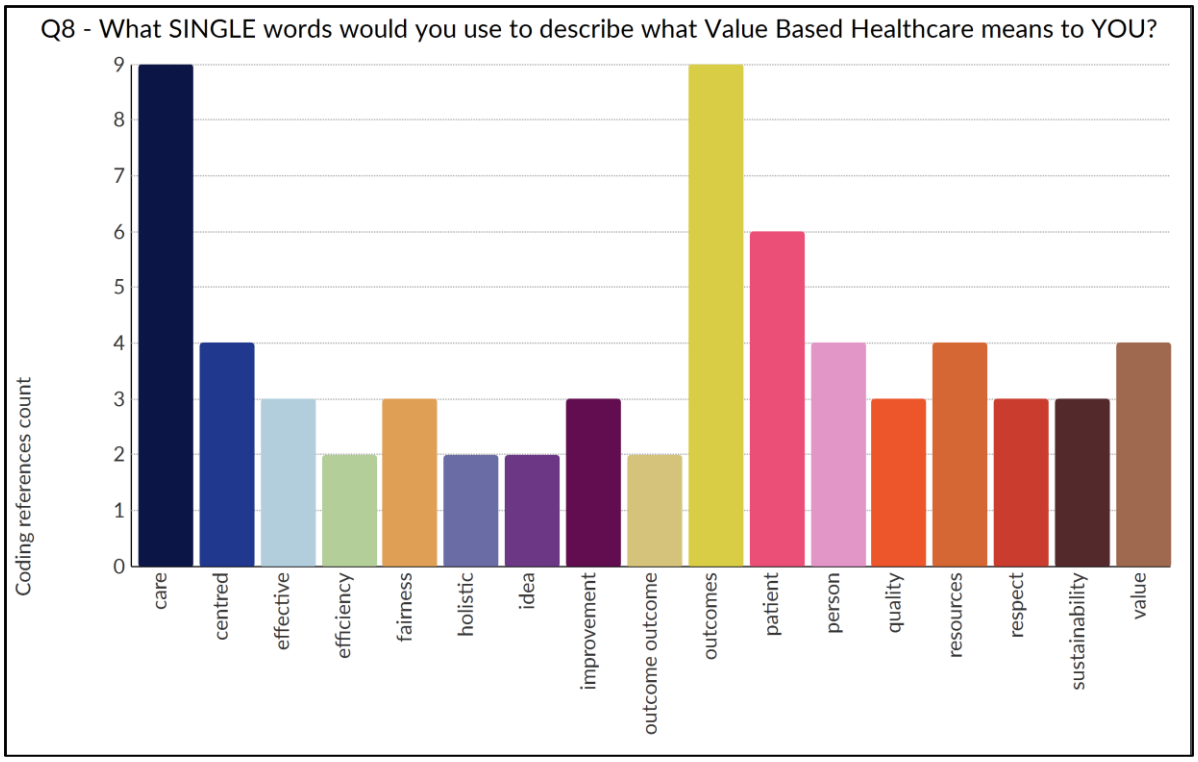


Figure 31 - Single Words to Describe What VBHC Means to you Thematic Analysis

Name	References
care	9
centred	4
effective	3
efficiency	2
fairness	3
holistic	2
idea	2
improvement	3
outcome outcome	2
outcomes	9
patient	6
person	4
quality	3
resources	4
respect	3
sustainability	3
value	4

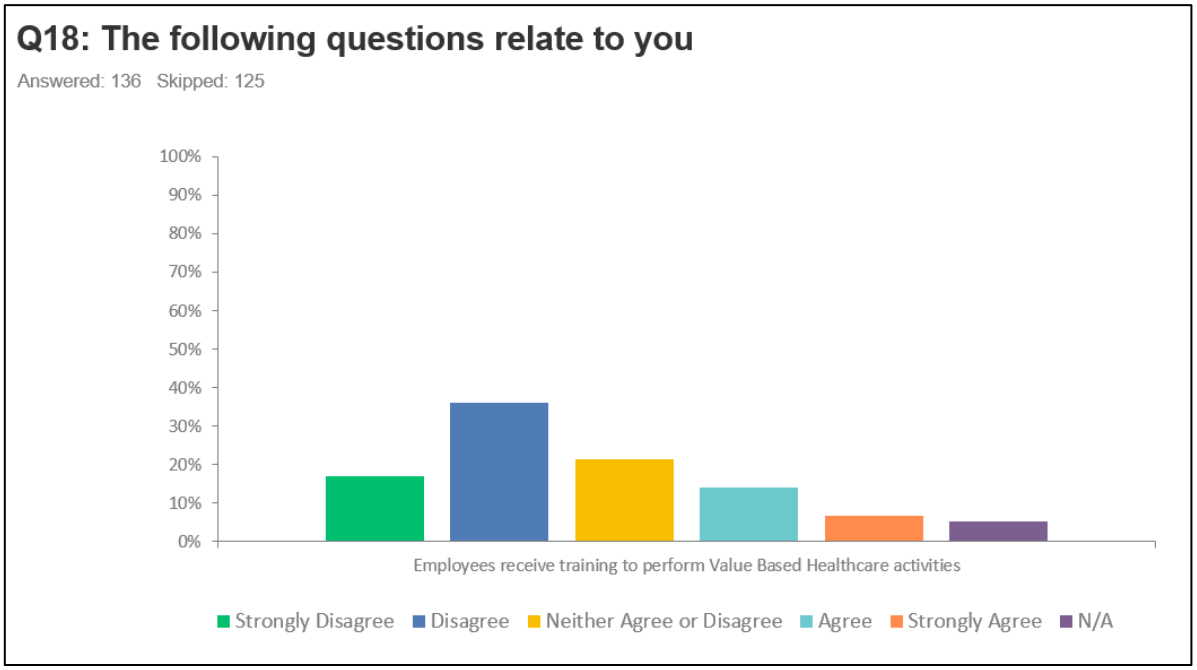
Table 39 - Single Words to Describe What VBHC Means to you Thematic Analysis

4.2.6. Results and Findings Conceptual Framework 5 – Skills & Capacity

This section provides the questionnaire results associated with the questions asked for the authors conceptual framework theme 5 focused skills and capacity and the 3 sub Failure Themes.

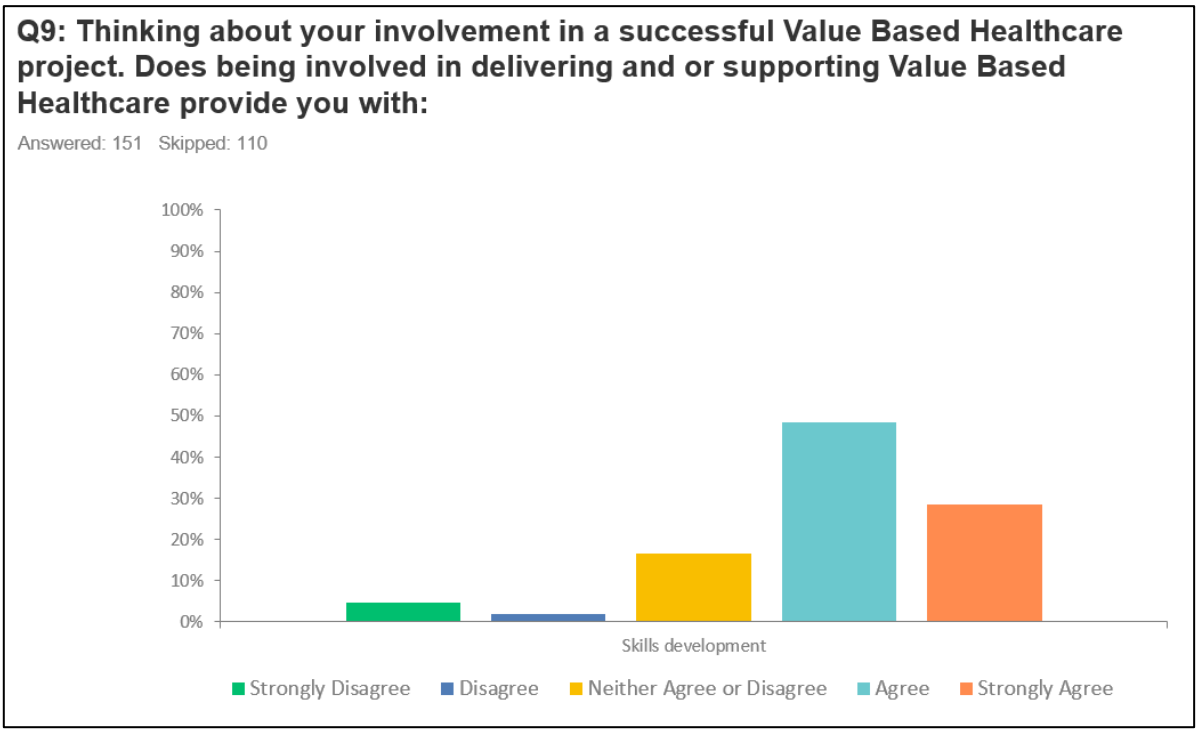
Failure Themes		Conceptual Framework Theme	
FT18	Lack of training or skills	CFT5	Skills & Capacity
FT19	Not enough time or resources	CFT5	Skills & Capacity
FT20	Not understanding terminology or shared language	CFT5	Skills & Capacity

- **FT18 – Lack of training or skills**



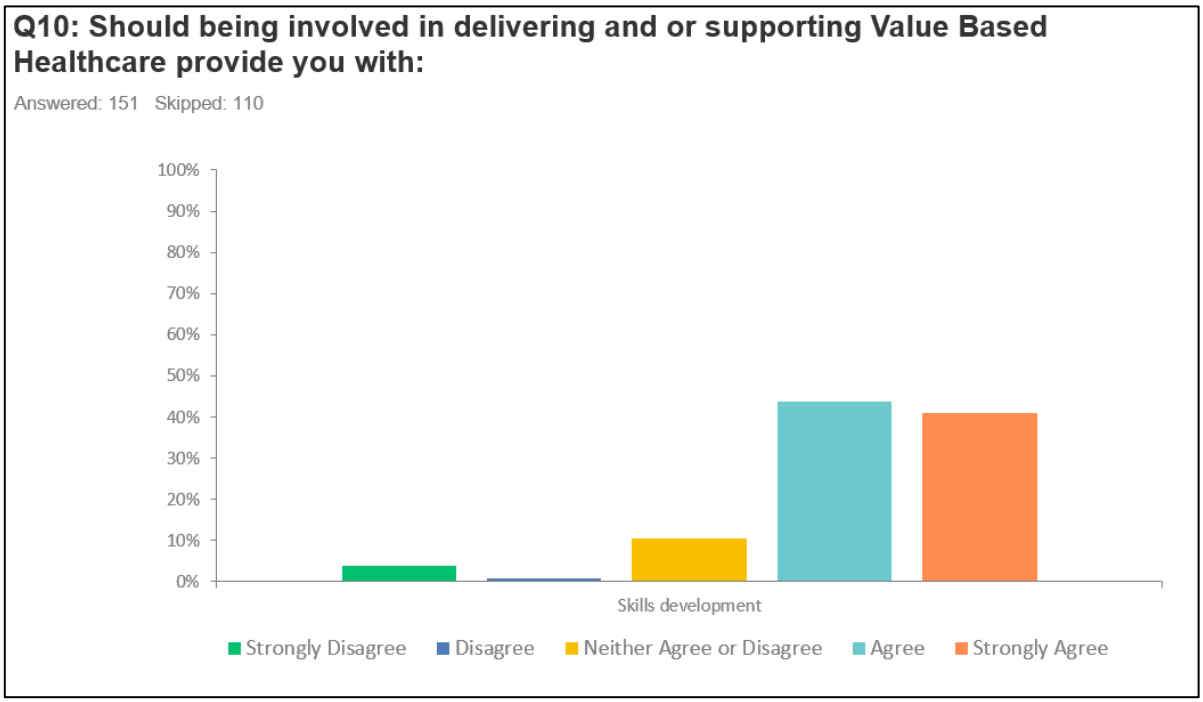
Research Charts 50 - Questionnaire Q18 Receiving Training to Perform VBHC Activities

Participants responded where they felt they did receive training to perform VBHC activities with 20.6% agreeing or strongly agreeing and 52.9% disagreeing or strongly disagreeing.



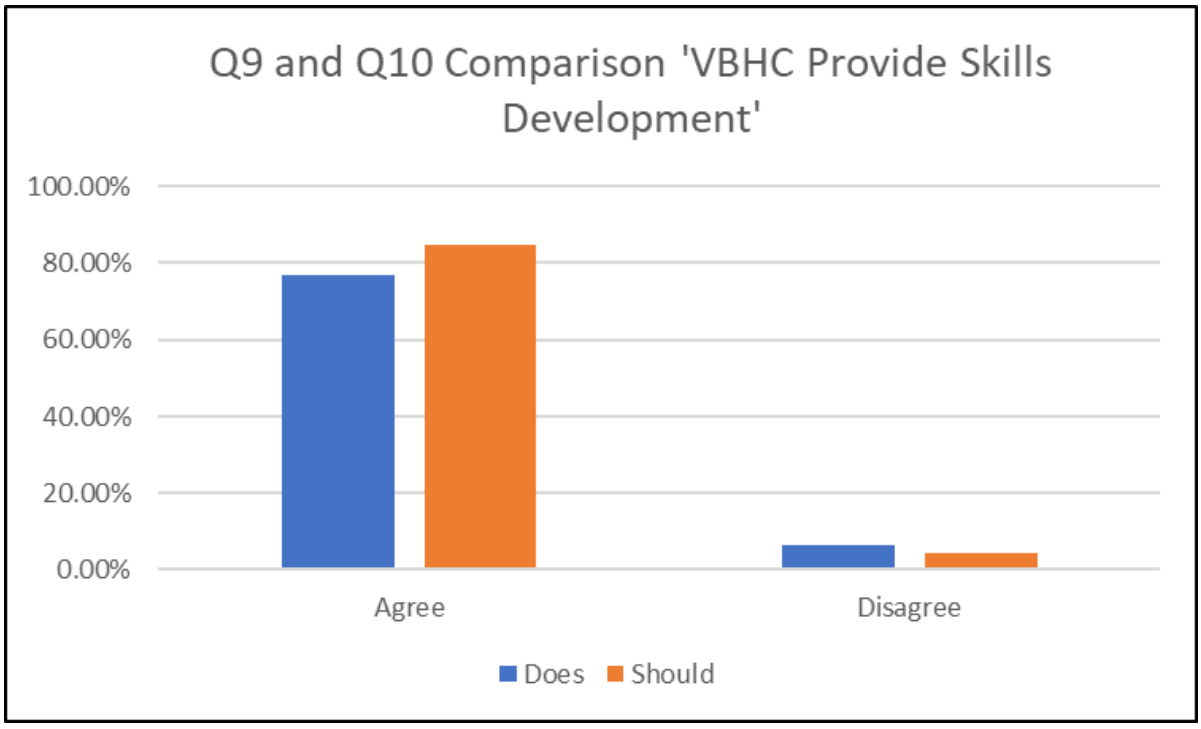
Research Charts 51 - Questionnaire Q9 Does Being Involved in VBHC Provide Skill Development

Participants responded where they felt that being involved in VBHC does provide them with skills development with 76.7% agreeing or strongly agreeing and 6.5% disagreeing or strongly disagreeing.



Research Charts 52 - Questionnaire Q10 Should Being Involved in VBHC Provide Skill Development

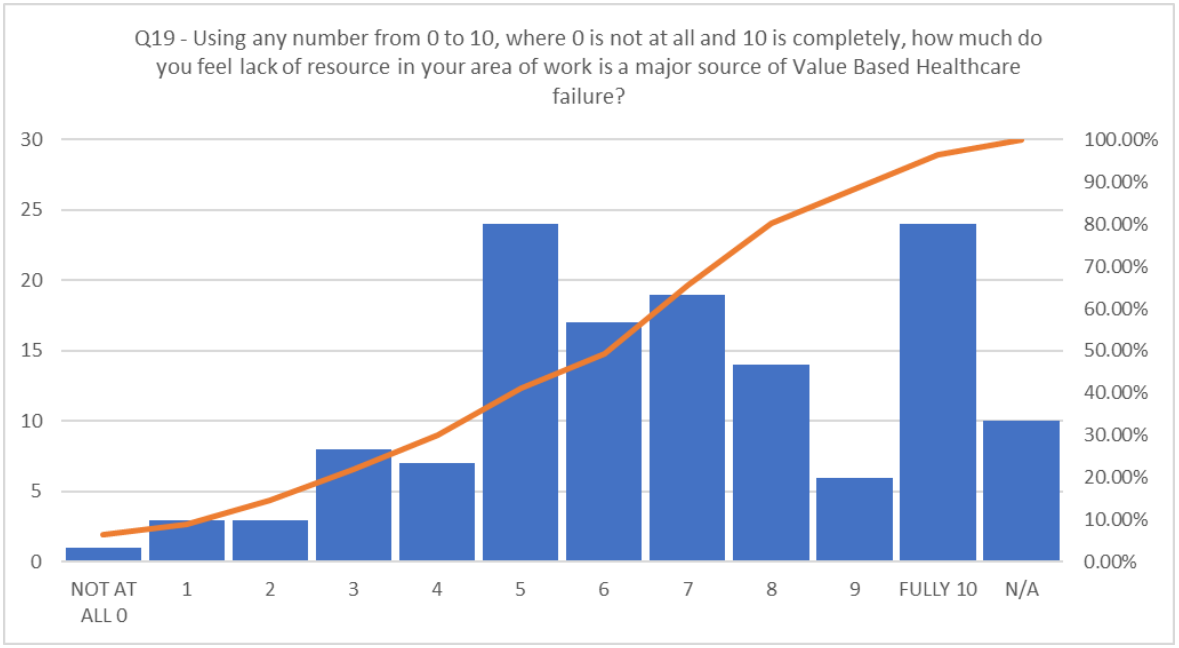
Participants responded where they felt that being involved in VBHC should provide them with skills development with 84.7% agreeing or strongly agreeing and 4.3% disagreeing or strongly disagreeing.



Research Charts 53 - Q9 And Q10 Comparison 'VBHC Provides Skills Development'

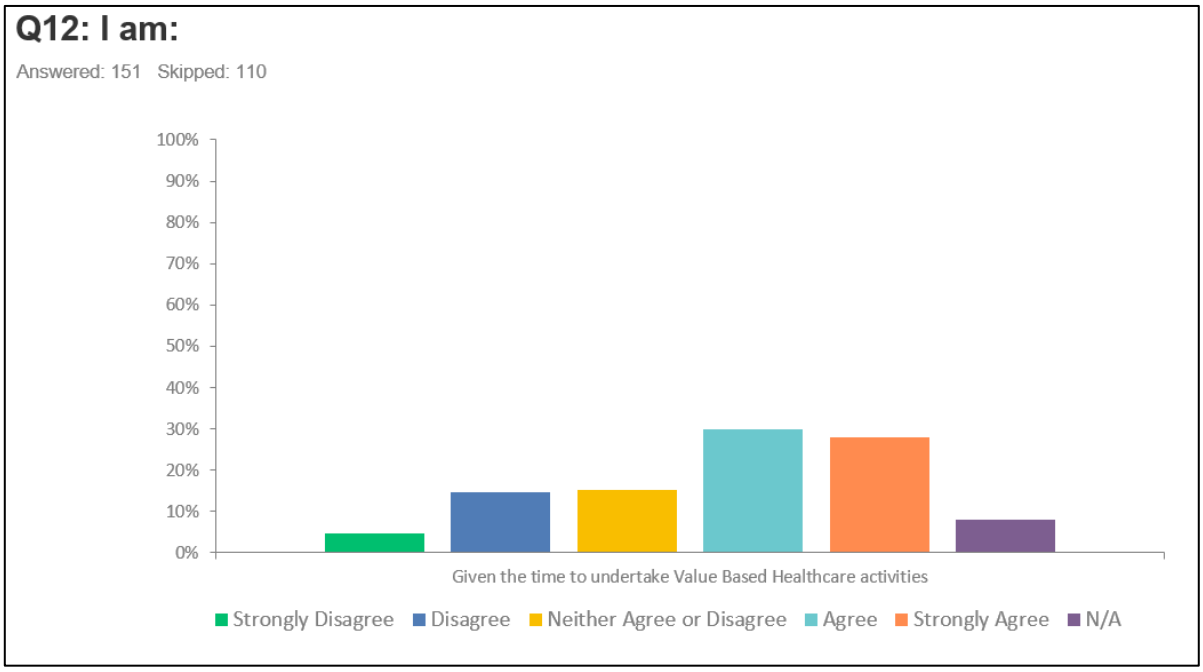
84.7% or respondents felt VBHC should provide them with skills development with 76.7% of respondents saying it does help provide an improved working environment.

- **FT19 – Not enough time or resources**



Research Charts 54 - Questionnaire Q19 How Much Do You Feel Lack of Resource in Your Area of Work is a Major Source of VBHC Failure

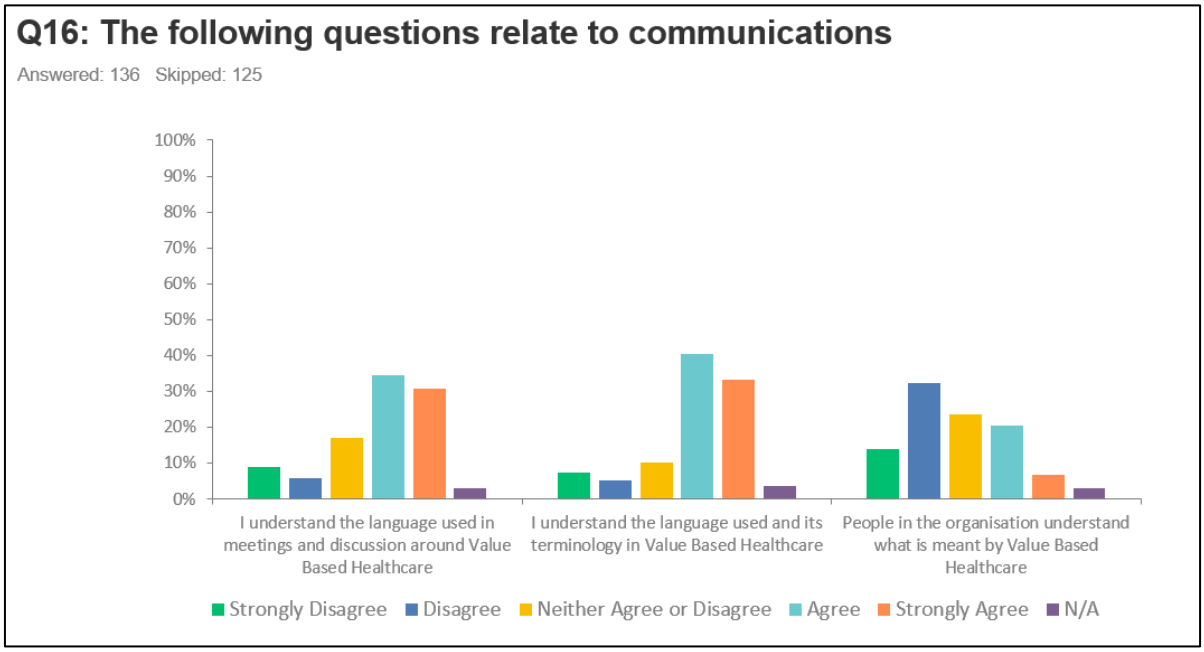
Participants responded 5 or above shows that 55.2% of people felt VBHC delivery was built into their day jobs and those responding 5 or below 41.2%.



Research Charts 55 - Questionnaire Q12 Given the Time to Undertake VBHC Activities

Participants responded where they felt they were given the time to undertake VBHC activities with 57.6% agreeing or strongly agreeing and 19.21% disagreeing or strongly disagreeing.

- **FT20 – Not understanding terminology or shared**



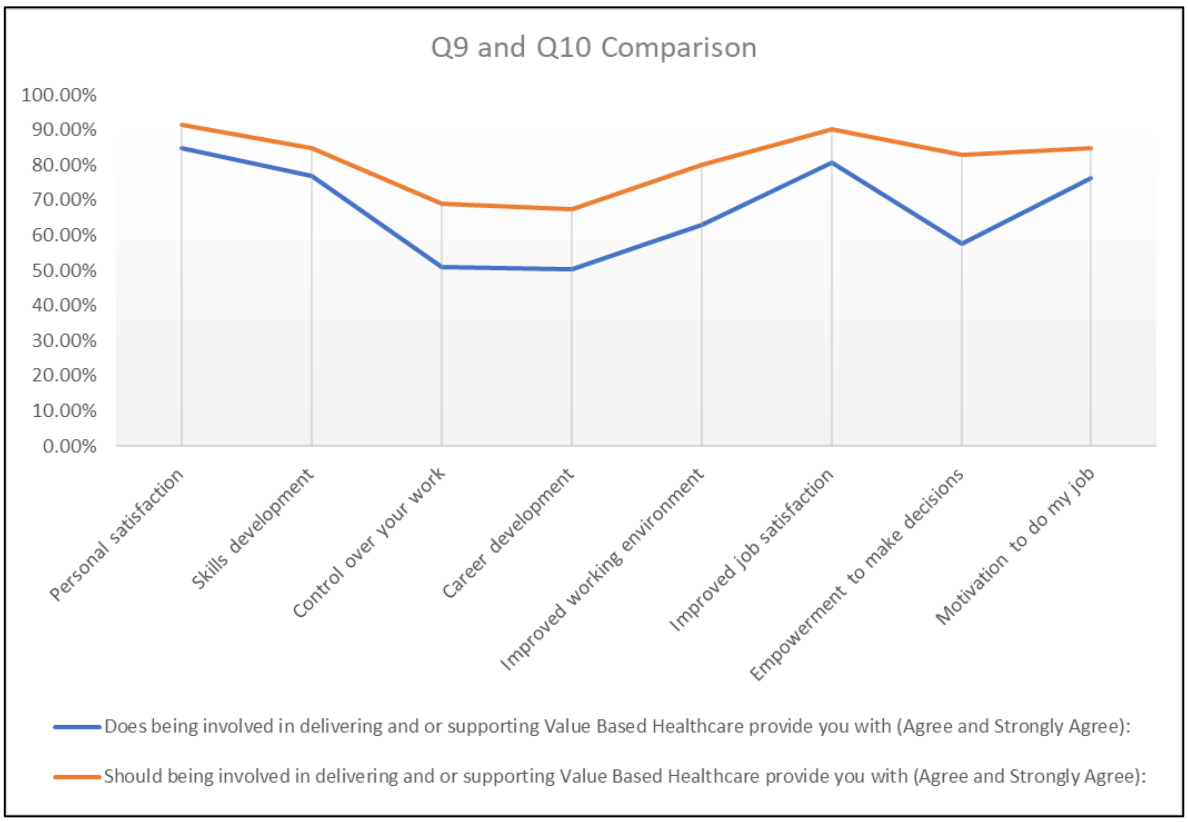
language

Research Charts 56 - Questionnaire Q16 Not Understanding Terminology or Shared Language

Participants responded where they felt they understood the language used in meetings with 65.4% agreeing or strongly agreeing and 14.7% disagreeing or strongly disagreeing. Participants responded where they felt they understood the language used and its terminology with 73.5% agreeing or strongly agreeing and 12.5% disagreeing or strongly disagreeing. Participants responded where they felt people in their organisation understood what is meant by VBHC with 27.2% agreeing or strongly agreeing and 46.3% disagreeing or strongly disagreeing.

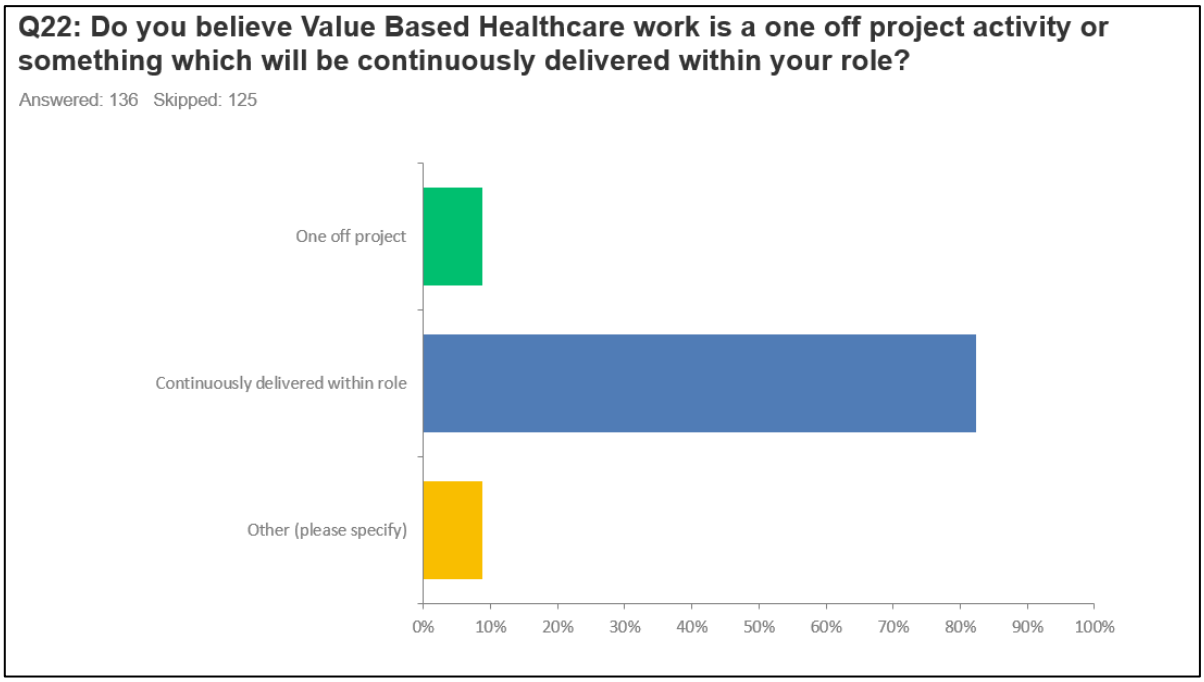
4.2.7. Other Findings

The questionnaire survey also provided a number of other key findings required to answer the authors research questions.



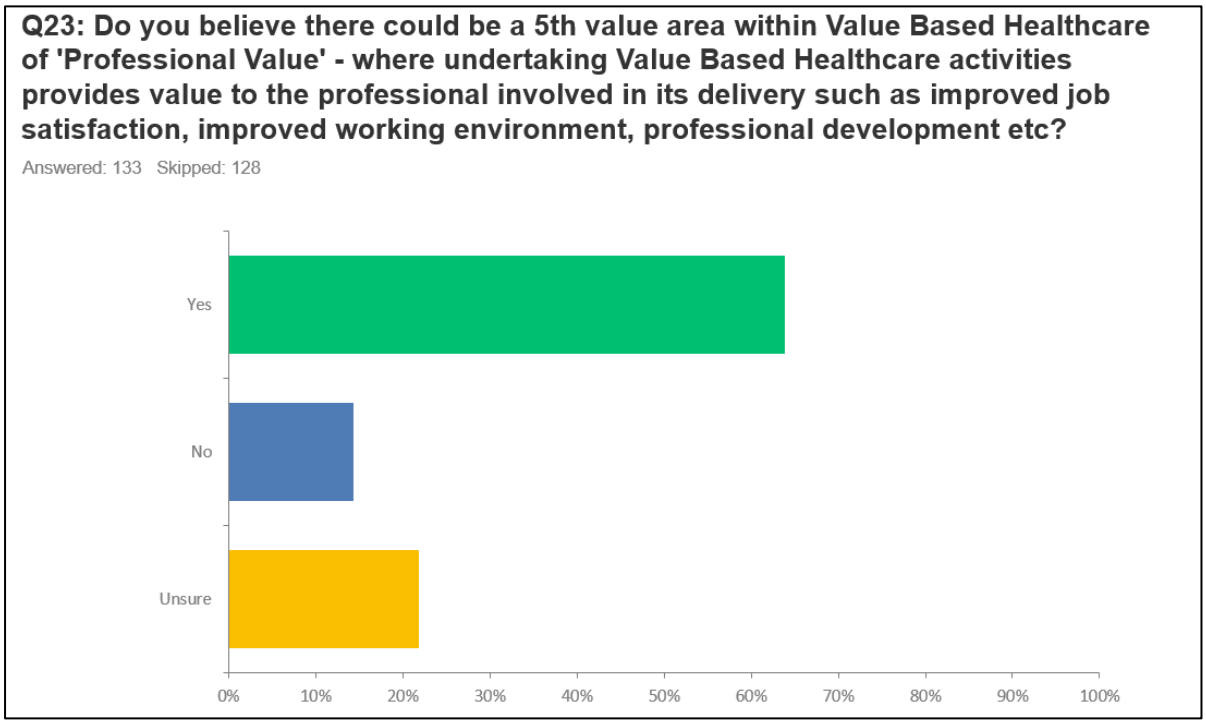
Research Charts 57 - Questionnaire Q9 And Q10 Comparison Should VBHC Provide 'XX' Versus Does VBHC Provide 'XX'

Findings comparing question 9 where participants were asked if VBHC does provide 'xx' and question 10 where participants were asked if VBHC should provide 'xx' shows across all the areas asked a correlation between does and should.



Research Charts 58 - Questionnaire Q22 Do You Believe VBHC Delivery is One-Off, Continuous or Other

Participants responded where they believed VBHC was a one-off project with 8.8% agreeing, 82.6% believing it to be continuously delivered within their role and 8.8% stating other.



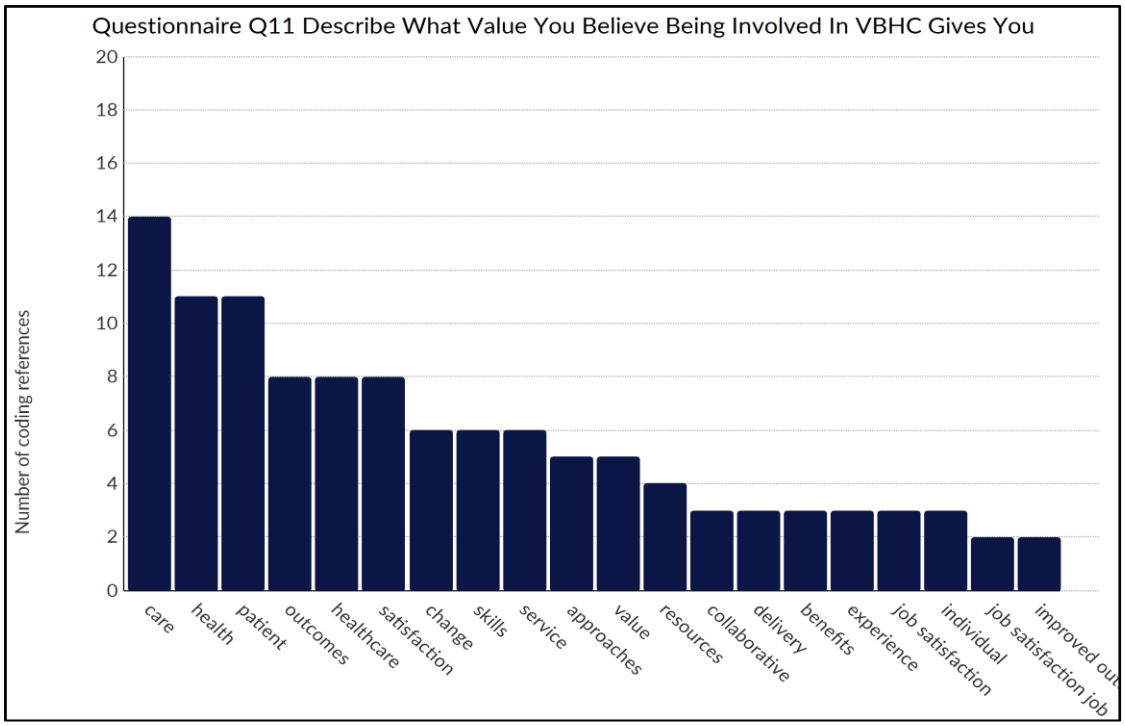
Research Charts 59 - Questionnaire Q23 Do you Believe there Should be A 5th VBHC Domain of 'Professional Value'

Participants responded where they believed there should be a new 5th VBHC benefit domain of 'Professional Value' with 63.9% agreeing and 14.3% disagreeing. 21.8% were unsure. VBHC was a one-

off project with 8.8% agreeing, 82.6% believing it to be continuously delivered within their role and 8.8% stating other.

Question 11 asked participants to 'Describe What Value You Believe Being Involved In VBHC Gives You', a word cloud and thematic analysis can be found in Research Charts 60 and Research Charts 61.

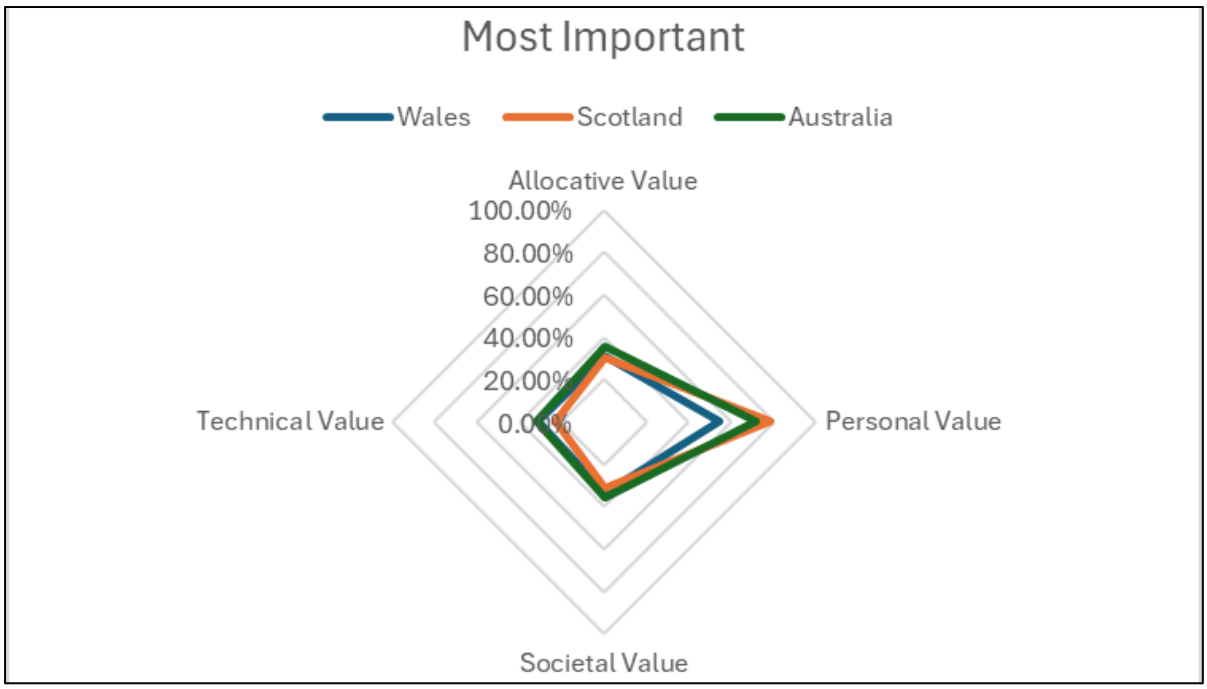
Research Charts 60 - Questionnaire Q11 Describe What Value you Believe Being Involved in VBHC Gives you



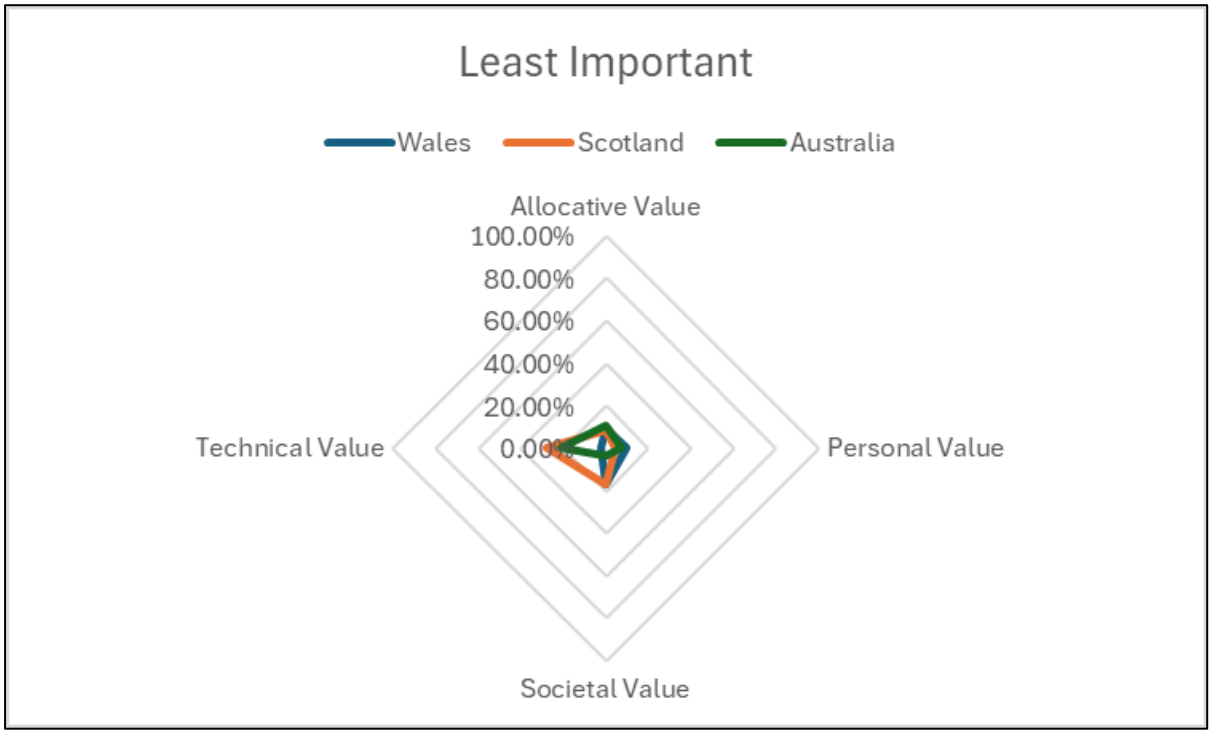
Research Charts 61 - Questionnaire Q11 Describe What Value you Believe Being Involved in VBHC Gives you Thematic Analysis

4.2.8. Findings by Country / Region

Question Q7 asked respondents to 'Rank the below Value Based Healthcare benefit areas in order of how you see their importance with 1 being most important and 4 being least important? You can rank areas equally'. The results of this grouped by Country / Region are shown in Research Charts 62 for Most Important and Research Charts 63 for Least Important.



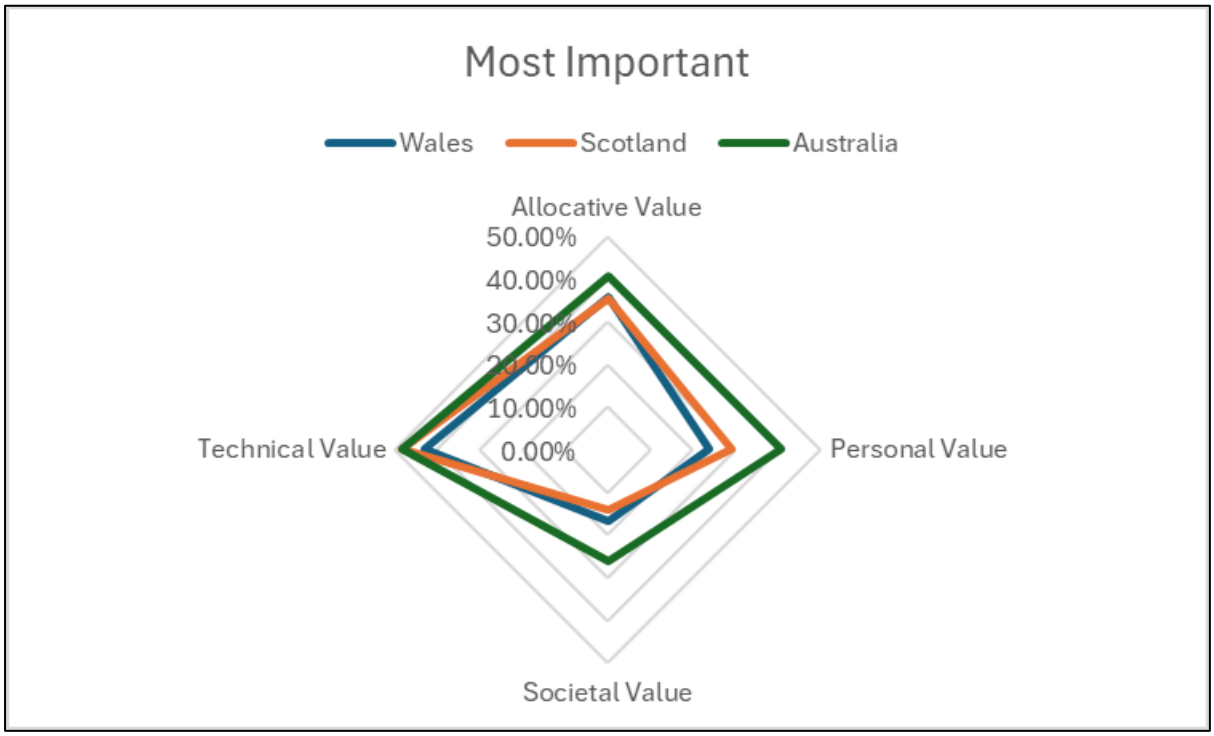
Research Charts 62 - Value Based Healthcare Most Important Benefit Area Based on Personal View by Country/Region



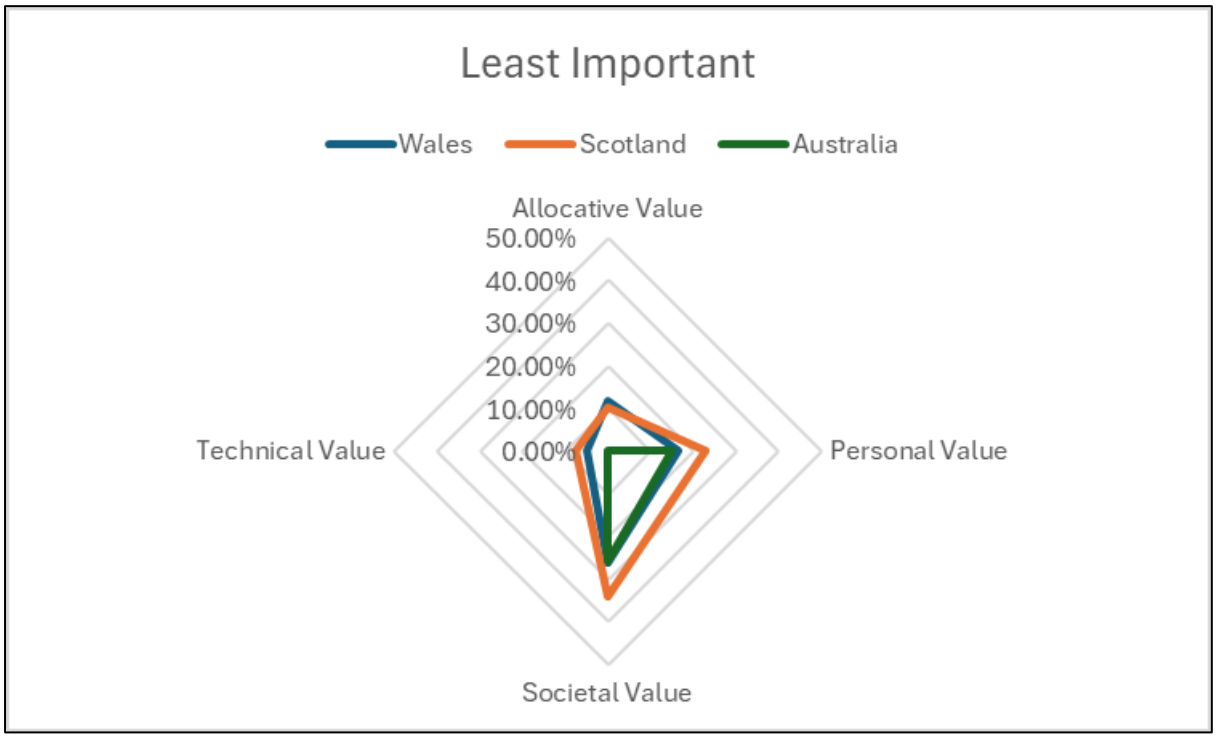
Research Charts 63 - Value Based Healthcare Least Important Benefit Area Based on Personal View by Country/Region

This data shows a commonality of view across geographical areas where there is consistency in the view of 'Personal Value' being most important. However, there is a slight divergence in the view of least important from an individuals perspective with individuals in Scotland and Australia viewing Technical Value as least important and in Wales individuals see Societal Value as least important.

Question Q14 asked respondents to 'Rank the below Value Based Healthcare benefit areas in order of how you believe YOUR ORGANISATION see's their importance with 1 being most important and 4 being least important? You can rank areas equally'. The results of this grouped by Country / Region are shown in Research Charts 64 for Most Important and Research Charts 65 for Least Important.



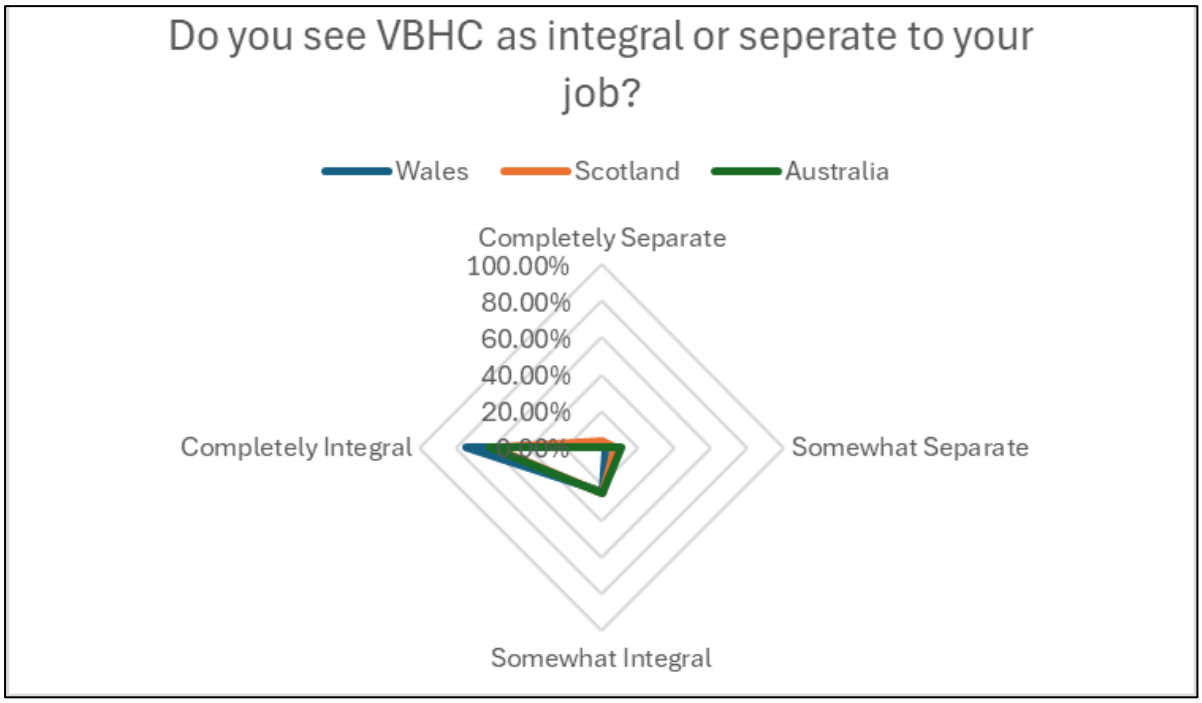
Research Charts 64 - Value Based Healthcare Most Important Benefit Area Based on Perceived Organisational View by Country/Region



Research Charts 65 - Value Based Healthcare Least Important Benefit Area Based on Perceived Organisational View by Country/Region

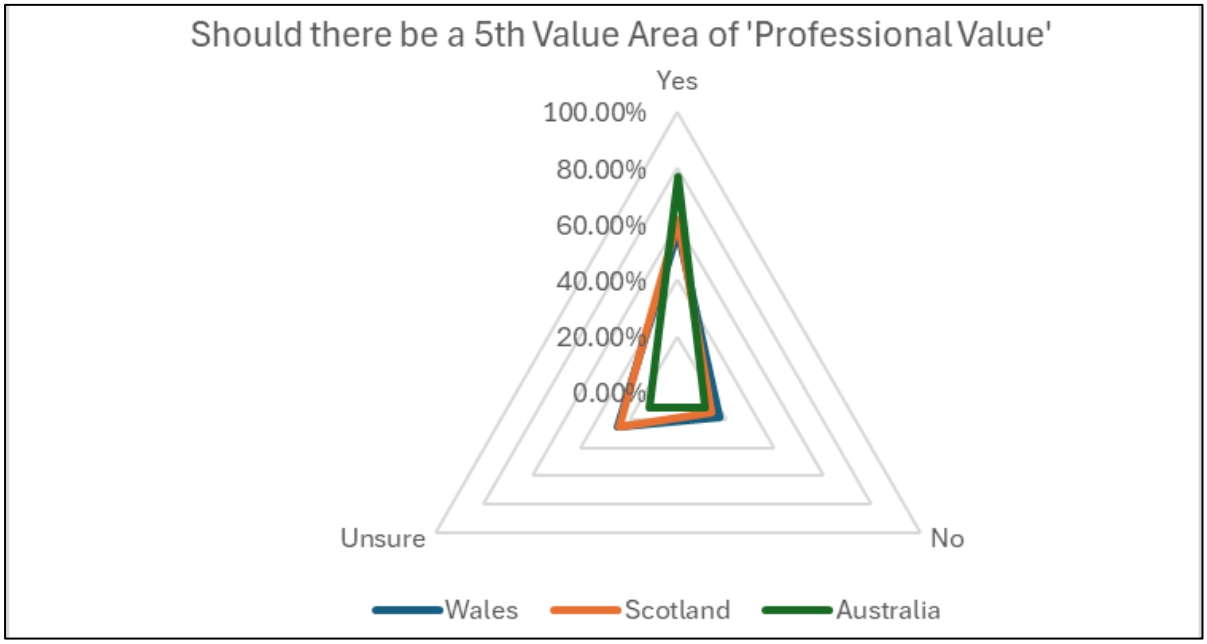
There is consistency again across regions where individuals view of the organisation showed individuals believed their organisations prioritised Technical Value over other areas, followed by Allocative, then Personal and finally Societal value.

Question Q13 asked respondents 'Do you see Value Based Healthcare as part of your job and integral or separate and an additional activity?'. Research Charts 66 shows the response by Country / Region.



Research Charts 66 - Do Your See VBHC as Integral or Separate to Your Job by Country/Region

Question 23 asked respondents 'Do you believe there could be a 5th value area within Value Based Healthcare of 'Professional Value' - where undertaking Value Based Healthcare activities provides value to the professional involved in its delivery such as improved job satisfaction, improved working environment, professional development etc?'. Research Charts 67 shows the response by Country / Region.



Research Charts 67 - Should There be a 5th Value Area of 'Professional Value' by Country/Region

4.3. Results and Findings Chapter Summary

This chapter has presented the empirical data the author has collected, aligning with the conceptual framework introduced in chapter 2.14. and concludes the authors phase 2c questionnaire with VBHC community research phase.

The findings support the importance of addressing the main research question 'To what extent does professional value and engagement play a role in the sustainable delivery of VBHC?'. The chapter also explores sub-questions including whether professionals derive value from delivering VBHC and the potential need for a specific "Professional" value domain within VBHC. Discussion on the impact of the findings in relation to confirming or expanding on the extant literature and the researchers contribution will be discussed in the next chapter along with how the contribution is an extension or a contradiction in what is currently known about VBHC.

Expert Interviews Summary

- The semi-structured interviews with expert respondents (referred to as ER1, ER2, etc.) helped validate the research methodology and the logic behind the conceptual framework.
- Most experts agreed that the methodology was valid and rigorous and some suggested additional areas for consideration such as diffusion of innovations in service organisations and professional standards in healthcare.
- There were no outliers from the expert interviews and there was agreement on all elements

Questionnaire Results Demographic Summary

Response Rate and Demographics:

- There were 261 respondents to the survey with a minimum response rate of 133. Respondents were from Australia, NHS Scotland and NHS Wales, and represented various roles with 64.3% delivering services directly to patients. This response rate provides a confidence level of 95% with a margin of error of 8.5%, 133 responses is enough to provide general trends or exploratory analysis, making answers to the questions significant and valid from a generalisation statistical perspective.

Conceptual Framework Themes Summary

Engagement:

- Feeling Part of a VBHC Movement - 66.2% of participants felt part of a VBHC movement while 41.2% did not.
- Sense of Accountability - 31.6% felt a strong sense of accountability for VBHC and 44.9% disagreed.
- Recognition and Reward - 99.9% felt recognised for their efforts in VBHC while 49.6% disagreed.
- Motivation - 76.1% agreed that VBHC provides motivation with 84.4% believing it should.

Individual Consequence:

- Career Progression - 52.9% agreed that VBHC improves career opportunities and 80.8% felt it improves job satisfaction.
- Personal Satisfaction - 84.7% found personal satisfaction in delivering VBHC.

Ownership:

- VBHC as Integral to Job - 87.4% viewed VBHC as integral to their job and 66.2% said VBHC is built into their day-to-day work.
- Control and Input - 56.6% felt they had control over their work in VBHC and 57.5% felt empowered to make decisions.

Shared Aims:

- Communication of VBHC Goals - 43.3% agreed that VBHC goals were communicated effectively and 80.9% felt they understood why VBHC activities were being undertaken.
- Clarity of Role - 69.1% understood their role in delivering VBHC though 41.0% felt their team did not have clear expectations.

Skills and Capacity:

- Training - 20.6% felt they received adequate training for VBHC activities while 52.9% disagreed.
- Resource Availability - 57.6% felt they had the time to undertake VBHC activities with 55.2% identifying a lack of resources as a major barrier.

Other Data

The chapter included detailed charts and tables that provide further detail on the responses comparing individual and organisational perceptions of VBHC benefits and presenting data on themes

such as leadership, communication and professional development. Participants responded where they believed there should be a new 5th VBHC benefit domain of 'Professional Value' with 63.9% agreeing. The findings presented in this chapter will be discussed in chapter 5 and reviewed in relation to the authors definition of professional value and their conceptual framework as well as understanding the results through the lens of socio-technical theory.

Summary

Professionals in healthcare often view their work through a lens of intrinsic and extrinsic value, which extends beyond traditional metrics of organisational success. The findings in this chapter reinforce the notion that professional engagement and recognition significantly influence the sustainable implementation of VBHC. Empirical data highlights that while many participants find motivation and satisfaction in delivering VBHC, gaps in training, communication and resource availability can hinder their ability to fully engage. These elements of professional experience are pivotal, suggesting that the integration of a "Professional Value" domain within VBHC could address unmet needs and align individual contributions with broader organisational goals.

The data underscores the connection between professional satisfaction and organisational performance. Professionals derive value not only from career progression and personal satisfaction but also from a clear understanding of their role within the VBHC framework. Chapter 5 will explore, the STS theory lens in providing a deeper understanding of how professional engagement and value can bridge the gap between individual agency and wider objectives, paving the way for more effective and sustainable healthcare delivery as well as validating the authors conceptual framework and answering the research questions.

CHAPTER 5 – DISCUSSION

5. Introduction to the Discussion Chapter

The purpose of this chapter is to critically evaluate the findings from this research and to compare the results with the existing literature to answer the guiding research questions. This chapter will interpret the implications of the results and address the authors research questions and objectives and link the findings to the original conceptual framework (See chapter 2). Through this chapter and its evaluation, the researcher seeks to provide insights into the sustainable delivery of VBHC through the lens of professional value and engagement and the theoretical lens of STS Theory. This chapter along with chapter 6 will deliver the researchers phase 4 of research which will answer the research questions and use STS theory as a prism to explain the researchers findings:

PHASE 4: DISCUSSION AND CONCLUSIONS

INPUTS – Conceptual framework, analysis and findings along with literature review material

- Ability to have answered the research question(s) posed
- Presentation of finalised conceptual framework
- Conceptual framework viewed through socio-technical theory lens
- Other questions posed as a result of this research and identification of further areas of study
- Identification of limitations such as a focus on Wales, NHS context of COVID and austerity etc

OUTPUT – Conclusion to the research question(s) and areas for further study

The chapter provides a comprehensive basis for understanding how the principles of VBHC and professional value can be integrated into existing healthcare systems and professionals day to day working practices. It draws upon the evidence gathered through the authors literature review to examine the theoretical and practical aspects of sustainable healthcare transformation. By addressing the challenges and opportunities discovered and discussed through this study, this chapter seeks to bridge the gaps in the literature and offer practical recommendations for policy and practice along with a new conceptual framework.

Research Questions and Objectives Restated

The primary research question guiding this study is:

- To what extent does professional value and engagement play a role in the sustainable delivery of Value-Based Healthcare?

Supporting sub-questions include:

- How do professionals derive value from being involved in and delivering Value-Based Healthcare?
- What features of 'professional' value offer the greatest benefits to professionals engaged in Value-Based Healthcare?

The objectives of this research are:

- To explore the relationship between professional value, engagement, and the sustainability of VBHC.
- To identify the cultural and organisational factors necessary to embed VBHC practices sustainably.
- To contribute to the academic and practical understanding of VBHC, with a particular focus on socio-technical systems and professional behaviours.

5.1. The Literature and Identified Gap Summary

The literature review highlighted the key essential principles of VBHC and sustainability challenges when embedding such frameworks in complex healthcare systems such as the NHS. The genealogy of VBHC and the seminal work by Porter and Teisberg (2006) demonstrates its evolution from an initial focus on cost-efficiency against value to a broader emphasis on value creation (Porter & Teisberg, 2004; Porter & Teisberg, 2006) for patients and healthcare providers. VBHC seeks to prioritise patient outcomes while considering resource allocation, equity and societal impact (*Expert Panel on effective ways of investing in Health (EXPH) Defining value in "Value-Based healthcare*", 2019). Despite its potential, VBHC literature often overlooks the human and cultural dimensions necessary for its implementation, particularly in complex, publicly funded systems like the NHS (Hurst et al., 2019; Nilsson et al., 2017a; Nilsson et al., 2017c).

A recurring theme in the organisational change literature is the importance of cultural alignment and engagement in achieving sustainable transformation. Kotter's (1996) 8-step model underscores the need for urgency, coalition-building and strategic vision, but it provides limited guidance on addressing the psychological and behavioural challenges faced by healthcare professionals and is very linear in practice. Similarly, Connor's (1993) concept of the 'burning platform' highlights the necessity of creating a compelling case for change but may inadvertently alienate staff by focusing on crisis-driven narratives (Bridges & Bridges, 2017) as opposed for the need of continuous change and

evolution. These frameworks often fail to account for the lived experiences and intrinsic motivations of professionals, which are crucial for sustaining VBHC (Searl et al., 2010) and other change initiatives.

The theoretical lens and contributions from STS (Trist & Bamforth, 1951b) offer valuable insights into the interplay and connection between social and technical factors. This perspective emphasises the optimisation of human roles and technological processes, aligning well with the principles of VBHC. However, contemporary applications of STS theory in VBHC remain limited, particularly when concerning the role of healthcare professionals as agents of change (Bateman & Rich, 2003).

Another significant gap exposed during the initial literature review was the consideration of professional value within current VBHC frameworks and delivery practices. While VBHC aims to optimise outcomes for patients, it often neglects the value it could provide to professionals working within the system responsible for its delivery and the impact this may have on their willingness and ability to deliver VBHC. Research by Mjåset et al. (2020) and Nilsson et al. (2017) suggests that professional engagement and discretionary effort are critical for VBHC success. Yet, the methods for fostering and delivering such engagement are underexplored. Studies like those by Radnor et al. (2011) provide a critique of improvement methodologies, such as Lean for failing to integrate human dimensions, thereby limiting their long-term impact and sustainability.

The gaps identified in the authors literature review highlight the need for a more holistic approach to VBHC implementation. This approach must integrate cultural readiness, professional engagement and socio-technical optimisation to ensure sustainable outcomes and delivery. By addressing these gaps, this research will contribute to the theoretical and practical advancement of VBHC, particularly within the context of the NHS in Wales and similar healthcare provided services.

5.2. Summary of Key Findings

The findings of this study reveal important insights into how professional value and engagement influence the sustainable delivery of VBHC. This section summarises the key findings, linking them to the research objectives and existing literature.

The findings underscore how important professional value and cultural alignment is in achieving sustainable VBHC implementation. Key themes include the need to engage professionals in value creation, aligning organisational and individual goals and fostering a culture of continuous improvement as shown in Table 40. These findings align with and extend the arguments of Porter and Teisberg (2006), who advocate for value-driven healthcare systems and Hurst et al. (2019), who emphasise behavioural and cultural considerations.

KEY FINDINGS	CONTRIBUTING AUTHORS	SUPPORTING COMMENT
VBHC sustainability depends on professional value	Porter & Teisberg (2004, 2006) Nilsson et al. (2017)	Professionals' engagement is essential for sustaining VBHC practices.
Cultural alignment is critical for VBHC implementation	Kotter (1996) Hurst et al. (2019)	Successful change requires cultural readiness and behaviour alignment.
Human-centric frameworks enhance change sustainability	Trist & Bamforth (1951) Mjåset et al. (2020)	Balancing social and technical factors is crucial for enduring success.
Engagement drives discretionary effort in VBHC	Rich & Bateman (2003) Searl et al. (2010)	Engaged professionals contribute beyond their formal roles.
Professional value enhances organisational resilience	Bridges & Bridges (2017) Radnor et al. (2011)	Recognition of professional value strengthens commitment to VBHC.

Table 40 - Summary of Key Professional Value and Cultural Alignment Themes (Source: The Researcher - Marc Penny 2025)

5.3. Interpretation of Results

5.3.1. Authors Conceptual Framework Theme 1 – Engagement

The research findings highlight the complexities of engagement in implementing VBHC, revealing both alignments with and divergences from established change theories and frameworks explored as part of this study. Engagement, as defined by the author through the literature, emphasises active staff participation in planning and decision-making processes, yet the study results highlight some difference in realities of this involvement in current practice.

The literature implies a lack of connection to a collective movement often hampers engagement. Kotter's emphasis on creating urgency and building coalitions (Kotter, 1996) implies that fostering a shared purpose is vital. This research anticipated finding evidence of disengagement among healthcare professionals, echoing Nilsson et al.'s findings that professionals view VBHC as

disconnected from their day-to-day work (Nilsson et al., 2018). However, the results of this research found that 66.2% of participants felt part of a VBHC movement or community, while 41.2% reported a weaker connections. This divergence suggests that while progress has been made in fostering collective belonging amongst the healthcare organisations that took part in the research, gaps remain, particularly for those who do not identify as part of the 'VBHC movement'. These findings extends Kotter's (1996) theory by demonstrating that engagement requires more than a guiding coalition; it necessitates mechanisms to sustain inclusion over time. The researcher reflected that the Kotter (1996) approach was significantly limited in its inability to sustain engagement due to its discreate project and time limited approach that results in binary outcomes (success of failure). This research conclusively demonstrates that professionals regard VBHC as a more permanent and directional programme of activity that must include ongoing collaboration and learning. Under these conditions, VBHC is equated to a series of learning experiments (similar to those proposed under TQM by Deming (1982) and Juran (1989). It is also presumed, under the Kotter (1996) approach that coalitions can be formed without any inhibitor whereas in the context of healthcare poor memory of change and interprofessional conflict can generate resistance or result in a superficial support for change. This research demonstrates that the essential model of VBHC and its current form and development provides a culturally sympathetic movement for change. By engaging with key stakeholders the researcher has found that engagement with VBHC and its sustainable deployment is likely to offer greater velocity of change than other models such as Kotter (1996), (by appealing to the professional value derived from stakeholders who govern systems and determine what is legitimate to change for the better value of the patient and the professional working within the system). From the researchers own experience, this has not been the case for other dominant change models – see 'Lean Healthcare' (Burgess & Radnor, 2013; Radnor et al., 2012), because they have ultimately ended up focusing on cost and process not outcomes or professional engagement and value.

The literature also highlights the significance of direct engagement in change processes, as Bamford and Daniel argue that exclusion diminishes commitment (2005), especially for highly skilled professionals. The study found only 31.6% of participants felt a strong sense of accountability for VBHC, with 44.9% expressing a lack of ownership. However, 55.8% believed their organisation valued their opinions, contrasting with 19.1% who did not. This contradiction suggests that while organisations are making efforts to engage professionals and empower them, these initiatives may not translate into perceived accountability or ownership in real life with words not matching actions. This finding critiques traditional change models, including ADKAR, which emphasises individual transformation but may underplay the systemic barriers preventing deeper engagement. The

researchers finding support the theme detected in the research that behaviour change, by significant organisational role models in the form of professionals and leaders will change culture and enable greater VBHC outcomes, and simultaneously the culture will offer validity and importance to other staff in the organisation. Such a progressive approach overcomes the organisation and cultural disfunctions of Kotter's (1996) permanent sense of fear.

Recognition and reward, essential for sustaining change (especially amongst professionals where identity is a primary motivator and sense of pride), were explored in the context of Mosadeghrad's assertion that undervaluation leads to disengagement (Mosadeghrad, 2013), the generally acknowledged fate of Lean. 51.6% of participants felt recognised for their contributions, while only 29.7% felt adequately rewarded. Despite this, 76.1% stated that VBHC provides motivation, aligning with expectations that rewards such as improved outcomes might outweigh recognition. This reflects a sense of integrity and the prioritisation of patient outcomes from the care process over the reward of the professional working in the system. This study builds on Mosadeghrad's work by demonstrating that recognition can be perceived differently from reward and that intrinsic motivators, while significant, may not fully offset the absence of tangible rewards (which may be further exacerbated during tough financial conditions such as those experienced during the course of this research). The research findings clearly demonstrate the vocational nature of healthcare where the central concept of providing the best care to patients outweighs personal gain.

Top-down communication, frequently cited as a barrier to engagement (Rawson & Davis, 2023), was another area the research reviewed. While 30.8% of participants believed VBHC communications were open and transparent, 36.0% disagreed. This finding reinforces critiques of top-down models, including Lewin's framework, which Shirey (2013) critiques for its lack of employee involvement. The results suggest that communication strategies must evolve from one-way information dissemination to inclusive 360-degree dialogue to bridge the perceived transparency gap. This study finds that the immaturity of VBHC and its need to be contextualised makes it difficult for executive top-down communication when the current mode is experimentation. At this stage, professional engagement with the essential model of VBHC and where the experience of VBHC is low then such communications would appear hollow to staff. In the context of healthcare, a service not a manufacturing process, interpersonal communication will always be needed to supplement formal cascade communication, and to avoid resistance to change via gossip or rumour.

Leadership was a factor identified with mixed perceptions of its role in driving VBHC sustainability during the literature review. While 47.1% of participants saw clear VBHC leadership, 30.2% disagreed. Similarly, 50.0% felt leadership encouraged involvement and 25.0% disagreeing. These results align with critiques of Kotter's model, which prioritises top-down leadership over distributed, visible leadership (Appelbaum et al., 2012) and similar to TQM models or change (direction needs to be led by more senior staff who respect the key stakeholders of their professional groups of staff). Only 39.7% of participants believed their managers provided personal leadership or were involved in VBHC, extending the challenge of visible leadership emphasised by Gupta and Moriates (2017). These findings extend the McKinsey 7S framework, particularly the "style" and "shared values" dimensions, by demonstrating that leadership visibility and authenticity are critical for embedding organisational change in healthcare. A critical theme in this research is the translation of VBHC into meaningful projects and that requires visible and engaged leadership as a sign of support and legitimisation of its importance and delivery.

In summary, the author's research contributes to significantly to theory by extending the understanding of engagement in healthcare reforms as well as showing how dependency of staff on each other's performance is reconciled without reducing professional autonomy. This study rejects significant parts of existing dominant change models, including Kotter's fear-driven autocracy, Lewin's poor attention to stakeholder engagement and ADKAR's individualism, by highlighting the subtle interplay between inclusion, recognition, communication and leadership. The findings suggest that while traditional frameworks provide valuable insights, they require adaptation to the complex, dynamic context of healthcare where professional autonomy and collective ownership are key. By integrating these findings this study advances the discourse on how to engage healthcare professionals effectively in VBHC, offering a more subtle perspective than existing models.

5.3.2. Authors Conceptual Framework Theme 2 – Individual Consequence

The theme of Individual Consequence explores how job satisfaction, personal fulfilment, career development and working conditions influence healthcare professionals' commitment to VBHC and its delivery. Individual consequence, defined by the author being job satisfaction and career development which must be considered as professionals are more likely to commit to and support change that align with their personal and professional goals to ensure sustainability, the research findings challenge and extend existing theories by revealing gaps in addressing the human dimension of organisational change. This may be a consequence of leadership buy in and commitment which may

remove some of the perceived risk of being involved with a new and somewhat unproven initiative such as VBHC which is only just emerging across the world (the consequence of reputational damage for individuals of a failed change programme are high for professionals and associated with significant negative personal and organisational memory of change).

The literature indicates that career progression opportunities are often overlooked in traditional change models. For instance, Kotter's Eight-Step Model prioritises organisational needs over personal career development, potentially leading to disengagement among employees who fail to see how their contributions to VBHC might advance their careers (Kotter, 1996). The study expected to find this misalignment reflected in participant responses. The results revealed a slightly different picture; while 44.0% disagreed that VBHC lacked career progression opportunities and only 19.7% reporting limited opportunities for advancement. 52.9% believed that the skills and knowledge gained through VBHC would benefit their career progression. This exposes a conflict in Kotter's (1996) model and highlights how longer term career development is associated with VBHC change and its sustained cycles of commitment over time versus the heroic projects advocated by Kotter.

Job satisfaction, often cited in the literature as key for sustaining healthcare reforms (van Engen et al., 2021), was another factor explored by the author. The literature argues that alignment between personal aspirations and organisational goals fosters greater engagement, as recognised by models like ADKAR (Hiatt, 2006). The study anticipated that professionals might derive limited satisfaction from their work under VBHC, given the broader challenges of reform. However, the findings suggest otherwise with 80.8% of respondents reporting that VBHC improves job satisfaction, and 90.1% believed it should improve job satisfaction. 82.4% expressed pride in delivering VBHC, and 78.7% felt a sense of accomplishment. These results create a virtuous circle of cultural change and improvement. Using Maslow's (1943) hierarchy of needs, professionals will be motivated by a higher-level drivers such as self-actualisation and this is the case for VBHC. In short VBHC can provide a pathway for professionals to achieve self-actualisation by aligning their work with their values and goals.

Personal satisfaction, which reflects fulfilment derived from the impact of work rather than the conditions or environment was also evaluated. ADKAR emphasises the role of personal fulfilment in fostering long-term commitment (Hiatt, 2006). The study found that 84.7% of participants experienced personal satisfaction through VBHC, while 91.4% believed VBHC should enhance personal fulfilment. These findings suggest that while VBHC can deliver personal satisfaction, there is still a gap

between expectations and reality. This study critiques Lewin's 3-Step Model (1947), which prioritises organisational processes over personal fulfilment, by highlighting the importance of aligning change initiatives with individual values to ensure sustainability.

The working environment, another key element for successful change also revealed important insights. The McKinsey 7S model underscores the interplay between organisational systems and working conditions (Peters, 1982), but its focus on structural elements may overlook the "lived experiences" of professionals working within the system. The study found that while 62.9% of participants agreed that VBHC improves their working environment, 34.6% felt that poor working conditions hindered their ability to deliver expected outcomes and care. Additionally, 80.1% believed VBHC should improve the working environment, revealing a gap between current perceptions and future expectations. These findings further reenforce the soft cultural elements, such as staff satisfaction and working environment as critical to demonstrating change visually as much as improving measurements.

This study contributes to theory by extending our understanding of how individual consequences influence the sustainability of organisational change. The authors findings underscore the necessity of integrating individual career development, job satisfaction, personal fulfilment and working conditions into change frameworks to ensure their sustainability. These combination of insights develop the literature by highlighting the critical role of individual alignment in driving commitment to healthcare reforms, visually demonstrating commitment to change and offering a more holistic approach to sustaining VBHC implementation.

5.3.3. Authors Conceptual Framework Theme 3 – Ownership

The conceptual framework theme of Ownership covering empowerment and autonomy examines how healthcare professionals' sense of control, involvement and ability to learn and make decisions influences their engagement with VBHC. Based on the principle that empowered individuals are more likely to support and sustain change, this theme builds on and evaluates existing change models by addressing gaps in recognising individual agency and autonomy within organisational transformations.

The literature suggests that when professionals perceive change initiatives as integral to their roles, they are more likely to embrace and sustain them. Kotter's Eight-Step Model and similar frameworks

focus on aligning individual contributions with organisational goals (Kotter, 1996), but they often fail to explore how individuals perceive the integration of these goals into their daily responsibilities, especially in complex and busy healthcare settings. In this study, 87.4% of respondents viewed VBHC as integral to their roles, with 62.3% identifying it as completely integral. Only 66.2% felt that VBHC delivery was embedded in their day-to-day work, and 39.1% agreed they had specific objectives related to VBHC. The ability to go from unclear specifications of VBHC at organisational level to the embedding of VBHC principles in daily activities can confirms that the essence of VBHC allows for quicker and more meaningful change adoption These findings examine Kotter's emphasis on overarching goals by revealing the importance of clarifying individual objectives to enhance alignment and engagement. There is also a misalignment between the individuals view of VBHC as part of their role and perhaps the reality from an organisational perspective, especially when it comes to being given objectives which makes it integral to the role from an organisational perspective.

Loss of control emerged as another component influencing professional engagement. The study found that while 56.6% of respondents felt they had control and input into VBHC delivery, only 15.4% felt involved in activities that directly affected them. 68.9% believed VBHC should provide control over their work, compared to 51.0% who felt it currently does. These findings extend the ADKAR model's emphasis on personal agency (Hiatt, 2006) by highlighting a gap between professionals' expectations of autonomy and their lived experiences in their day-to-day jobs. This study finds significant deficiencies in the Lewin 3-Step Model's when applied to complex healthcare environments, with a limited focus on individual control within organisational change processes, advocating for a more subtle approach to empowering professionals.

The ability to make mistakes and learn from them is integral to fostering a culture of innovation and continuous improvement (psychological safety). The literature overlooks this aspect of change management especially in safety critical settings and where licenses to practice will be revoked for reckless improvement projects. The study found that 57.6% of participants felt they were allowed to make mistakes and learn from them, but only 7.6% agreed that their managers encouraged such learning. Additionally, 64.0% felt they could provide feedback on VBHC activities. Decision-making and involvement also significantly influence professionals' engagement with VBHC. While 54.3% of respondents felt involved in decisions affecting them, 72.1% disagreed with the statement that they had no ability to input into decisions. 82.8% believed VBHC should empower them to make decisions, compared to 57.5% who felt it currently does. These findings reflect the modern complex health and

care workplace and again provide tangible evidence or senior leadership support for learning and the perception that VBHC change is an ongoing process and not a one-off project. Modern workplaces call for greater empowerment, delegation from professionals but a maintenance of good professional practice by engaging with VBHC practices.

This research extends our understanding of how empowerment and autonomy is reconciled under VBHC and how the approach recognises the importance of addressing individual perceptions of integration, control, learning and decision-making within VBHC implementation. These findings develop the literature by revealing the need for change frameworks that prioritise individual agency and autonomy as critical components of sustainable and responsibly managed healthcare reform.

5.3.4. Authors Conceptual Framework Theme 4 – Shared Aims

The Shared Aims theme emphasises the importance of aligning organisational goals with the expectations and understanding of healthcare professionals and their values as motivators. Successful implementation of VBHC requires clear communication of goals and strategies, ensuring that professionals across all levels of the organisation are working cohesively towards a commonly held objective, which is particularly important in complex settings such as healthcare. The research highlights significant challenges in this area, which are covered by the author's three failure themes within Shared Aims – 'Lack of vision, context and certainty', 'Poor or unclear expectations' and 'Unclear benefits or aims'.

A lack of clear vision and context creates confusion and disengagement among healthcare professionals. If goals are poorly communicated or frequently shifted, staff feel uncertain about the organisation's direction. While 80.9% of participants agreed they understood why VBHC activities were being undertaken, only 43.3% felt the organisation effectively communicated VBHC goals and strategies, and 29.4% disagreed or strongly disagreed. This finding corroborates existing theories on organisational change which emphasise the importance of a clear and compelling vision in driving engagement and momentum. It extends knowledge by quantifying the communication gap in VBHC specific contexts, offering a perspective on how this issue manifests in healthcare settings. Established frameworks advocate for a balanced approach to organisational change, addressing hard elements like strategy and systems alongside softer aspects such as shared values and staff skills. Similarly, Kotter's Eight-Step Model highlights the importance of creating a clear and compelling vision to build

engagement and momentum. This suggests that when vision and context are absent, the commitment necessary for sustained change is eroded, corroborating broader organisational change literature.

Unclear expectations further exacerbate the challenges of implementing VBHC. If professionals are uncertain about their specific roles in delivering VBHC, they may face difficulties translating strategic objectives into practice. Only 32.4% of respondents agreed or strongly agreed that all members of their team had a clear understanding of what was expected of them, while 41.0% disagreed or strongly disagreed in relation to VBHC. While 69.1% reported understanding their personal role in supporting VBHC, this disparity between individual and team clarity highlights inconsistencies in expectation-setting. This finding aligns with research suggesting that unclear expectations lead to inconsistent practices, supporting existing theories while extending them by identifying the specific gap between individual and team-level clarity in VBHC initiatives.

Unclear benefits or aims of VBHC were another barrier identified in the research and literature review. Professionals are less likely to engage with change initiatives if they do not perceive tangible benefits or if organisational priorities seem misaligned with their values (van Engen et al., 2021). When ranking the importance of VBHC benefit areas, 70.9% of respondents identified ‘Personal Value’ as the most important, followed by ‘Societal Value’ (31.8%) and ‘Allocative Value’ (30.5%). Conversely, participants believed their organisations prioritised ‘Technical Value’ (46.6%) over ‘Personal Value’ (30.1%) and ‘Societal Value’ (15.0%). This misalignment corroborates critiques of models like the Theory of Change, which argue that an overemphasis on measurable outcomes often neglects the qualitative, value-driven aspects that resonate with staff. The findings extend this assessment by illustrating how such misalignments manifest in VBHC-specific contexts, offering actionable insights for organisations to address these gaps and through the authors conceptual framework. This disconnect between individual and organisational priorities can reduce motivation and engagement, as professionals may struggle to see how VBHC benefits align with their own values or those of their patients.

The findings show the need for organisations to establish and maintain shared aims. Clear, consistent communication of VBHC goals, coupled with realistic expectations and alignment of organisational priorities with professional values, is essential to fostering a sense of purpose and direction. This analysis corroborates existing organisational change models while extending STS theory by highlighting the specific interplay of vision, expectations, and value alignment in complex healthcare systems implementing VBHC (Stilwell et al., 2016).

5.3.5. Authors Conceptual Framework Theme 5 – Skills & Capacity

The Skills & Capacity conceptual framework theme reveals further insights into how training, resources and shared understanding impact the sustainability of VBHC delivery. Insufficient preparation and support often result in rushed or incomplete efforts that hinder long-term success. Existing theoretical models including Peter Senge's Learning Organisation Theory offer only vague perspectives on organisational change. This study shows the need for a more balanced understanding of the skills and capacity required for sustainable and successful VBHC implementation (derived form the service nature of healthcare).

A significant barrier identified was the lack of training or skills among professionals, with only 20.6% of participants agreeing they received adequate training for VBHC activities. Although 84.7% believed VBHC should contribute to skill development, the findings expose a clear gap between expectations and practical implementation. As discussed by Braithwaite et.al (2015) and Mannion et.al (2017) skills are one of the key interconnected organisational elements necessary for successful change (Peters, 1982). This study questions the McKinsey 7S model's structural emphasis, arguing that healthcare reforms require a deeper focus on building professional capacity and capability. This study's findings compliment Senge's concept of personal mastery and highlights individual skill development is not merely an operational necessity but a critical driver of systemic alignment (Senge, 1993). These findings extend both frameworks by demonstrating that skills development must be explicitly prioritised to achieve long-term sustainability in healthcare and skills build upon the improving workplace.

Time and resource constraints emerged as a key challenge from the study, with 57.6% of participants agreeing they had sufficient time to undertake VBHC activities. The view of resource requirements is different to the rapid and urgent deployment of resources for Kotter's project-based model and this study favours resources that are deployed to continuously improving organisational settings as opposed to a "burning platform". This study shows that a balanced approach is needed to maintaining momentum for professionals by allocating resources in a timely manner to implement reforms effectively and continuously on need. This study supports Senge's systems thinking view and acknowledges the interconnected and dependent nature of resource allocation for dynamic and evolving care services.. This study supports and extends Senge's perspective that pragmatic time and resources are needed to holistically enable VBHC systemic reform efforts (Senge, 1993).

The study also recognises the lack of "shared language" (beyond official designed communication modes) and terminology can be a barrier during change – see Radnor (2013), Only 27.2% of participants agreed people in their organisation understood the principles of VBHC, compared to 73.5% who personally felt confident with the terminology. Senge's work on shared mental models highlights the importance of a common understanding to align organisational goals and actions (Senge, 1993). This study counters the assumption that shared understanding naturally emerges through engagement alone and calls for deliberate, structured efforts to develop shared cognitive frameworks, and to enhance linguistic alignment to support collective understanding and change. Kotter emphasises the importance of communication but fails to advocate for consistent and accessible vocabulary, particularly in complex systems where technical and clinical terminologies often intersect and management concepts often lack resonance and meaning.

5.4. Results Interpretation Relating to Theory of Change and Change Theories Summary

The following Table 41 summaries the findings of this study relating to the authors 5 themes of their conceptual framework for VBHC failure and sustainability, comparing them to key theories and literature reviewed and explored during this study. For each conceptual theme, the table identifies whether this study's findings extend, corroborate, critiques or contradict the theories and concepts.

AUTHORS CONCEPTUAL FRAMEWORK THEME	KEY THEORIES / AUTHORS	THEORETICAL CONTRIBUTION	RATIONALE
Engagement	ADKAR Model (Hiatt, 2006)	Contradicts	The study critiques ADKAR's focus on individual transformation, showing systemic barriers hinder deeper engagement. Organisations valued opinions (55.8%) but failed to translate this into perceived accountability (31.6%).
Individual Consequence	ADKAR Model (Hiatt, 2006)	Extends	Job satisfaction and personal fulfilment align with ADKAR's focus but extend its scope by showing how VBHC facilitates self-actualisation, contributing to alignment with individual goals and values.
Ownership	ADKAR Model (Hiatt, 2006)	Extends	Highlights a gap between expectations of autonomy and lived experiences, extending ADKAR's emphasis on personal agency to include structural empowerment.

AUTHORS CONCEPTUAL FRAMEWORK THEME	KEY THEORIES / AUTHORS	THEORETICAL CONTRIBUTION	RATIONALE
Engagement	Kotter's Eight-Step Model (1996)	Extends	While Kotter's emphasis on building coalitions aligns with the findings, this study highlights the need for sustained inclusion mechanisms to bridge gaps in engagement over time. Progress in collective belonging is noted, but gaps for those outside the movement are identified.
Individual Consequence	Kotter's Eight-Step Model (1996)	Extends	The study critiques Kotter's prioritisation of organisational needs over career development, showing that integrating career progression enhances sustained commitment to VBHC.
Ownership	Kotter's Eight-Step Model (1996)	Critiques	Identifies gaps in clarifying individual objectives and empowering professionals, revealing the need for more detailed alignment of individual and organisational goals.
Shared Aims	Kotter's Eight-Step Model (1996)	Extends	Supports Kotter's emphasis on clear vision but highlights the challenges of maintaining cohesive communication and setting realistic expectations within healthcare reforms.
Skills & Capacity	Kotter's Eight-Step Model (1996)	Extends	Extends Kotter's approach by addressing the need for continuous professional development and tailored capacity-building in healthcare reforms.
Engagement	Lewin's Three-Step Model (1947)	Corroborates	The findings reinforce critiques of top-down communication models, suggesting a need for inclusive, transparent dialogue to bridge transparency gaps noted by participants.
Individual Consequence	Lewin's Three-Step Model (1947)	Contradicts	Critiques Lewin's process-oriented focus by demonstrating the importance of individual fulfilment for sustainable change.
Ownership	Lewin's Three-Step Model (1947)	Critiques	The findings suggest a lack of focus on individual control and agency within Lewin's organisational change framework.
Individual Consequence	Maslow's Hierarchy of Needs (1943)	Extends	VBHC's ability to deliver job satisfaction and pride aligns with Maslow's self-actualisation tier, extending its application to healthcare reforms.

AUTHORS CONCEPTUAL FRAMEWORK THEME	KEY THEORIES / AUTHORS	THEORETICAL CONTRIBUTION	RATIONALE
Engagement	McKinsey 7S Framework (Peters, 1982)	Extends	Leadership visibility and authenticity are highlighted as critical dimensions, extending the "style" and "shared values" components of McKinsey's framework.
Individual Consequence	McKinsey 7S Framework (Peters, 1982)	Extends	Emphasises soft elements like staff satisfaction, underscoring their importance alongside structural processes for achieving alignment and sustainability.
Ownership	McKinsey 7S Framework (Peters, 1982)	Extends	Extends the "shared values" and "style" dimensions by emphasising the importance of empowerment and feedback mechanisms in change initiatives.
Shared Aims	McKinsey 7S Framework (Peters, 1982)	Extends	Aligning organisational goals with professional values highlights the need to prioritise shared aims beyond structural alignment.
Skills & Capacity	McKinsey 7S Framework (Peters, 1982)	Extends	Reveals gaps in training and preparation, extending the "skills" dimension by integrating insights on the lived experiences of healthcare professionals.
Engagement	Mosadeghrad (2013)	Extends	Recognition and reward are differentiated, with intrinsic motivators like improved outcomes shown to partially offset the absence of tangible rewards. This nuance builds on Mosadeghrad's assertions.
Skills & Capacity	Senge's Learning Organisation Theory (1993)	Corroborates	Supports the emphasis on fostering a culture of continuous learning and adaptation but highlights specific barriers to training in VBHC contexts.
Shared Aims	Theory of Change	Critiques	Argues that overemphasis on measurable outcomes can overlook qualitative, value-driven aspects critical to engaging staff effectively.

Table 41 - Summary Results Interpretation Relating to Theory of Change and Change Theories

5.5. Results Interpretation by Geographical Area Response

5.5.1. Geographical Individual vs Organisational Perceptions

Analysis of VBHC responses by geographical area reveals significant divergences between individual and organisational priorities (similar to that seen on an individual basis). Across all regions, Personal

Value was consistently ranked by individuals as the most important benefit whilst Technical Value was deemed the least important. Conversely, respondents believed their organisations prioritised Technical Value above all other benefit areas, with Personal and Allocative Value seen as secondary and Societal Value as the least prioritised.

This misalignment is explicitly identified by the author's conceptual framework, particularly Theme 4 Shared Aims. The failure themes within this framework highlight specific barriers:

- Failure Theme 15 - Lack of vision, context, and certainty
- Failure Theme 16 - Poor or unclear expectations
- Failure Theme 17 Unclear benefits or aims

The divergence in perceived priorities illustrates a systemic lack of clarity in communicating VBHC's organisational goals, resultant uncertainty among professionals which hinders cohesive engagement (and the development of a critical mass of collective staff to drive VBHC change programmes). When professionals perceive their values and priorities as misaligned with organisational objectives, their willingness to engage in VBHC initiatives is diminished, as noted in the literature. This divergence seems consistent across all regions that participated in this research.

5.5.2. Geographical Engagement and Ownership

The study findings reflect the key challenges (Conceptual Framework Theme 1 'Engagement' and Conceptual Framework Theme 3 'Ownership') and show that professionals who perceive VBHC as disconnected from their core responsibilities struggle to internalise its principles resulting in limited VBHC impact. The limited sense of ownership observed suggests that efforts to empower professionals, as discussed in the literature, are insufficiently translated into practice. While 57.5% of respondents felt empowered to make decisions, only 15.4% reported being involved in activities that directly affect them, reflecting a disconnect between strategic intentions and operational realities. These findings were replicated across the different regions that participated in this research and form a general VBHC pattern.

5.5.3. Regional Context and Adaptability

The geographical differences in VBHC implementation underscore the importance of adaptability, as highlighted in the authors Conceptual Framework Theme 5: Skills & Capacity. Regions with stronger leadership and cultural alignment reported higher integration of VBHC principles into day-to-day practices. The study detected that key barriers persist including time and resource constraints, insufficient training and a lack of shared language. These are captured in the authors Failure Themes:

- 18 - Lack of training or skills
- 19 - Not enough time or resources
- 20 - Not understanding terminology or shared language

Only 20.6% of respondents agreed they received adequate training for VBHC activities, and 57.6% reported insufficient time to fulfil VBHC responsibilities. These constraints highlight systemic gaps in preparing and equipping professionals for VBHC regardless of the region they are based in, limiting their ability to deliver sustainable outcomes. Additionally, only 27.2% of participants believed their colleagues understood VBHC principles, pointing to a lack of consistent and accessible terminology, which hinders shared understanding and collaboration. It is noted that the provision of VBHC training and the ability to set specific training modules is difficult as the phenomenon is emerging and evolving (and may require specific localisation at the employer and service level.

5.5.4. Geographical and Regional Summary

While regional variations exist, the research findings demonstrate common systemic challenges that must be addressed for VBHC implementation to succeed cohesively and sustainably. Misaligned priorities between individual professionals and organisational strategies reveal gaps in communication, leadership and resource allocation, which are linked to the authors Failure Themes 15 Lack of vision, context and certainty, 16 Poor or unclear expectations and 17 Unclear benefits or aims, within the Conceptual Framework's Theme 4: Shared Aims. Addressing these gaps requires not only clearer articulation of VBHC goals but also mechanisms that translate strategic objectives into actionable, locally relevant practices.

Geographical contexts offer unique opportunities to tailor interventions. By embracing regional cultural strengths and adapting approaches to local healthcare dynamics, organisations can foster greater alignment with Conceptual Framework Theme 1: Engagement and Conceptual Framework Theme 3: Ownership. Previous healthcare transformations highlight the importance of prioritising

professional autonomy and embedding VBHC as integral to roles, yet the persistence of Failure Themes 1 Not feeling part of a movement, 2 Lack of direct engagement with change and 11 Not integral to the role, shows these lessons are not universally understood or applied. Targeted efforts to involve professionals in decision-making and to communicate the tangible benefits of VBHC are crucial.

Regional adaptability is essential to addressing the authors Conceptual Theme 5: Skills & Capacity, particularly in overcoming barriers such as inadequate training, insufficient resources and a lack of shared language, as seen in Failure Themes 18 Lack of training or skills, 19 Not enough time or resources and 20 Not understanding terminology or shared language. Learning from previous change initiatives, organisations must focus on co-designing solutions with professionals, ensuring feedback loops are robust and responsive and fostering environments conducive to continuous improvement and learning. Leveraging local strengths while addressing these systemic barriers can create a more cohesive and adaptive healthcare system where VBHC principles resonate deeply and sustainably across diverse practices.

5.6. Interpretation of the Discussion from a Socio-Technical Systems Theory Perspective

This section will critically analyse the findings of the study through the lens of STS theory (the underpinning background theoretical lens). This section will explore the interaction between social and technical sub-systems and how they shape sustainable change and delivery of sustainable improvement in the modern context of VBHC. In short, this study has extended STS into this contemporary and vital area of healthcare reform. The lens will be used to examine key theoretical concepts including purpose, measures of success, fit, autonomy, dependency, and empowerment. As a result, the author will evaluate how well STS principles describe and potentially predict his results from how VBHC is applied in practice. In doing so he will also expose areas of contradiction, and extension of STS in this context.

This study contributes to STS theory by offering insights into the interplay and connectivity between professionals, technology and organisational systems in complex, dynamic and poorly adapting healthcare settings. It extends existing theoretical frameworks by integrating empirical findings that highlight misalignments and opportunities.

5.6.1. Purpose of Healthcare Systems

STS theory suggests that healthcare systems are socio-technical entities designed to balance technical efficiency with social components of people and structures for learning and timely decision-making. The primary purpose of these systems enhances clinical outcomes by fostering environments that integrate patient care, professional skills and satisfaction with an alignment with organisational/national goals. This study has shown that traditional healthcare systems prioritise de-personalised processes ad prioritise financial and clinical efficiency over professionals' engagement. Such a system breaks the dependency of service change and staff engagement (those who enact the service). This study shows a misalignment in organisational objectives, where only 43.3% of respondents believed VBHC goals were communicated effectively, despite 80.9% understanding why VBHC activities were being undertaken. The void between direction setters and service delivery professionals is a significant omission for STS and suggests meaningful progress will be limited by a lack of such clarity (a similar perspective would also be taken by those who advocate TQM as a means of enhancing healthcare service provision – see Deming 1982).

This study extends our understanding of how "purpose" (the reason why a system actually exists) is perceived at various organisational levels. There were disconnects observed between individual professionals' intrinsic motivations and organisational objectives which highlights a critical gap in the implementation of VBHC of those countries / regions that participated (meaningful and aligned engagement with the change agenda). The findings suggest that healthcare systems must redefine success to include the role of professional satisfaction and engagement as a key component to enlisting support and increasing the velocity of organisational change. Such a view further develops the work of Braithwaite et al. (2017), who argued for the centrality of professionals in achieving high-quality outcomes especially in organisations where knowledge workers are central to any form of adaptive changes to the organisation.

5.6.2. Measures of Success

High-performing healthcare STS systems require feedback measures that integrate patient outcomes, organisational efficiency and professional engagement to provide balanced measures of success and show how making a change leads to improvement (learning and experience of staff). STS theory critiques approaches that measure success purely through quantifiable outcomes, neglecting qualitative dimensions such as patient and professional satisfaction as well as cultural norms especially that of psychological safety and the voice of staff in making, learning from, and sustaining

change. This study reveals a disparity between what participants believe should be prioritised and what they perceive their organisation prioritises. For example, 70.9% of participants ranked 'Personal Value' as the most important VBHC benefit, yet they believed their organisations prioritised 'Technical Value' (46.6%). In effect a vacuum exists between the value derived from the essence of VBHC and improvements in practice and a clear direction of organisational resources to tackle larger and system wide problems.

This study extends the work of Aiken et al. (2011), who emphasised the importance of balancing staff and patient outcomes, by analysing how misaligned organisational priorities hinder engagement. The finding that 49.6% of respondents felt their contributions to VBHC were inadequately recognised critiques the assumption that technical efficiency alone drives system success from an STS perspective. This study contributes to theory by demonstrating the necessity of reframing measures of success to include the professional value domain, thus broadening the scope of socio-technical metrics in healthcare systems and using measures as a conduit for meaningful engagement and learning.

5.6.3. Fit, Learning and Adaptation

STS theory suggests that a well-functioning system requires alignment or fit between technical systems and social dynamics, alongside the capacity for continuous learning and adaptation. This study provides a critique to this theoretical expectation for VBHC deployments examined by demonstrating a lack of fit between VBHC systems and professional roles. For instance, 52.9% of respondents reported insufficient training for VBHC activities, while 55.2% identified resource constraints as a major barrier to effective implementation. These findings demonstrate the challenges in aligning technical processes with professionals' day-to-day workflows. This study offers a rebuttal to Senge (1993) by illustrating how healthcare organisations fail to foster continuous learning environments with 84.7% of participants acknowledging that VBHC should support skill development but only 76.7% felt it actually did so. To achieve a maximum rate of change, this deficiency in the current interpretation of VBHC represents another resource gap and without such skills development then progress will be limited and likely to reinforce VBHC as an aspirational intention and a pragmatic daily management process – but it will fail to change core organisation systems, services and integrated pathways.

5.6.4. Steady State Versus Future State

STS theory argues that systems must balance stability (steady state) with adaptability (future state) to navigate complex, dynamic environments such as healthcare settings. This study develops the understanding of this balance by analysing VBHC as a continuous delivery system, recognised by 82.6% of respondents, while identifying its lack of future-proof design. For example, resource limitations and shifting organisational or governmental priorities were consistently identified as barriers to sustained implementation.

The study extends the work of Walker et al. (2004) by evaluating how healthcare systems struggle to maintain resilience amidst competing demands and also maintain clarity of focus (direction setting). While STS theory would suggest that adaptability requires robust feedback mechanisms, this study finds that such mechanisms are insufficiently developed in VBHC contexts, with only 64.0% of respondents feeling they could provide meaningful feedback on VBHC activities. This study contributes to theoretical developments by exposing resource allocation and professional involvement as keys to influence the dynamic between steady and future states in complex healthcare systems. The previous section of this chapter has also identified the lack of capacity to learn to fuel staff development and greater VBHC sustainable improvement working as individuals and groups of dependent professionals.

5.6.5. Empowerment and Hierarchy

STS theory argues against rigid hierarchies as they limit innovation and professional autonomy, advocating instead for balanced structures that empower individuals while maintaining organisational coherence. This study evaluates the role of empowerment within hierarchical systems, revealing that while 57.5% of respondents felt empowered to make decisions within VBHC, 72.1% felt excluded from decisions affecting their roles. These findings critique the assumption that hierarchical structures inherently facilitate alignment between organisational and professional goals.

This study develops Mumford's (2006) study by illustrating the duality of empowerment and hierarchy in healthcare systems. It contributes to theory by demonstrating how professional autonomy can act as a counterbalance to hierarchical rigidity, provided sufficient feedback loops and involvement in decision-making in place. The findings further develop STS theory by analysing how empowerment can mitigate disengagement in systems that rely heavily on top-down directives such as those experienced in NHS organisations.

5.6.6. Technology

STS theory suggests that well-integrated technology serves as an enabler for professional engagement and efficiency. This study identifies a misalignment between VBHC technologies and professional workflows. Respondents consistently identified technical inefficiencies, such as systems failing to integrate with existing clinical processes, as a source of frustration. Building on the work of Baxter and Sommerville (2011), this study develops our understanding of how poorly implemented technologies exacerbate disengagement. The findings contribute to theory by illustrating the importance of co-design and participatory approaches in technology deployment, aligning technical capabilities with professional needs and expectations.

5.6.7. Autonomy

STS theory emphasises the importance of autonomy in fostering motivation and engagement. This study evaluates this principle by revealing a gap between perceived and desired autonomy among professionals. While 68.9% of respondents believed VBHC should enhance their control over work, only 51.0% felt it did so in practice. This misalignment contradicts the assumption that systems inherently support professional autonomy through technical improvements alone. The study extends Deci and Ryan's (2000) Self-Determination Theory by analysing how autonomy interacts with hierarchical and technological constraints in healthcare. It contributes to STS theory by demonstrating the critical need for systemic designs that prioritise autonomy without compromising organisational coherence.

5.6.8. Summary of Results Relating to Socio-Technical Theory

This study contributes to STS theory by extending our understanding of how healthcare systems operate as integrated socio-technical systems under the prevailing intention of deploying VBHC. The study contradicts traditional assumptions by analysing barriers such as misaligned goals, insufficient training and limited feedback mechanisms, all of which hinder professional engagement in VBHC in its sustainable delivery (Pasmore, 1988). This study findings do develop the seminal work of Trist and Bamforth (1951) by demonstrating how joint optimisation remains a challenge in complex, resource-constrained environments and dynamic environments. Table 42 is provided for the reader as a summary of this study's findings in relations to the key aspects of STS theory.

ASPECT	SOCIO-TECHNICAL THEORY SUGGESTS	STUDY FINDINGS	ANALYSIS
Purpose of Healthcare Systems	Systems balance technical efficiency with social well-being, integrating patient care, professional satisfaction, and organisational goals.	**Misalignment between organisational priorities and professionals' motivations;** only 43.3% felt VBHC goals were communicated effectively.	Extends: Highlights the need to redefine purpose by integrating professional satisfaction into organisational goals.
Measures of Success	Success integrates patient outcomes, efficiency, and professional engagement, critiquing reliance on quantifiable metrics.	70.9% ranked 'Personal Value' as most important, but 46.6% perceived **organisations prioritised 'Technical Value**.'	Extends: Demonstrates necessity of reframing success metrics to include professional value alongside technical outcomes.
Fit, Learning, and Adaptation	Alignment between technical systems and social dynamics, with capacity for learning and adaptation to challenges.	52.9% reported **insufficient training**, and 55.2% cited resource constraints as barriers to implementation.	Extends: Illustrates challenges in fostering continuous learning and aligning systems with professionals' workflows.
Steady State Versus Future State	Systems must balance stability with adaptability to remain resilient in dynamic environments.	82.6% viewed VBHC as continuous delivery, but **insufficient feedback loops hinder adaptability**; only 64.0% felt they could provide feedback.	Extends: Evaluates how resource allocation and feedback gaps impact adaptability in healthcare systems.
Empowerment and Hierarchy	Balanced structures empower individuals while maintaining organisational coherence, avoiding rigid hierarchies.	57.5% felt empowered to make decisions, but 72.1% felt **excluded from decision-making related to their roles**.	Extends: Explores how empowerment can counteract disengagement caused by hierarchical rigidity in NHS settings.
Technology	Well-integrated technology enables professional engagement and efficiency.	**Misaligned VBHC technologies disrupt workflows**; poor integration identified as a source of frustration.	Extends: Highlights the role of co-design in ensuring technology aligns with professional workflows and expectations.
Autonomy	Autonomy fosters motivation and engagement, requiring balance with organisational coherence.	68.9% believed VBHC **should enhance autonomy**; only 51% felt it achieved this in practice.	Contradicts: Challenges the assumption that technical systems inherently support professional autonomy.

Table 42 - Results Relating to Socio-Technical Theory

Complex healthcare organisations function as STS where the interplay between social and technical elements determines their outcomes and sustainability (especially in the modern service settings and the inherent complexity of caring for people and their comorbidities). Such interconnectedness

explains why empowerment, holism, fit, learning, adaptation, dependency, feedback, efficiency and proactive planning through feedforward processes are key to achieving sustainable VBHC and the noted omissions identified and explored within this study.

Empowerment within healthcare systems is essential as it fosters better VBHC outcomes because it enables professionals to take ownership of their roles, aligning their intrinsic motivations with organisational objectives. Empowered professionals are more likely to innovate and engage deeply with VBHC principles, creating a ripple effect of improved outcomes for both patients and professionals. STS theory argues that rigid hierarchies often stifle this engagement, but empowering decision-making at all levels counteracts such rigid command and control structures by promoting autonomy and collaboration.

Holism ensures that healthcare systems are viewed as interconnected wholes rather than fragmented components (across Primary, Secondary and Social care). By considering the interdependence of professionals, organisational structures and technical systems holism allows VBHC to be implemented in a way that acknowledges the broader ecosystem of care delivery, especially in the UK. This perspective is important in aligning professionals' values and engagement with patient outcomes, financial sustainability and local and national goals. Without this integrated and comprehensive approach, VBHC risks neglecting critical components such as professional satisfaction, which are integral to its success.

Fit, learning and adaptation drive better VBHC by ensuring that social and technical elements are aligned and systems are responsive to emerging challenges. Fit addresses how well professional roles, workflows and motivations integrate with VBHC systems and deployments, while learning fosters environments where professionals can refine processes and adapt to changing needs. Adaptation builds on these principles by enabling organisations to adjust policies and practices in an agile way as needed. Together, these elements create a framework where VBHC systems are not only well-designed but also flexible and agile enough to remain effective over time.

Dependency looks at the interconnectivity within healthcare systems, where the success of VBHC relies on collaboration across all stakeholders within the system. Professionals depend on well-functioning systems to provide resources, support and feedback mechanisms, while organisations rely

on professional engagement to deliver value-based outcomes. This mutual dependency highlights the need for systems that recognise and optimise the roles of all actors, fostering sustainability and shared ownership of VBHC goals.

Feedback loops play a key role in the continuous improvement and sustainability of VBHC. They provide mechanisms for professionals to voice concerns, refine processes, take ownership and align their daily working practices with VBHC principles. Effective feedback ensures that professionals feel valued and that their contributions have a tangible impact, which strengthens their engagement and the system's adaptability and agility to real-world conditions.

Efficiency enhances VBHC outcomes by ensuring that professionals are supported in their roles, enabling them to deliver high-quality care without being overburdened by unnecessary administrative or systemic inefficiencies. When efficiency is prioritised in alignment with professional well-being, it contributes to the dual goals of improved patient outcomes and organisational sustainability.

Feedforward, alongside robust information flows, goals, and values strengthens VBHC by enabling proactive planning and alignment across organisational levels. Feedforward processes anticipate challenges, ensuring smoother integration of VBHC principles. Effective information flows support transparency and collaboration, while shared goals and values align professional motivations with systemic objectives. Together, these elements ensure that VBHC systems are cohesive and focused on delivering meaningful outcomes for patients and professionals.

In summary, complex healthcare systems function as socio-technical systems where the interplay of empowerment, holism, fit, dependency, feedback and proactive processes like feedforward determine their success. This study extends our application and understanding of STS theory into healthcare settings and its importance in understanding and deploying sustainable VBHC.

5.7. Summary of Results Relating to The Authors Conceptual Framework and Findings

Table 43 provides a summary of the findings discussed so far in this chapter relating to the authors conceptual framework viewed through the prism of Change Theory / Models and STS theory.

CONCEPTUAL FRAMEWORK THEME (CFT)	FAILURE THEMES (FT)	FINDINGS SUMMARY	CHANGE MODELS AND SOCIO-TECHNICAL THEORY EVIDENCE
CFT1: Engagement	FT1: Not feeling part of a movement	66.2% felt part of a VBHC movement, but gaps remain for those who felt less connected. Sustained inclusion beyond coalition-building is required.	**Kotter's Eight-Step Model**: Progress in fostering collective belonging aligns with building coalitions but highlights the need for sustained inclusion mechanisms. **Socio-Technical Theory**: Misaligned social systems hinder professionals' identification with organisational goals.
	FT2: Lack of direct engagement with change	Only 31.6% reported strong accountability for VBHC; organisational efforts to value opinions (55.8%) failed to translate into perceived ownership.	**ADKAR Model**: Highlights systemic barriers to engagement beyond individual transformation. **Socio-Technical Theory**: Disempowered professionals lack control over social systems, reducing meaningful participation in change processes.
	FT3: Lack of recognition or reward	51.6% felt recognised, but only 29.7% felt adequately rewarded. Intrinsic motivators partially offset the lack of tangible rewards.	**Maslow's Hierarchy of Needs**: Recognition contributes to self-actualisation but tangible rewards remain critical. **Mosadeghrad**: Differentiates recognition and reward; intrinsic motivators only partially bridge the gap. **Socio-Technical Theory**: A balanced reward system enhances professional engagement.
	FT4: Poor/top-down communications	Transparency gaps persist; only 30.8% believed VBHC communications were open and transparent.	**Lewin's Three-Step Model**: Reinforces critiques of top-down communication. **Socio-Technical Theory**: One-way communication undermines feedback loops and shared understanding, essential for system-wide alignment.
	FT5: Poor leadership	Leadership visibility mixed: 47.1% saw clear VBHC leadership; 39.7% reported personal engagement by managers.	**McKinsey 7S**: Emphasises leadership style as critical for shared values. **Socio-Technical Theory**: Visible leadership aligns organisational goals with professional values, promoting system coherence.
	FT6: No visible leadership	Weak leadership visibility impacts sustained VBHC engagement.	**Kotter**: Critiques prioritisation of top-down over distributed leadership. **Socio-Technical Theory**: Empowered leadership enhances the interdependence of technical and social subsystems.
CFT2: Individual Consequence	FT7: Poor career opportunities	52.9% believed VBHC skills supported career development, addressing critiques of traditional change models that ignore professional growth.	**Kotter**: Critiques for prioritising organisational over career goals. **Socio-Technical Theory**: Skill development aligns technical efficiency with personal fulfilment, enhancing systemic sustainability.

CONCEPTUAL FRAMEWORK THEME (CFT)	FAILURE THEMES (FT)	FINDINGS SUMMARY	CHANGE MODELS AND SOCIO-TECHNICAL THEORY EVIDENCE
	FT8: Poor job satisfaction	80.8% reported improved job satisfaction under VBHC, aligning with professional aspirations.	**ADKAR**: Aligns with fulfilling individual goals. **Maslow**: VBHC supports self-actualisation. **Socio-Technical Theory**: Positive working environments enhance system fit and sustain professional engagement.
	FT9: Poor personal satisfaction	84.7% experienced satisfaction, though gaps remain between reality and expectations (91.4%).	**Lewin**: Fails to account for personal satisfaction as a sustainability driver. **Socio-Technical Theory**: Satisfaction bridges the gap between individual goals and organisational priorities.
	FT10: Poor working environment	62.9% reported improved working conditions under VBHC, but 34.6% identified barriers to achieving outcomes.	**McKinsey 7S**: Working conditions extend beyond structure to include culture. **Socio-Technical Theory**: Fit between roles and environments improves systemic performance and sustainability.
CFT3: Ownership	FT11: Not integral to the role	87.4% saw VBHC as integral to their roles; only 39.1% reported clarity in objectives.	**Kotter**: Lack of individual clarity critiques organisational focus on overarching goals. **Socio-Technical Theory**: Ownership integrates professional roles with technical systems, creating alignment and reducing resistance.
	FT12: Loss of control	Gaps between expected (68.9%) and actual (51.0%) control highlight autonomy challenges.	**ADKAR**: Personal agency is essential but underdelivered. **Socio-Technical Theory**: Autonomy fosters engagement, aligning system design with individual empowerment.
	FT13: Not being allowed to make mistakes and learn from them	Only 7.6% felt managers encouraged learning from mistakes, limiting innovation and improvement.	**Senge's Learning Organisation**: Highlights gaps in fostering learning cultures. **Socio-Technical Theory**: Continuous learning systems are critical for aligning professional growth with system adaptation.
	FT14: Not involved in decision-making	57.5% felt empowered to decide, but 72.1% reported exclusion from key decisions.	**McKinsey 7S**: Shared values must translate into inclusive decision-making. **Socio-Technical Theory**: Inclusion strengthens social-technical alignment, reducing hierarchical barriers.
CFT4: Shared Aims	FT15: Lack of vision, context, and certainty	43.3% felt organisational goals were communicated effectively despite 80.9% understanding VBHC's purpose.	**Theory of Change**: Vision and measurable outcomes must align. **Socio-Technical Theory**: Clear goals reduce misalignments between technical outputs and social expectations.

CONCEPTUAL FRAMEWORK THEME (CFT)	FAILURE THEMES (FT)	FINDINGS SUMMARY	CHANGE MODELS AND SOCIO-TECHNICAL THEORY EVIDENCE
	FT16: Poor or unclear expectations	Only 32.4% felt team expectations were clear; personal role clarity was higher at 69.1%.	**Kotter**: Focus on vision does not always translate into clear expectations. **Socio-Technical Theory**: Shared aims require alignment across teams and hierarchical levels for cohesive outcomes.
	FT17: Unclear benefits or aims	Participants prioritised personal value (70.9%) over perceived organisational focus on technical value (46.6%).	**ADKAR**: Misalignment of perceived and actual benefits reduces engagement. **Socio-Technical Theory**: Value alignment between professionals and organisations fosters sustained commitment to systemic goals.
CFT5: Skills & Capacity	FT18: Lack of training or skills	20.6% received sufficient training; expectations for skill development (84.7%) exceeded delivery.	**McKinsey 7S**: Critiques lack of focus on skills. **Socio-Technical Theory**: Training aligns technical systems with professional expertise, fostering sustainability.
	FT19: Not enough time or resources	57.6% reported inadequate time or resources for VBHC delivery.	**Kotter**: Balancing urgency with adequate resources enhances long-term success. **Socio-Technical Theory**: Resource constraints disrupt social-technical equilibrium, reducing system efficiency.
	FT20: Not understanding terminology or shared language	27.2% believed their colleagues understood VBHC principles, despite high personal confidence (73.5%).	**Senge**: Shared mental models enhance alignment. **Socio-Technical Theory**: Common language fosters understanding across social and technical subsystems, ensuring consistency in goal setting and implementation.

Table 43 - Summary of Results Relating to The Authors Conceptual Framework and Findings

5.8. Summary of Answering the Research Question

Overarching Research Question:

To what extent does professional value and engagement play a role in the sustainable delivery of Value-Based Healthcare (VBHC)?

Professional value and engagement are indispensable to the sustainable delivery of VBHC, as they directly influence organisational resilience, professional satisfaction and the alignment of goals between individuals and the healthcare system. The findings reveal that professional engagement underpins discretionary effort, collective ownership and continuous improvement which are key

drivers of VBHC sustainability. While 55.8% of participants felt their opinions were valued within their organisations, only 31.6% reported a strong sense of accountability for VBHC outcomes. This indicates that although healthcare organisations make efforts to include professionals, these efforts often fail to translate into deeper involvement or ownership.

Cultural alignment was another key element, with VBHC implementation requiring a shared purpose that resonates with the values of healthcare professionals. This study found that 66.2% of participants felt part of a broader VBHC movement or community, suggesting progress in fostering collective belonging. A significant minority (41.2%) reported weaker connections, underscoring the need for sustained inclusion mechanisms to strengthen the sense of community among all stakeholders. These findings extend Kotter's Eight-Step Model by emphasising that long-term engagement requires continuous efforts to bridge inclusion gaps over time.

Additionally, organisational efforts to recognise professional contributions were inconsistent. While 51.6% of participants felt recognised for their work, only 29.7% felt adequately rewarded. Despite this, intrinsic motivators such as improved patient outcomes were effective, with 76.1% of participants finding motivation in VBHC principles. This aligns with Mosadeghrad's assertion that undervaluation risks disengagement, but it also highlights the unique role of intrinsic motivation in offsetting systemic shortcomings.

The interplay between engagement and professional value is central to bridging organisational goals and individual aspirations. These findings demonstrate that VBHC sustainability depends on embedding professional value as a core component of healthcare transformation, requiring a holistic approach that integrates recognition, communication, and empowerment.

Sub-Question 1:

How do professionals derive value from being involved in and delivering VBHC?

Professionals derive value from VBHC through increased job satisfaction, personal fulfilment, career development opportunities and the alignment of organisational goals with their values. This study found that 80.8% of respondents reported that VBHC improved their job satisfaction, and 90.1%

believed it had the potential to enhance satisfaction further. Additionally, 82.4% of participants expressed pride in delivering VBHC, and 78.7% felt a sense of accomplishment. These findings highlight the alignment of VBHC with intrinsic motivators such as purpose and pride, which resonate deeply with healthcare professionals.

Personal fulfilment, defined as the satisfaction derived from meaningful work, was also significant. For example, 84.7% of participants reported personal fulfilment through VBHC, while 91.4% believed it had the potential to enhance fulfilment further. These findings align with ADKAR's emphasis on personal transformation but critique the model by revealing systemic barriers that prevent fulfilment from being fully realised.

There were notable gaps in perceived and actual rewards. Only 29.7% of participants felt adequately rewarded, suggesting that intrinsic motivators cannot fully offset the absence of tangible recognition. This aligns with Nilsson et al.'s (2018) findings, which emphasise the need for systemic improvements to bridge the gap between professional contributions and organisational support.

Another critical aspect was the opportunity for career development. While 52.9% of participants felt that VBHC contributed to their career progression, 44.0% reported limited opportunities for advancement. This indicates that while VBHC offers professional growth, these benefits are unevenly distributed, necessitating targeted efforts to integrate career progression into organisational change strategies.

Sub-Question 2:

What features of 'Professional' value offer the greatest benefits to professionals engaged in VBHC?

The features of professional value that offer the greatest benefits to professionals engaged in VBHC include recognition, empowerment, alignment with individual and organisational goals and the creation of supportive working environments.

- Recognition and Empowerment:

  - Empowerment emerged as a critical factor in fostering engagement. While 57.5% of participants felt empowered to make decisions related to VBHC, only 15.4% felt adequately involved in activities directly affecting them. Furthermore, 68.9% of respondents believed VBHC should provide greater control over their work, compared to 51.0% who felt it currently did. This highlights a gap between professional expectations and organisational practices.
  - Additionally, the ability to learn from mistakes and innovate was identified as essential. However, only 7.6% of participants felt encouraged by their managers learn from mistakes limiting individuals ability to take risks and innovate within VBHC. This suggests that empowerment must be coupled with supportive leadership to drive meaningful change.

- Alignment with Goals:
  - Professionals who viewed VBHC as integral to their roles were more engaged, with 87.4% acknowledging its relevance to their work. However, only 66.2% felt it was embedded in their day-to-day activities, indicating a need to clarify individual objectives within broader organisational goals.

- Supportive Environments:
  - The working environment significantly influenced professional engagement. While 62.9% agreed that VBHC improved their working conditions, 34.6% cited poor conditions as barriers to achieving expected outcomes. Additionally, time and resource constraints were major challenges, with only 57.6% of respondents agreeing they had sufficient time for VBHC activities. These findings extend McKinsey's 7S framework by emphasising the need to balance structural processes with the lived experiences of professionals.

- Shared Aims and Communication:
  - Clear communication of VBHC goals was another critical feature. Although 80.9% of participants understood why VBHC activities were undertaken, only 43.3% felt organisational goals and strategies were effectively communicated. This highlights the importance of aligning organisational and individual priorities through transparent and consistent communication.

In summary this study has highlighted that professional value and engagement are critical to VBHC sustainability, offering practical insights into how organisations can foster a culture of inclusion, recognition, and continuous improvement. So much so that this research found that 63.9% of participants believed there should be a new 5th VBHC benefit domain of 'Professional Value' with 14.3% disagreeing and 21.8% being.

By addressing systemic barriers such as inadequate communication, resource constraints and gaps in recognition, organisations can align professional aspirations with organisational goals, creating a resilient and adaptive healthcare system focused on valuing the professional within the system and the value they should derive from delivering VBHC.

These findings critique traditional change management models, extending and critiquing the dominance of models like Kotter's and McKinsey's to better address the complex, dynamic nature of healthcare environments from an STS perspective. The integration of professional value into VBHC frameworks represents a significant step toward achieving sustainable healthcare transformation, particularly within public systems like the NHS in Wales.

5.9. Conceptual Framework Discussion

The researcher presented their draft conceptual framework in chapter 2, developed and derived from the authors phase 1A 'literature review and desktop exercise' and phase 1B 'conceptual framework development' (Figure 32).

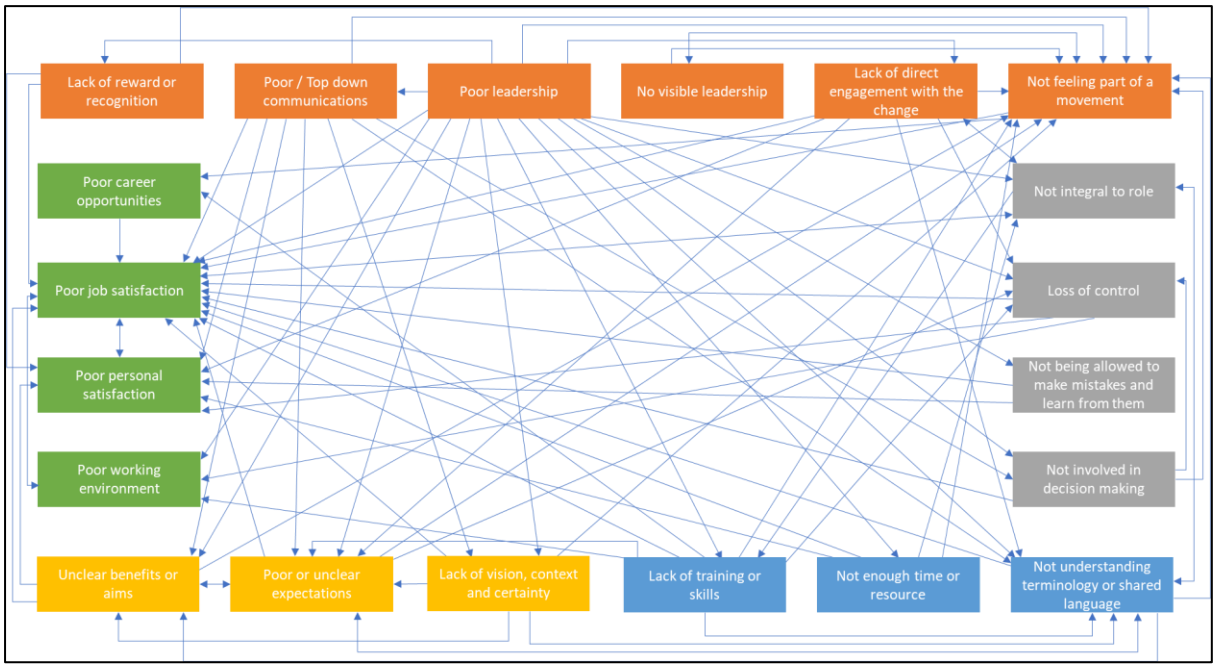


Figure 32 - Draft Authors Conceptual VBHC Sustainability Framework (Source: The Researcher - Marc Penny 2025)

After phase 2A 'semi-structured interview expert review' the author refined the draft conceptual VBHC sustainability framework (Figure 32). From the interviews no additional 'Conceptual Framework Themes' nor 'Failure Themes' were identified by the expert interviewees. What the interviews did reveal were differences in relationships identified between the failure themes. In essence the expert interviews confirmed 'the ingredients' but developed further the 'recipe' of sustainable VBHC delivery. This change in 'recipe' developed a revised VOXI for the failure theme relationships where were validated by the expert interviewees. Figure 33 provides the researchers finalised conceptual VBHC sustainability framework, showing the key elements of the conceptual framework and the validated relationship between each one. Given the changes in relationships the researcher has had to develop a more complicated and comprehensive conceptual framework which shows these relationships, and whilst this framework provides a useful academic tool and visualisation, it makes it difficult to read and understand from a practical application perspective.

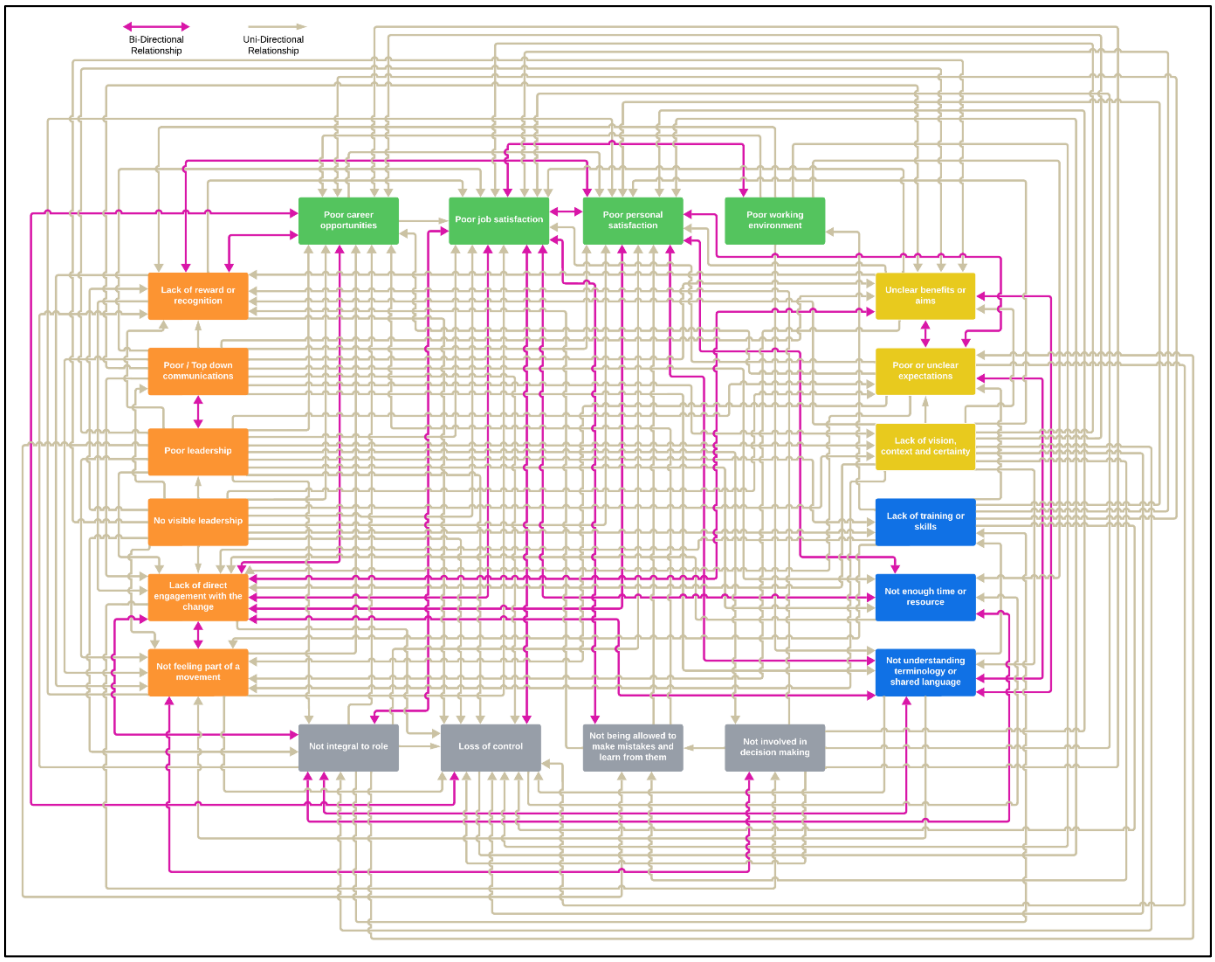


Figure 33 - Finalised Authors Conceptual VBHC Sustainability Framework (Source: The Researcher - Marc Penny 2025)

The framework shows unidirectional relationships in tan and bidirectional relationships in purple. The researchers has analysed the relational directions for each failure theme as shown in Table 44 and Table 45. This analysis helps show those failure theme elements which are drivers or influencers of sustainability which can be directly influenced and those which are important for the sustainable delivery of VBHC but are influenced by others on whether their present of not.

The following failure themes are those which influence the most other failure themes, and are considered by the research as ones requiring critical focus given their impact on so many other of the conceptual framework themes:

- FT6 No visible leadership
- FT5 Poor leadership
- FT15 Lack of vision, context and certainty
- FT4 Poor / Top down communications
- FT18 Lack of training or skills

With FT8 Poor job satisfaction and FT9 Poor personal satisfaction not driving other elements but are elements which are influenced by other aspects of the framework. These 2 failure themes cannot be directly influenced but must be achieved through the delivery of the wider elements of the conceptual framework.

FAILURE THEME		OUTWARD RELATIONSHIP COUNT
FT6	No visible leadership	15
FT5	Poor leadership	14
FT15	Lack of vision, context and certainty	12
FT4	Poor / Top down communications	11
FT18	Lack of training or skills	9
FT11	Not integral to the role	7
FT10	Poor working environment	6
FT14	Not involved in decision making	6
FT16	Poor or unclear expectations	5
FT1	Not feeling part of a movement	4
FT3	Lack of recognition or reward	4
FT17	Unclear benefits or aims	4
FT13	Not being allowed to make mistakes and learn from them	3
FT2	Lack of direct engagement with change	2
FT7	Poor career opportunities	2
FT12	Loss of control	2
FT20	Not understanding terminology or shared language	2
FT19	Not enough time or resources	1
FT8	Poor job satisfaction	0
FT9	Poor personal satisfaction	0

Table 44 - Conceptual VBHC Sustainability Framework Failure Theme Outward Relationship Count (Source: The Researcher - Marc Penny 2025)

Similarly FT12 Loss of control, FT9 Poor personal satisfaction, FT8 Poor job satisfaction and FT7 Poor career opportunities all show that they are more likely to be influenced by a combination of other framework elements as opposed to being able to influence these failure themes directly (Table 45).

FAILURE THEME		INWARD RELATIONSHIP COUNT
FT12	Loss of control	13
FT9	Poor personal satisfaction	12
FT8	Poor job satisfaction	11
FT7	Poor career opportunities	10
FT1	Not feeling part of a movement	6
FT3	Lack of recognition or reward	6
FT16	Poor or unclear expectations	6
FT19	Not enough time or resources	5
FT2	Lack of direct engagement with change	4
FT17	Unclear benefits or aims	4
FT20	Not understanding terminology or shared language	4
FT11	Not integral to the role	3
FT13	Not being allowed to make mistakes and learn from them	3
FT15	Lack of vision, context and certainty	3
FT18	Lack of training or skills	3
FT14	Not involved in decision making	2
FT10	Poor working environment	1
FT4	Poor / Top down communications	0
FT5	Poor leadership	0
FT6	No visible leadership	0

Table 45 - Conceptual VBHC Sustainability Framework Failure Theme Inward Relationship Count (Source: The Researcher - Marc Penny 2025)

To improve accessibility and readability for a practical application the author has developed Figure 34 - Finalised Authors Conceptual VBHC Sustainability Framework Easy View (Source: The Researcher - Marc Penny 2025) and Figure 35 - Finalised Authors Conceptual VBHC Sustainability Framework Practical Visualisation (Source: The Researcher - Marc Penny 2025) which are bother aimed at the practical application of the framework. The easy read versions show the key Conceptual and Failure Themes that need to be considered and how they sit within a wider VBHC deployment system.

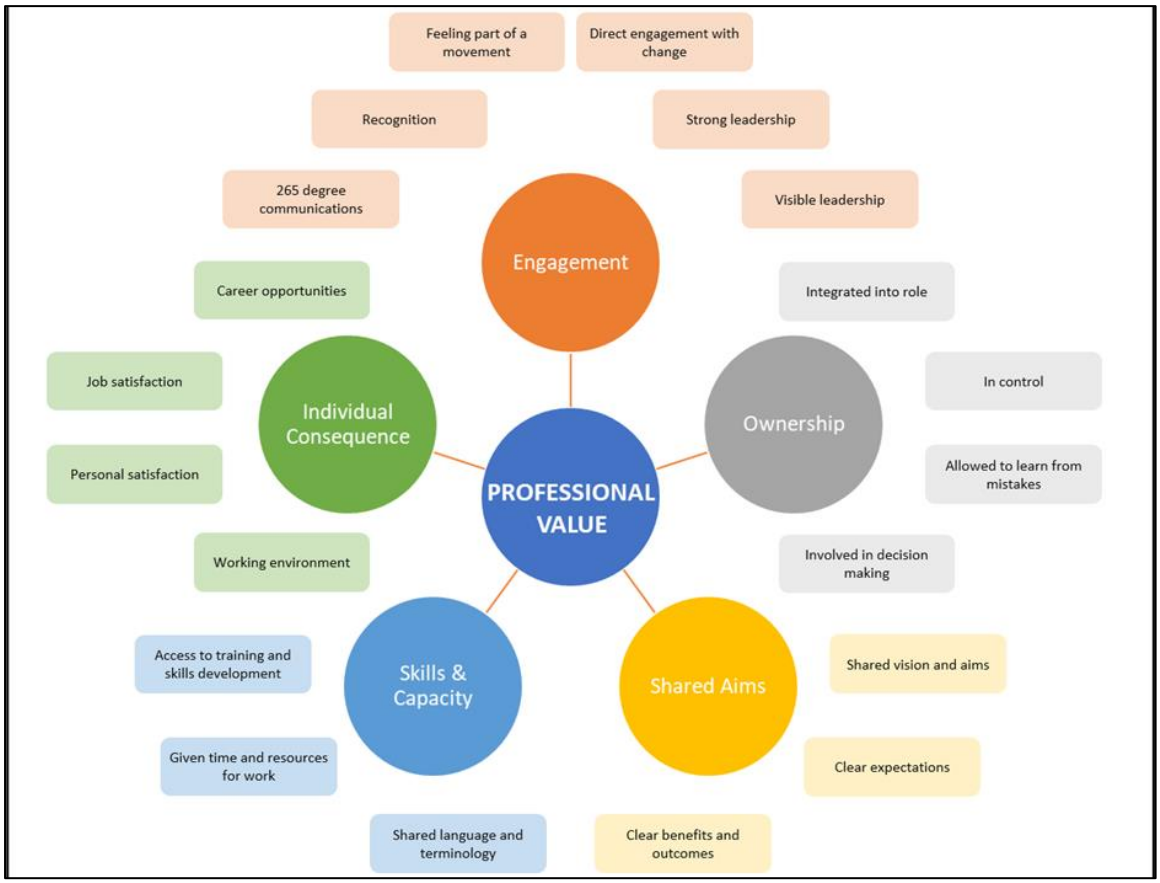


Figure 34 - Finalised Authors Conceptual VBHC Sustainability Framework Easy View (Source: The Researcher - Marc Penny 2025)

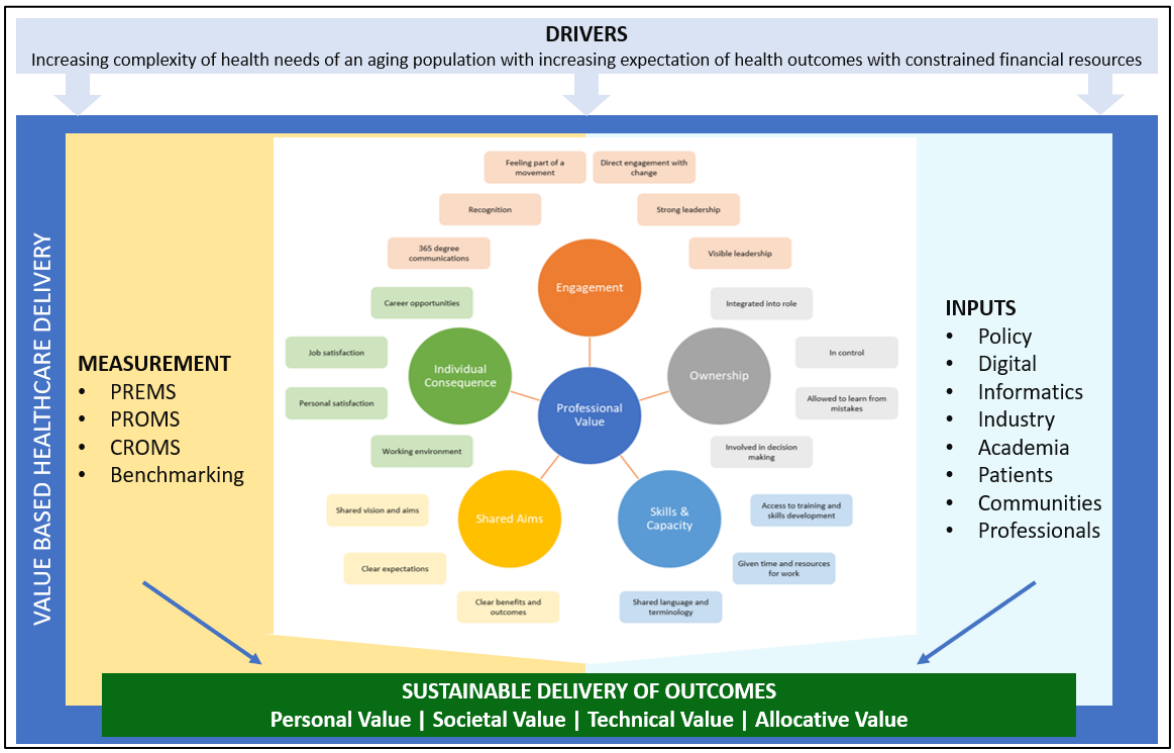


Figure 35 - Finalised Authors Conceptual VBHC Sustainability Framework Practical Visualisation (Source: The Researcher - Marc Penny 2025)

Through the different phases of research along with the expert interviews, the author has successfully validated their conceptual framework with identification of key themes which are either primary influencers of those which are primarily influenced. This framework provides a more holistic approach to implementing and sustainably embedding VBHC as opposed to other change models explored, many of which do not adequately take consideration of the complexity of healthcare settings, their need to continually change and develop and the drivers and motivations of its workforce.

5.10. Discussion Chapter Summary & Conclusions

This study has demonstrated the key role of professional value and engagement in the sustainable delivery of Value-Based Healthcare (VBHC). By addressing the authors central research question – 'To what extent does professional value and engagement play a role in the sustainable delivery of VBHC?', the findings reveal that professional engagement and value alignment are not merely supportive elements but are fundamental to the success of VBHC initiatives.

Professional engagement facilitates discretionary effort, fosters a sense of ownership and drives cultural alignment, which are essential for embedding VBHC within healthcare systems. Although 66.2% of participants felt part of a broader VBHC movement, significant gaps in inclusion remain, particularly for those who do not identify with this collective purpose. This reinforces Kotter's emphasis on coalition-building but extends it by underscoring the need for mechanisms that sustain long-term engagement. The study critiques existing change management models like ADKAR for underplaying systemic barriers to individual transformation and highlights the importance of professional autonomy in enabling sustainable change.

Professionals derive value from VBHC through increased job satisfaction, personal fulfilment and career development opportunities. 80.8% of participants reported improved job satisfaction and 84.7% experienced personal fulfilment, indicating that VBHC aligns with intrinsic motivators such as purpose and pride. However, tangible rewards remain limited with only 29.7% of participants feeling adequately recognised for their work and effort. This disconnect demonstrates that while intrinsic motivators can partially offset systemic limitations, a balanced approach that integrates recognition and tangible rewards is critical.

The features of professional value that offer the greatest benefits include recognition, empowerment, alignment with organisational and individual goals, and supportive environments. Empowerment emerged as a key factor with 57.5% of participants feeling empowered to make decisions, though gaps in involvement and autonomy remain. Only 7.6% of participants reported being encouraged by managers to learn from past mistakes thus limiting their ability to take risks and innovate, highlighting the need for leadership practices that support professional autonomy and learning. These findings extend STS theory by emphasising the importance of co-designing systems that balance technical and social elements to foster professional agency.

Communication and shared aims also play roles in bridging organisational goals and professional values. While 80.9% of participants understood the rationale behind VBHC initiatives, only 43.3% felt organisational goals were effectively communicated. This highlights the need for transparent and consistent messaging to align expectations and foster cohesion. Resource and time constraints were identified as significant barriers, with only 57.6% of participants agreeing they had sufficient time for VBHC activities. These findings reinforce the importance of aligning structural processes with the "lived experiences" of professionals, extending traditional change models and showing their inadequacies for the practice of modern health and care change management.

In conclusion, professional value and engagement are indispensable for the sustainable delivery of VBHC. By addressing systemic barriers and aligning organisational priorities with professional goals, healthcare organisations can create a culture of inclusion, recognition, and continuous improvement. This research contributes to the theoretical and practical understanding of VBHC by critiquing traditional change models and proposing a more nuanced, socio-technical approach that prioritises professional empowerment and alignment. For publicly funded healthcare systems like the NHS, these insights provide a pathway to achieving sustainable, value-based transformation that benefits both patients and professionals. The next chapter will present the conclusions of this study and declare the implications of studying VBHC for its key stakeholders.

CHAPTER 6 – CONCLUSION

6. Introduction to The Conclusion Chapter

This final chapter brings together the key findings of the research, reflecting on the original research questions and their answers before considering the broader implications for stakeholders involved in VBHC initiatives within healthcare organisations. It builds on the discussions presented in earlier chapters, reinforcing the relevance of professional value and engagement in ensuring the sustainability of VBHC in publicly funded healthcare settings. This chapter concludes the research phase 4 as below:

PHASE 4: DISCUSSION AND CONCLUSIONS

INPUTS – Conceptual framework, analysis and findings along with literature review material

- Ability to have answered the research question(s) posed.
- Presentation of finalised conceptual framework
- Conceptual framework viewed through socio-technical theory lens.
- Other questions posed as a result of this research and identification of further areas of study.
- Identification of limitations such as a focus on Wales, NHS context of COVID and austerity etc

OUTPUT – Conclusion to the research question(s) and areas for further study.

The chapter explores implications for policymakers, healthcare professionals and NHS leaders before identifying key areas for future research. Acknowledging study limitations, it calls for further research of the framework to ensure its relevance in evolving healthcare contexts. The chapter finally challenges scholars and practitioners to leverage professional engagement and STS for sustainable VBHC improvements by adopting the researchers findings and conceptual framework.

6.1. Summary of Findings and Discussions

This research explores the overarching research question:

- To what extent does professional value and engagement play a role in the sustainable delivery of Value-Based Healthcare (VBHC)?

And to effectively address this, the study examined two sub-questions:

1. How do professionals derive value from being involved in and delivering VBHC?
2. What features of ‘Professional’ value offer the greatest benefits to professionals engaged in VBHC?

The findings develop five key conceptual themes that influence the success and sustainability of VBHC: Engagement, Individual Consequence, Ownership, Shared Aims and Skills & Capacity. Each theme provides insights into how professionals perceive their role in VBHC and the factors that drive or hinder long-term sustainability.

- Engagement: While 66.2% of participants felt part of a VBHC movement, a significant 31.6% did not feel accountable for its success, raising concerns about sustained professional commitment beyond initial enthusiasm. This helps address the first sub-question by showing that a sense of ownership and inclusion is crucial for professionals to derive value from their involvement in VBHC.
- Individual Consequence: The study reveals that 80.8% of participants reported improved job satisfaction through VBHC, suggesting that professional engagement positively impacts well-being. However, a lack of career progression opportunities and tangible rewards remains a barrier. This finding aligns with the second sub-question by highlighting that professionals derive value from VBHC when personal growth and recognition are incorporated.
- Ownership: While 87.4% of respondents viewed VBHC as integral to their role, only 39.1% felt they had clear objectives, indicating a misalignment between organisational expectations and individual responsibilities. This demonstrates that clear role definition and structured implementation strategies are essential for professionals to see value in their contributions.
- Shared Aims: Despite 80.9% of participants understanding VBHC principles, only 43.3% believed organisational goals were effectively communicated. This highlights a gap in ensuring that VBHC aligns professional aspirations with broader system-wide objectives, which is crucial for long-term engagement.
- Skills & Capacity: Training and resource limitations emerged as major barriers, with only 20.6% of respondents feeling adequately trained. Additionally, time constraints affected professionals' ability to implement VBHC effectively. This underscores that skill development and institutional support are necessary for professionals to fully engage with and benefit from VBHC.

This study contributes to VBHC literature by demonstrating that PV and engagement are not just facilitators but prerequisites for sustainable healthcare transformation. It extends STS theory by showing that alignment between professional motivation and organisational goals is vital for embedding VBHC into long-term practice.

The findings confirm that professionals derive value from VBHC when it enhances job satisfaction, career development and role clarity. However, for VBHC to be sustainable there must be structured engagement, clearer communication and better resource allocation. Answering the second sub-question, the study suggests that integrating a fifth VBHC domain of "Professional Value" could strengthen professional motivation, leading to improved patient outcomes and a more resilient healthcare system.

6.2. Reflections on The Research Journey

Reflecting on the research journey I've been on there are a few reflections and areas I may do differently if I had to undertake it again.

A lot of the research was conducted during the immediate post COVID19 period, where both society and healthcare were getting used to the new normality post pandemic. This period may have impacted and influenced not only responses but also may have had some impact on peoples time and ability to input into the study. The research was undertake with the support of my employing organisation which allowed me access to people and data as well as some time to undertake the research, however this did not include any budget for deeper investigation methods or wider geographical scope. Also a lot of the research was undertaken in my own time and if I had the opportunity it would be good to have more dedicated time for the research allowing for more focused engagement and wider scope.

6.3. The Authors Conceptual Framework

Figure 36 presents the final validated 'Conceptual Value Based Healthcare Sustainability Framework' which shows the key 'Themes' that must be considered as part of a sustainable deployment of VBHC in healthcare settings, these Themes are:

- CFT1 Engagement
- CFT2 Individual Consequence
- CFT3 Ownership
- CFT4 Shared Aims
- CFT5 Skills & Capacity

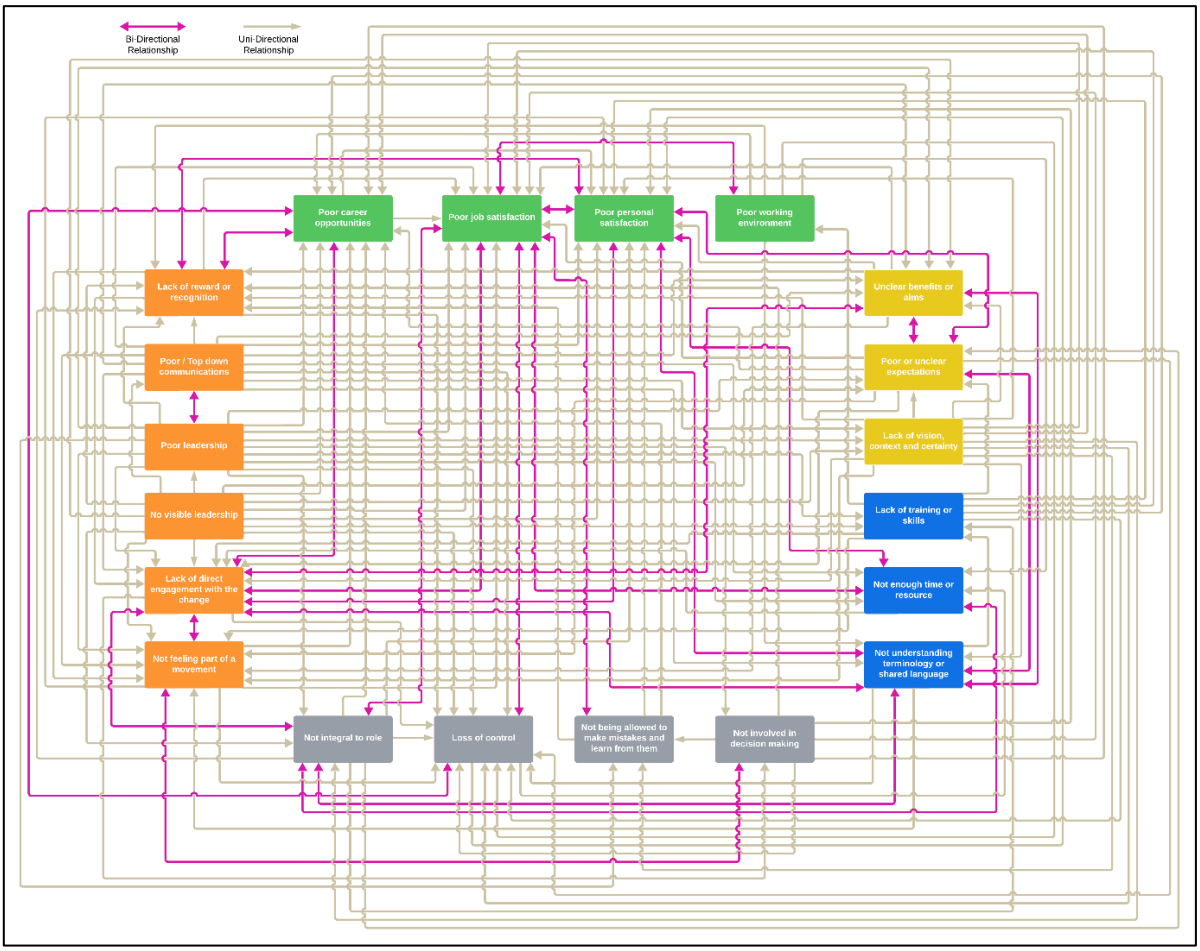


Figure 36 – Conceptual Value Based Healthcare Sustainability Framework (Source: The Researcher - Marc Penny 2025)

Figure 36 is an academic framework and not easy to read of understand, to enable easy and practical application for professionals in healthcare settings the researcher has produced easy read versions (Figure 37 & Figure 38) which show clearly the key conceptual themes, the sub failure themes along with how the model and themes sit within a wider VBHC deployment. The failure themes are as follows (Table 46):

FAILURE THEMES		CONCEPTUAL FRAMEWORK THEME	
FT1	Not feeling part of a movement	CFT1	Engagement
FT2	Lack of direct engagement with change	CFT1	Engagement
FT3	Lack of recognition or reward	CFT1	Engagement
FT4	Poor / Top-down communications	CFT1	Engagement
FT5	Poor leadership	CFT1	Engagement
FT6	No visible leadership	CFT1	Engagement
FT7	Poor career opportunities	CFT2	Individual Consequence
FT8	Poor job satisfaction	CFT2	Individual Consequence
FT9	Poor personal satisfaction	CFT2	Individual Consequence
FT10	Poor working environment	CFT2	Individual Consequence
FT11	Not integral to the role	CFT3	Ownership
FT12	Loss of control	CFT3	Ownership
FT13	Not being allowed to make mistakes and learn from them	CFT3	Ownership
FT14	Not involved in decision making	CFT3	Ownership
FT15	Lack of vision, context and certainty	CFT4	Shared Aims
FT16	Poor or unclear expectations	CFT4	Shared Aims
FT17	Unclear benefits or aims	CFT4	Shared Aims
FT18	Lack of training or skills	CFT5	Skills & Capacity
FT19	Not enough time or resources	CFT5	Skills & Capacity
FT20	Not understanding terminology or shared language	CFT5	Skills & Capacity

Table 46 - Conceptual Framework Themes and Failure Themes Grouping (Source: The Researcher - Marc Penny 2025)

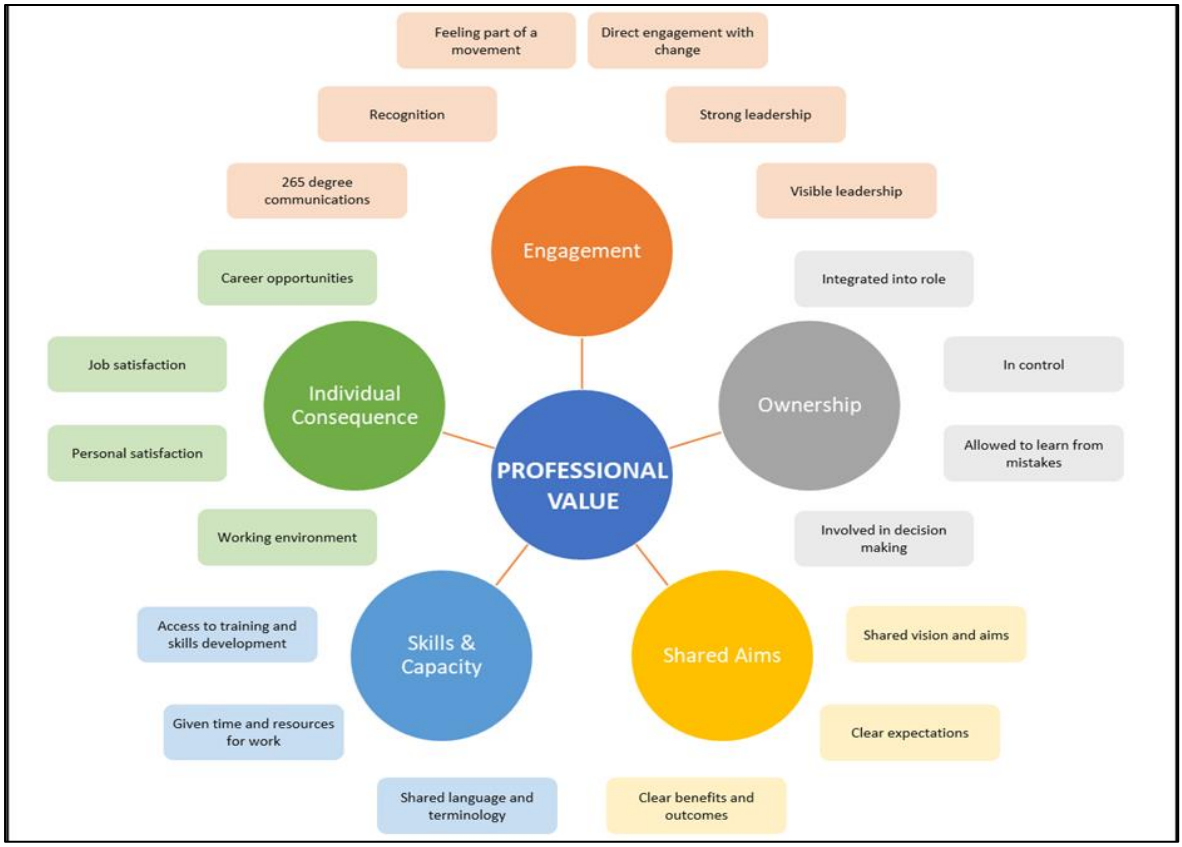


Figure 37 - Conceptual VBHC Sustainability Framework Easy View (Source: The Researcher - Marc Penny 2025)

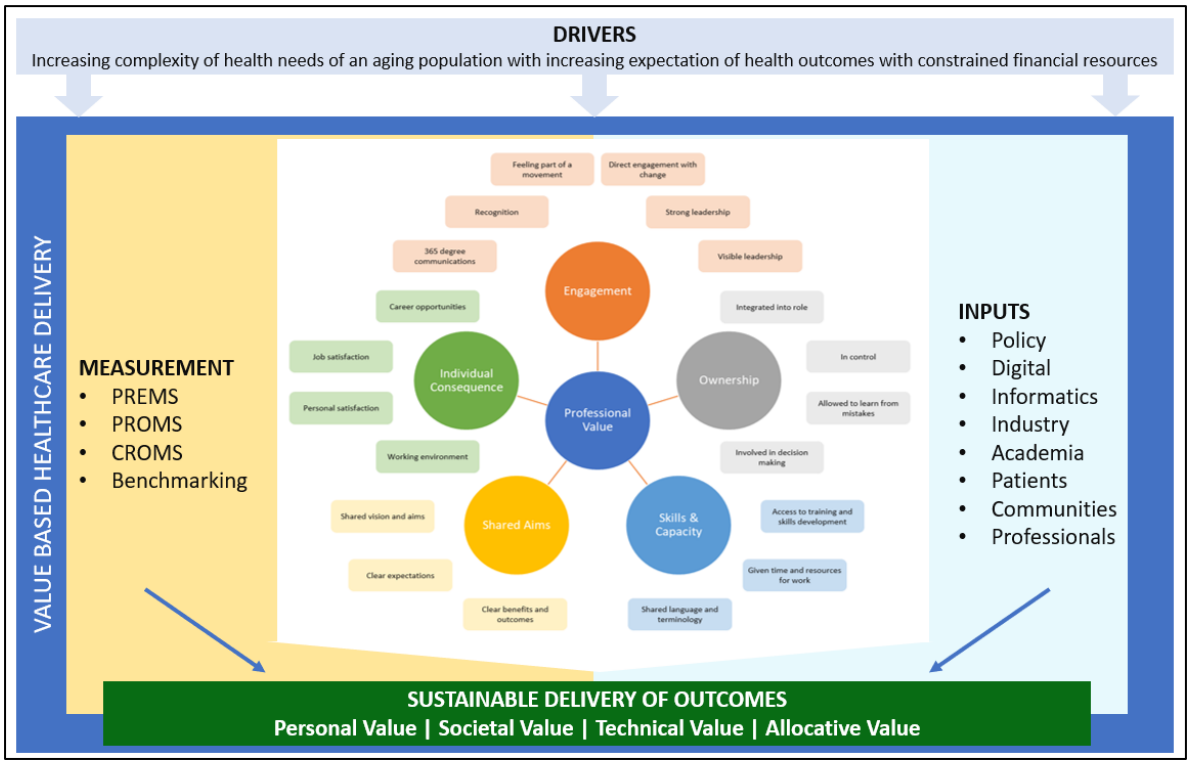


Figure 38 - Conceptual VBHC Sustainability Framework Practical Visualisation (Source: The Researcher - Marc Penny 2025)

Table 46, Figure 36, Figure 37 and Figure 38 provide the key conceptual framework outputs from this research.

6.4. Contribution

6.4.1. Value Based Healthcare

This research contributes to the existing and developing area of VBHC knowledge, building on the works of the likes of Porter and Gray. The majority of literature and research to date in this field is associated with the current accepted 4 value areas of Personal, Technical, Societal and Allocative value, however this research helps extend that knowledge and accepted 4 value areas with the introduction of a 5th value area of 'Professional Value'. The researcher has provided an additional contribution in defining 'Professional Value' as '*Professional Value refers to actions that enhance (and do not undermine) engagement, personal impact, ownership, shared goals and capability.* Additionally, this research adds to the practical elements associated with implementing VBHC in publicly funded / provided healthcare settings, such as the U.K. NHS, providing new knowledge on delivering sustainable change and benefits when delivering VBHC projects and change.

Although not a specific contribution, this research demonstrates methodological rigour through its use of a mixed method design, incorporating triangulation across semi-structured interviews, surveys,

internal documents and secondary sources. The inductive approach enabled refinement of the conceptual framework in light of qualitative and quantitative findings, while purposive and theoretical sampling ensured depth and relevance across different organisational contexts. This methodological combination provided rich, context-sensitive insights that enhance the credibility and transferability of the study's conclusions.

6.4.2. Applied Research

The research explores with the real life challenges facing healthcare systems worldwide with an increasing global population, increased life expectancy with people living longer but with more complex health needs and comorbidities, the impact of the COVID-19 pandemic and its continuing affects and the ever increasing global spend on health and its diminishing returns on life expectancy and quality of life (Roser et al., 2013).

The research provides opportunities to plug a gap in the current knowledge of VBHC delivery, allowing refinement of policy and delivery plans for healthcare systems and organisations, ensuring the right interventions are made to ensure the professional within the system derives value from their involvement. Specifically, the research can be applied to Cwm Taf Morgannwg University Health Board as well as the wider National Value in Health Centre (Wales) VBHC deployment frameworks and guides.

6.4.3. Conceptual framework

The author developed conceptual framework is in itself a contribution to both academia and delivery and provides a unique contribution. The framework developed contributes to the body of knowledge, theory and practical understanding of how to deliver VBHC by ensuring PV is understood and actions taken to address each element of the conceptual framework.

6.4.4. Change Theory

The research reinforces many of the existing change theories discussed in the literature review and instrumental in the development of the authors conceptual framework, many of which have been extensively applied into healthcare over many years such as ADKAR (Hiatt, 2006), Lewin Change Management Model (Lewin, 1951), Kotter's 8 steps (Kotter, 1996) and McKinsey 7s (Peters, 1982).

6.4.5. Socio-Technical Theory

The research reinforces and helps extend STS Theory (Trist & Bamforth, 1951a) which was firstly introduced in 1960s manufacturing, then more latterly with Lean improvement theory within healthcare but stopped short of understanding its application to and impacts on VBHC. The research findings support the theory of STS relevance and its extension into VBHC with socio / cultural elements and technical / structural elements being equally important in delivering system change and sustainability as the authors conceptual framework suggests.

6.4.6. Implications for Other Groups

Additionally to the above there are a number of specific groups where the research and conceptual framework can make a contribution, including:

- Academia (Health, Organisational / Business Management, Change Practices)
    - Use case studies when teaching complicated system dynamics such as those in healthcare settings
    - Student placements while on degrees into organisations to understand the complexity of healthcare settings
    - When discussing and delivering change in healthcare settings and the deficit in other models in delivering successful sustainable change in healthcare settings
- Healthcare systems and organisations (Cwm Taf Morgannwg University Health Board, Pan Wales NHS, UK wide NHS and similar international healthcare organisation)
    - Build into training
    - Build into wider organisational culture and behaviours initiatives
    - Celebrate success and share best practice
- Professional managers and leaders in healthcare and the professional practice within the NHS
    - Providing a more comprehensive view of the professional in delivering sustainable change
- Policy Makers (Implications for Welsh / UK / International Government Policy, NHS and Healthcare systems Policy and Strategy)

6.5. To the Practitioner

This research offers several key contributions to both academic understanding and professional practice. Primarily, it sheds light on the criticality of effective leadership in navigating the multifaceted challenges encountered in contemporary healthcare organisations. The findings underscore that

leadership extends beyond task delegation, encompassing the creation of inclusive cultures and adaptive strategies that foster both individual and organisational development.

Furthermore, this study reveals how psychological safety and emotional intelligence serve as integral components of successful project outcomes. The cultivation of trust within teams was shown to directly influence morale, communication, and resilience, all qualities that are vital in dynamic, high-pressure settings. This highlights the importance for leaders to not only drive performance but also to sustain team cohesion and wellbeing.

From a practical standpoint, these insights suggest a growing need for project leaders to invest in interpersonal skills and emotional literacy. It is recommended that organisations consider embedding structured training programmes focused on inclusive leadership, active listening and conflict resolution within their VBHC delivery frameworks. Such measures would not only enhance team functionality but also contribute to long-term organisational agility and employee retention.

The study advocates for a reassessment of traditional leadership models within VBHC and project contexts. As team compositions become increasingly diverse and geographically dispersed, leadership styles must evolve to accommodate varying perspectives, working patterns and cultural nuances. This aligns with the contemporary shift towards more empathetic, situational and values-driven approaches to leadership.

Overall, this research provides a compelling case for integrating soft skills development into the core competency set of VBHC leaders. By doing so, organisations can better prepare their leaders to meet the evolving demands of modern project work, thereby driving sustained success across VBHC initiatives.

6.6. Limitations of This Research

There are a number of limitations the author has had to consider for research and study providing a defined scope and boundaries. These include:

- Geographical

- The research has focused on a set number of geographical areas. Those included within the study are Wales, Scotland, and Australia. The author chose these geographical areas for a number of reasons, being:
    1) Each geographical region is or has undertaken Value based Healthcare implementation, thus within the geographical area there are suitable populations to be included in the study.
    2) Ability to evaluate geographical regions within the same overall Country UK (Wales, Scotland) operating within similar but autonomous healthcare systems and an international comparator with although a different healthcare system, similarities in function and delivery exist.
- These 4 geographical areas set the delimitation of the research, and whilst providing significant data and insights potential future study could review a wider geographical area.

- Timeframe
    - Cross Sectional study was chosen to provide a snapshot at a single point in time (i.e. the timeframe for the authors research and study) helping understand the prevalence of key characteristics associated with the authors research question and aims. Although this approach has suited the requirements of the researcher and provided valuable insights, what is unknown is any changes in those insights over time or maturity of Value Based Healthcare implementation.
- Sample and population.
    - Populations were chosen based on the geographical regions discussed above and samples from within those populations were chosen randomly and outside of the control of the researcher. Broadcast invitation to participate were made by individual organisational Value Based Healthcare leads to any member of staff they were aware of involved in or impacted by the implementation or delivery of Value Based Healthcare within their organisation. At the time of this assignment a total sample size of 136 responses (excluding partial returns) have been made.
    - Sample was focused on those directly or indirectly involved in Value Based Healthcare initiatives and excludes those not involved.
- Research Methods
    - The research methods used were restricted to a simple mixed method of survey and semi structured interview providing a mix of quantitative and qualitative data. Although providing data and insights required for the research question other methods may have yielded other insights for consideration.

- Data
    - The study data has contained itself to only that which has been gathered by the author as part of this research and the pan Wales Value Based Healthcare maturity assessment. No other data has been included nor existing research data sets used.
- Organisational Type
    - The research has focused on healthcare systems which are either fully publicly provided or as in the case of Australia has a significant element of public provision with private top up.
    - This delimitation has allowed for close comparison between the 4 regions selected to take part but provides no insights into other healthcare systems where structures, resources and ultimately 'business' drivers may be different.

6.6 Practical Applications

The research findings can be used in a number of practical applications within Wales and further afield.

These include:

- Policy – This research can help inform future policy, specifically within Wales and the Welsh NHS but also in other healthcare systems. The practical findings can be used to ensure policy takes clear account of the cultural enablers required to deliver sustainable benefits from Value Based Healthcare by having clear policy relating to the elements of the conceptual framework presented in this research. These should include clear direction of policy relating to the 5 identified conceptual framework themes of:
    - Engagement
    - Ownership
    - Skills and Capacity
    - Shared Aims
    - Individual Consequence
- Delivery – Delivery plans for Value Based Healthcare can be refined to include all elements of the conceptual framework ensuring clear focus and delivery strategies are in place for the key elements of the framework, namely the 20 identified failure themes:
    - Not feeling part of a movement
    - Lack of direct engagement with change
    - Lack of recognition or reward
    - Poor / Top-down communications

- Poor leadership
- No visible leadership
- Poor career opportunities
- Poor job satisfaction
- Poor personal satisfaction
- Poor working environment
- Not integral to the role
- Loss of control
- Not being allowed to make mistakes and learn from them.
- Not involved in decision making
- Lack of vision, context and certainty
- Poor or unclear expectations
- Unclear benefits or aims.
- Lack of training or skills
- Not enough time or resources
- Not understanding terminology or shared language

Inclusion of these framework elements based on this research would indicate improved success when embedding sustainable VBHC practices and sustainable delivery of benefits.

- Professional change engagement – the conceptual framework can be applied to engagement strategies with professionals working within the healthcare system to ensure PV is being acknowledged and developed, increasing the likelihood of success of VBHC delivery by valuing those within the system.

6.7 Future Research

The author has identified opportunities for further research, these opportunities have been identified through the study as well as previously discussed delimitations.

- Geographical – widen this research and apply to a wider geographical area, currently the research has been focused on UK and 1 other nation. The research should explore, and conceptual framework tested against a greater range of geographical areas. In doing so a focus should be on the different cultures within those geographical areas and any specific requirements these may have on the finding of this research.
- Organisational type – widen this research and apply to other types of healthcare systems, ones which are not solely or predominantly public funded service. The research should

continue to explore the conceptual framework and its applicability to other types of healthcare system which are either more privately, or insurance aligned in their delivery. Does the conceptual framework fit in this different contextual setting, do any changes need to be made, are there things where are more or less important in a different organisational type?

- Timeframe – consider further research in the form of a longitudinal study where repeated measurement it taken over a period of time allowing for further understanding and analysis around trends as well as potential changes in the drivers and priority of elements within the conceptual framework over time, dependent on time and potential maturity of Value Based Healthcare delivery within an organisation
- Strategy alignment – from the research and analysis undertaken to date the data suggests a divergence between individual view and perceived organisational view of the priority and importance of the 4 Value Based Healthcare Principles. Further research to understand this divergence in views and prioritisation should be undertaken to understand why there is a divergence and how important this divergence in impacting the success of Value Based Healthcare sustainable delivery. Change management theories such as Kotter's Eight-Step Change Model (Kotter, 1996), Lewin's Change Management Model (Levasseur, 2001), the McKinsey 7-S Framework (Singh, 2013), and the ADKAR Model (Hiatt, 2006) all recognise the significance of a shared vision or strategy in facilitating organisational change so understanding the impact of the apparent divergence found by this research should be explored further.
- Benefits Delivery Linked to the Conceptual framework – data surrounding the sustainable delivery of befits of Value Based Healthcare is limited, partly due to limited standardisation on how to assess and measure Value Based Healthcare improvements. Further research could be undertaken to further understand any potential link between the conceptual framework developed and its impact on the delivery of sustainable Value Based Healthcare benefits.
- Measurement of professional value – consider further research which takes the conceptual framework and concept of professional value and understand how this may be measured as part of sustainable delivery of Value Based Healthcare and its embedding as part of performance matrix within organisations.

6.8 Concluding Remarks

The author has developed a conceptual framework through qualitative research validated by experts and healthcare professionals showing a clear link between sustaining VBHC and providing professionals who deliver VBHC with value of their own. A strong message and support for a new additional value domain of ‘Professional Value’ in the authors view should be included within standard

VBHC deployments as supported by this research and building on others from both health and wider change experts. The answer to the question 'To what extent does professional value and engagement play a role in the sustainable delivery of Value Based Healthcare?' is professionals play a key and vital role in the sustainable delivery of VBHC and to ignore this is to fail in the sustainable delivery of its aims and objectives.

In addition, while traditional healthcare measures often focus on clinical outcomes such as life expectancy, this research supports VBHC theory and the importance of incorporating broader quality of life indicators that reflect individual experiences and wellbeing. Metrics such as autonomy, emotional resilience and a sense of purpose at work should be given greater weight, recognising that sustainable healthcare must address not only longevity but also the lived quality of life for both patients and professionals.

It is hoped that this thesis will inspire further research into VBHC and encourage others to build upon the work presented here. The findings underscore the importance of professional value in sustaining VBHC, and it is anticipated that future studies will explore this concept further, refining and expanding the framework introduced in this research. It is hoped that this thesis serves as a catalyst for practical implementation, providing individuals and organisations with a structured approach to embedding VBHC principles effectively and sustainably. By recognising and reinforcing the role of professionals in VBHC sustainability, this work lays the foundation for deeper inquiry and broader adoption of professional value as an essential component of healthcare transformation.

It is my sincere hope that others will take up the mantle, advancing both the academic discourse and real-world application of VBHC, ensuring that healthcare systems continue to evolve in ways that enhance both patient and professional experiences.

Marc Aneurin Morgan Penny

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Appendix A - Philosophical Appraisal HARP (Heightening your Awareness of your Research Philosophy) Questionnaire

Heightening your Awareness of your Research Philosophy (HARP Statements)

A: Please indicate your agreement or disagreement with the statements below. There are no wrong answers.	*Strongly Agree*	*Agree*	*Slightly Agree*	*Slightly Disagree*	*Disagree*	*Strongly Disagree*	*Score**
Your views on the nature of reality (ontology)							
1: Organisations are real, just like physical objects.	☐	☒	☐	☐	☐	☐	2
2: Events in organisations are caused by deeper, underlying mechanisms.	☐	☒	☐	☐	☐	☐	2
3: The social world we inhabit is a world of multiple meanings, interpretations and realities.	☐	☐	☐	☐	☒	☐	-2
4: 'Organisation' is not a solid and static thing but a flux of collective processes and practices.	☐	☐	☒	☐	☐	☐	1
5: 'Real' aspects of organisations are those that impact on organisational practices.	☒	☐	☐	☐	☐	☐	3
Your views on knowledge and what constitutes acceptable knowledge (epistemology)							
6: Organisational research should provide scientific, objective, accurate and valid explanations of how the organisational world really works.	☒	☐	☐	☐	☐	☐	3
7: Theories and concepts never offer completely certain knowledge, but researchers can use rational thought to decide which theories and concepts are better than others.	☐	☒	☐	☐	☐	☐	2
8: Concepts and theories are too simplistic to capture the full richness of the world.	☐	☐	☒	☐	☐	☐	1
9: What generally counts as 'real', 'true' and 'valid' is determined by politically dominant points of view.	☐	☐	☐	☒	☐	☐	-1
10: Acceptable knowledge is that which enables things to be done successfully.	☐	☒	☐	☐	☐	☐	2
Your views on the role of values in research (axiology)							
11: Researchers' values and beliefs must be excluded from the research.	☐	☐	☐	☐	☐	☒	-3
12: Researchers must try to be as objective and realistic as they can.	☐	☒	☐	☐	☐	☐	2
13: Researchers' values and beliefs are key to their interpretations of the social world.	☐	☐	☒	☐	☐	☐	1
14: Researchers should openly and critically discuss their own values and beliefs.	☐	☐	☒	☐	☐	☐	1
15: Research shapes and is shaped by what the researcher believes and doubts.	☐	☐	☒	☐	☐	☐	1

A: Please indicate your agreement or disagreement with the statements below. There are no wrong answers.	*Strongly Agree*	*Agree*	*Slightly Agree*	*Slightly Disagree*	*Disagree*	*Strongly Disagree*	Score*
Your views on the purpose of research							
16: The purpose of research is to discover facts and regularities, and predict future events.	☐	☐	☐	☐	☐	☐	2
17: The purpose of organisational research is to offer an explanation of how and why organisations and societies are structured.	☐	☐	☐	☐	☐	☐	2
18: The purpose of research is to create new understandings that allow people to see the world in new ways.	☐	☐	☐	☐	☐	☐	3
19: The purpose of research is to examine and question the power relations that sustain conventional thinking and practices.	☐	☐	☐	☐	☐	☐	2
20: The purpose of research is to solve problems and improve future practice.	☐	☐	☐	☐	☐	☐	3
Your views on what constitutes meaningful data							
21: Things that cannot be measured have no meaning for the purposes of research.	☐	☐	☐	☐	☐	☐	-2
22: Organisational theories and findings should be evaluated in terms of their explanatory power of the causes of organisational behaviour.	☐	☐	☐	☐	☐	☐	1
23: To be meaningful, research must include participants' own interpretations of their experiences, as well as researchers' interpretations.	☐	☐	☐	☐	☐	☐	2
24: Absences and silences in the world around us are at least as important as what is prominent and obvious.	☐	☐	☐	☐	☐	☐	2
25: Meaning emerges out of our practical, experimental and critical engagement with the world.	☐	☐	☐	☐	☐	☐	3
Your views on the nature of structure and agency							
26: Human behaviour is determined by natural forces.	☐	☐	☐	☐	☐	☐	1
27: People's choices and actions are always limited by the social norms, rules and traditions in which they are located.	☐	☐	☐	☐	☐	☐	2
28: Individuals' meaning-making is always specific to their experiences, culture and history.	☐	☐	☐	☐	☐	☐	2
29: Structure, order and form are human constructions.	☐	☐	☐	☐	☐	☐	2
30: People can use routines and customs creatively to instigate innovation and change.	☐	☐	☐	☐	☐	☐	2

Heightening your Awareness of your Research Philosophy (HARP Statements)

B: Scoring key

Each answer you gave is given a number of points as shown in the table below:

Strongly Agree	*Agree*	*Slightly Agree*	*Slightly Disagree*	*Disagree*	*Strongly Disagree*
3	2	1	-1	-2	-3

*Write the number of points into the score column

C: Research Philosophy

Write your score for each answer in the table below:

Positivism: Questions 1, 6, 11, 16, 21, 26							
Question	1 (ontology)	6 (epistemology)	11 (axiology)	16 (purpose)	21 (data)	26 (structure/ agency)	Total
Answer score	2	3	-3	2	-2	1	3

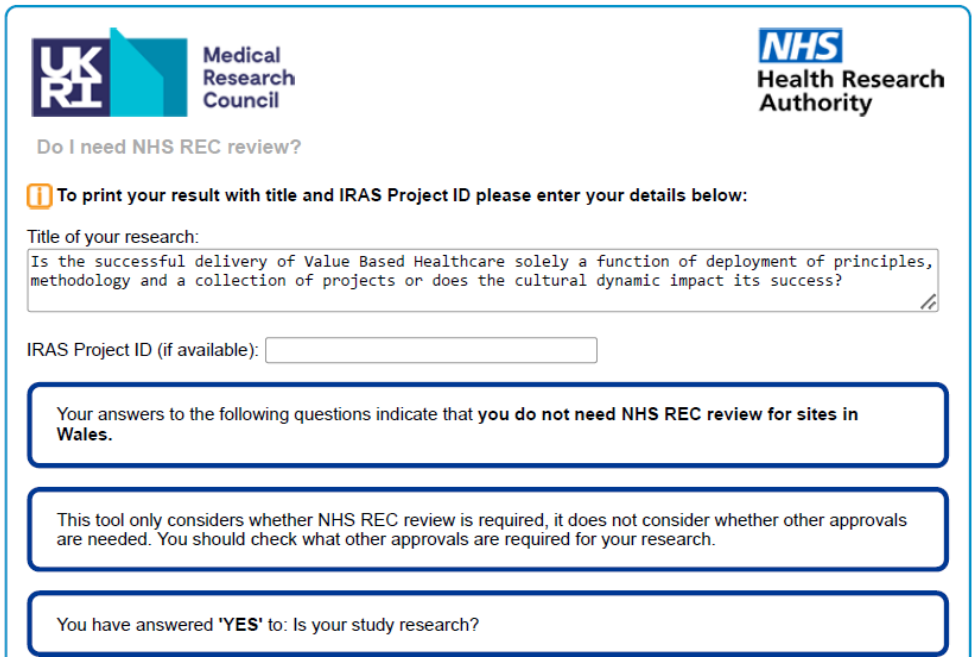
Postmodernism: Questions 4, 9, 14, 19, 24, 29							
Question	4 (ontology)	9 (epistemology)	14 (axiology)	19 (purpose)	24 (data)	29 (structure/ agency)	Total
Answer score	1	-1	1	2	2	2	7

Critical Realism: Questions 2, 7, 12, 17, 22, 27							
Question	2 (ontology)	7 (epistemology)	12 (axiology)	17 (purpose)	22 (data)	27 (structure/ agency)	Total
Answer score	2	2	2	2	1	2	11

Pragmatism: Questions 5, 10, 15, 20, 25, 30							
Question	5 (ontology)	10 (epistemology)	15 (axiology)	20 (purpose)	25 (data)	30 (structure/ agency)	Total
Answer score	3	2	1	3	3	3	15

Interpretivism: Questions 3, 8, 13, 18, 23, 28							
Question	3 (ontology)	8 (epistemology)	13 (axiology)	18 (purpose)	23 (data)	28 (structure/ agency)	Total
Answer score	-2	1	1	3	2	2	7

Appendix B - Ethics Approvals



Medical Research Council

NHS Health Research Authority

Do I need NHS REC review?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

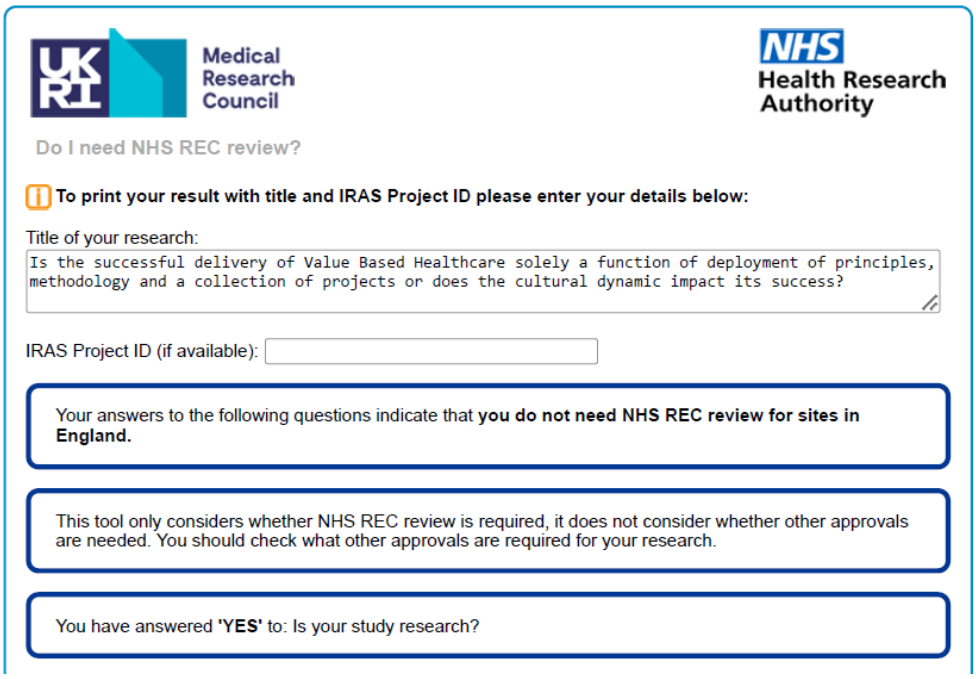
Is the successful delivery of Value Based Healthcare solely a function of deployment of principles, methodology and a collection of projects or does the cultural dynamic impact its success?

IRAS Project ID (if available):

Your answers to the following questions indicate that **you do not need NHS REC review for sites in Wales.**

This tool only considers whether NHS REC review is required, it does not consider whether other approvals are needed. You should check what other approvals are required for your research.

You have answered **'YES'** to: Is your study research?



Medical Research Council

NHS Health Research Authority

Do I need NHS REC review?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

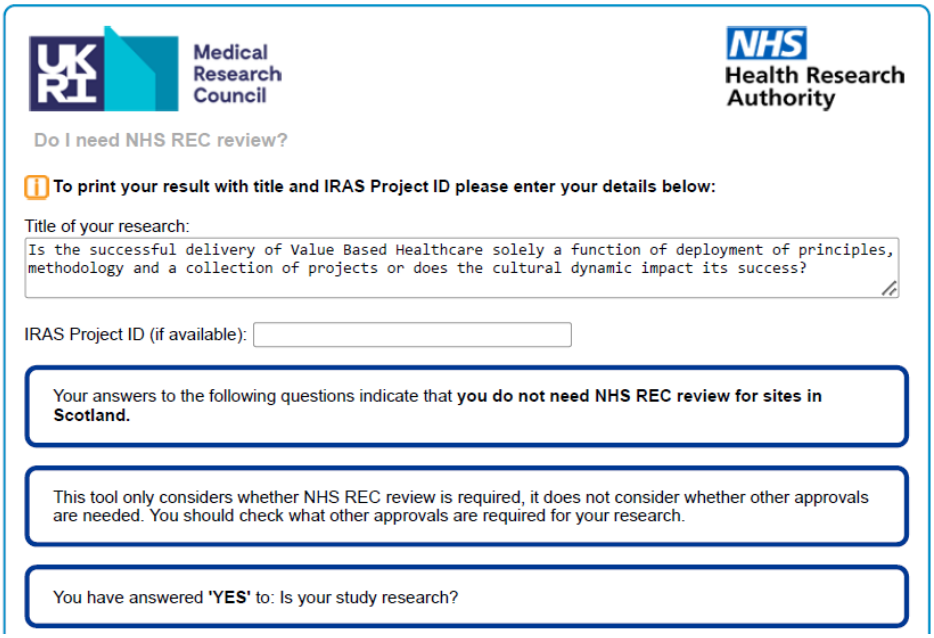
Is the successful delivery of Value Based Healthcare solely a function of deployment of principles, methodology and a collection of projects or does the cultural dynamic impact its success?

IRAS Project ID (if available):

Your answers to the following questions indicate that **you do not need NHS REC review for sites in England.**

This tool only considers whether NHS REC review is required, it does not consider whether other approvals are needed. You should check what other approvals are required for your research.

You have answered **'YES'** to: Is your study research?



Medical Research Council

NHS Health Research Authority

Do I need NHS REC review?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

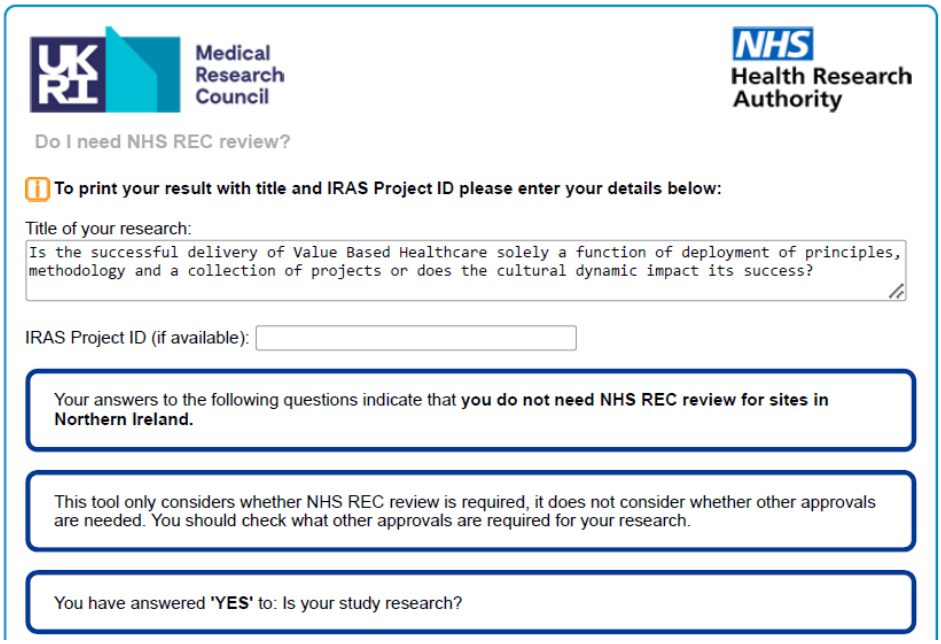
Is the successful delivery of Value Based Healthcare solely a function of deployment of principles, methodology and a collection of projects or does the cultural dynamic impact its success?

IRAS Project ID (if available):

Your answers to the following questions indicate that **you do not need NHS REC review for sites in Scotland.**

This tool only considers whether NHS REC review is required, it does not consider whether other approvals are needed. You should check what other approvals are required for your research.

You have answered **'YES'** to: Is your study research?



Medical Research Council

NHS Health Research Authority

Do I need NHS REC review?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

Is the successful delivery of Value Based Healthcare solely a function of deployment of principles, methodology and a collection of projects or does the cultural dynamic impact its success?

IRAS Project ID (if available):

Your answers to the following questions indicate that **you do not need NHS REC review for sites in Northern Ireland.**

This tool only considers whether NHS REC review is required, it does not consider whether other approvals are needed. You should check what other approvals are required for your research.

You have answered **'YES'** to: Is your study research?

Declaration: *The project will be conducted in compliance with the University's Research Integrity Framework (P1415-956). This includes securing appropriate consent from participants, minimizing the potential for harm, and compliance with data-protection, safety & other legal obligations. Any significant change in the purpose, design or conduct of the research will be reported to the SOM-REC Chair, and, if appropriate, a new request for ethical approval will be made to the SOM-REC.*			
Signature of PI or PGR Student	[redacted]		
Signature of first supervisor (if appropriate)	[redacted]		
Decision of SOM-REC	Approved		
Ethical Risk Assessment	Green ☒	Yellow ☐	Red ☐
Signature of SOM-REC Chair or SOM-REC deputy Chair	[redacted]		
Date	06/02/2023		
SOM-REC Reference number (office use only)	SOM-REC-STAFF 174		

Appendix C - Literature Review Journal Article Scores and Ratings

Journal Name	Articles Cited	AJG 2024 Rating	Journal Citation Indicator (JCI)
Academic Medicine	3		2.01
Academy of Management Journal	4	4*	2.31
Academy of Management Review	1	4*	3.45
Administrative science quarterly	2	4*	1.98
American Sociological Review	1	4*	3.63
Annals of Contemporary Developments in Management & HR (ACDMHR)	1		
Annals of Surgery	1		4.8
Annual review of psychology	1		4.24
Applied Ergonomics	2		0.88
Australian Journal of Public Administration	1	2	0.84
BMC Health Services Research	5		0.92
BMC Medical Ethics	2		1.04
BMJ	3		10.16
BMJ Quality & Safety	2		1.72
British Journal of Management	1	4	1.04
British Medical Journal Open	1		0.68
Business & Society	1	3	1.25
Clinical Orthopaedics and Related Research	1		2.16
Corporate Communications: An International Journal	1	1	
Cureus	1		0.29
Current Opinion in Ophthalmology	1		0.75
Current sociology	1	2	0.86
Ecology and society	1		0.86
EPMA Journal	1		1.33
European Journal of Marketing	1	3	
Evidence-Based Nursing	1		1.45
FFF Clinical Finance Journal	1		
Frontiers in Psychology	2		0.97
Frontiers in Public Health	2		1.02
Future Healthcare Journal	3		
Group & Organization Management	1	3	1.08
Handbook of Qualitative Research	1		
Harvard Business Review	5	3	0.33
Health Affairs	2		3.27
Health Management	2		0.55
Health Research Policy and Systems	1		1.3
Health Services Management Research	2	1	0.56
Health Systems and Policy Analysis	1	2	1.3
Health, Risk & Society	1		0.65
Healthcare	1		
Human Relations	5	4	1.87
Human Resource Management International Digest	1	2	1.13
Human Rights Law Review	1		1.39
IISE Transactions on Healthcare Systems Engineering	1		0.41
Information Systems Journal	1	4	1.83
Interfaces	1		
International Journal for Quality in Health Care	2		0.73
International Journal of Health Care Quality Assurance	2	1	0.42
International Journal of Health Planning and Management	1		0.66
International Journal of Health Policy and Management	2		0.98
International Journal of Human Resource Management	1		1.13
International Journal of Industrial Engineering and Management	1		0.36
International Journal of Lean Six Sigma	1	1	0.79
International Journal of Management Reviews	1	3	1.35
International Journal of Operations & Production Management	3	4	1.8
International Journal of Project Management	1	2	1.72
International Journal of Quality & Reliability Management	2	2	0.55
International Journal of Quality and Service Sciences	1		
International Journal of Service Industry Management	1		
International Review of Administrative Sciences	1	3	0.93
JONA: The Journal of Nursing Administration	1		0.9
Journal of Applied Psychology	1		2.65
Journal of Change Management	4	1	0.7
Journal of Environmental Management	1	3	1.49
Journal of general internal medicine	1		1.34
Journal of Health Organization and Management	5	1	0.57
Journal of Health Services Research & Policy	1	2	
Journal of Healthcare Leadership	1		1.12
Journal of Healthcare Management	1		0.56
Journal of Management	2	4*	2.03
Journal of Management development	1		0.62
Journal of Management Studies	1	4	1.55
Journal of marketing	2	4*	2.34
Journal of Marketing Research	1	4*	1.1
Journal of Nursing Management	2		1.57
Journal of Operations Management	1	4*	
Journal of Organizational Behavior	1	4*	
Journal of Organizational Change Management	1	2	0.63
Journal of Patient Safety	1		
Journal of retailing	1	4	1.84
Journal of service research	1	4	1.97
Leadership & Organization Development Journal	1	1	1.02
Leadership in Health Services	3	1	0.63
Medical Journal of Australia	2		1.27
MIT Sloan Management Review	2	3	0.32
Museum management and marketing	1	2	
NEJM Catalyst	2		
Nurse Education in Practice	1		1.42
Ocular Immunology and Inflammation	1		0.94
Organization Development Journal	1		1.02
Oxford Library of Psychology	1		0.9
Postgraduate Medical Journal	1		0.83
Psychological Bulletin	1	4	4.83
Psychological Inquiry	1		1.62
Public Administration	1		
Qual Saf Health Care	1		
Research and Theory for Nursing Practice	1		0.35
Research in personnel and human resources management	1		
SAGE Open Medicine	1		0.51
Social Policy and Society	1	2	1
Social Research Methods	1		1.56
Social Science & Medicine	2	4	1.67
Sociotechnical Systems: A Sourcebook	1		
Studies in continuing education	1		0.87
Systems Research and Behavioral Science	1		
The Academy of Management Review	2		3.45
The Health Foundation	1		
The Jossey-Bass Business & Management Series	1		
The Jossey-Bass Social and Behavioral Science Series	1		
The Journal of Marketing	1		
The Journal of the Operational Research Society	1		0.64
The Lancet	2		24.4
The Milbank Memorial Fund Quarterly	1		
The Milbank Quarterly	4		2.02
The New England Journal of Medicine	2		25.31
The Official Journal of the Academy of Family Physicians of Malaysia	1		
The TQM Journal	1	1	1.06
Total Quality Management	1		0.83
Total Quality Management & Business Excellence	2	2	0.83
Transylvanian Review of Administrative Sciences	1		0.48
Trials	1		0.5
Uncertainty in Economics	1		
Valahian Journal of Economic Studies	1		
Value In Health	1		1.4
World Psychiatry	1		
Grand Total	**184**		

Appendix D – Conceptual Framework Expert Reviewers Personal Biographies

Professor Hamish Laing

After a career as an NHS Plastic, Reconstructive and Sarcoma Surgeon at the Welsh Centre, Hamish was Executive Medical Director and Chief Information Officer at ABM University Health Board, Wales where he initiated a Value-Based Healthcare (VBHC) programme.

Appointed to a personal chair in Swansea University in 2018 and the founding Director of the Value-Based Health and Care (VBHC) Academy in 2021, Hamish researches, teaches and consults about VBHC for Health, Social Care and the life-science Industry sectors.

Hamish represents Wales at the EFPIA VBHC Think-Tank in Brussels and works with several global Life Sciences companies on their VBHC transformation. An expert affiliate to the EU Alliance for Value in Health and Welsh Value in Health Centre, Hamish is a Senior Fellow of the Faculty of Medical Leadership and Management, a Fellow of BCS, the Chartered Institute for IT in the UK and non-executive director of Life Sciences Hub Wales.

Professor Sally Lewis

Professor Sally Lewis, founder of Kintsugi International, is a distinguished leader in the field of value-based healthcare (VBHC). A career spanning 30 years as a general practitioner, medical leader and policy advisor, Sally has dedicated her career to transforming healthcare systems worldwide.

As the former National Clinical Director for Value-Based and Prudent Healthcare in NHS Wales and the founder of the internationally recognised Welsh Value in Health Centre, she has pioneered the implementation of VBHC, making substantial contributions to global healthcare improvements. Her work has been recognised by many institutions including the World Economic Forum, Harvard Business School, Bertelsmann-Stiftung, OECD, HTAi and the Australian Healthcare and Hospitals Association. She teaches internationally on the principles of value-based healthcare, from undergraduates to executive education.

Professor Nicholas Rich

Professor Nicholas ‘Nick’ Rich is an expert in the field of operations management and specialises in the design of high-performance organisational systems (high-quality manufacturing and service

businesses) and highly reliable organisational systems (safety-critical industries and healthcare sectors).

Nick is a much-applied academic and has worked with some of the world's most famous businesses and healthcare organisations. He is a government adviser, has written government reports, nine books and over 100 publications.

Doctor Alice Andrews

Dr. Alice Andrews's expertise focuses on the implementation of health care delivery solutions designed around outcomes that matter to patients and that support the professionalism of the health care workforce. Andrews currently is senior research scientist and senior lecturer at the Geisel School of Medicine at Dartmouth College (USA) and before that was director of education for the Value Institute for Health and Care and on faculty of the medical and business schools at the University of Texas at Austin (USA). Dr. Andrews is on the editorial review board for the Journal of Patient Experience and the Journal of Health Organization and Management. She serves as juror for the Value Based Healthcare Prize of the Value Based Healthcare Center Europe and was previously on the advisory board for the Value in Health National Programme for NHS Wales. Andrews holds a Ph.D. in organisational behaviour from Cornell University and an M.S. in the evaluative clinical sciences from Dartmouth College.

Magda Golebiowska

Magda Golebiowska is a Value in Health Improvement Manager in CVUHB. She has over 15 years of experience in healthcare and charitable organisations across Europe. She has worked within various fields, including health promotion, prevention and screening, eating disorders, oncology and congenital anomalies. She has master's degrees in Public Health and Dietetics and is a doctorate student at Swansea University. In her research she focuses on the implementation of value-based healthcare. She is a certified Agile project manager and an experienced Lean manager.

Doctor Tom Howson

Dr Tom Howson is the Head of Innovation and Transformation for the Bevan Commission and oversees the Commission's diverse portfolio of innovation programmes, projects and partnerships. Tom's academic background is grounded in the study of Biomedical Sciences, whilst his doctorate at Swansea

University Medical School focussed on the study of innovation management activity in the Life Science and Health sectors. Tom has previously worked within the Intellectual Property (IP) industry and for health and social care innovation accelerator programmes. In addition, Tom is an NIHR Evidence Reviewer, co-lead on the health workstream of the innovation lab research centre at Swansea University and a Trustee for an International Maternal Health charity. Tom has a collection of academic publications and presentations at various international conferences and forums.

Rhian Hamer

Rhian Hamer is a proven transformation consultant with experience of leading and championing change across public and private sectors, including central government, financial services, local authorities and health. Rhian is a values-driven leader who is passionate about transforming businesses with energised teams, using a systems approach. She's a firm believer that relationships, not power, drive delivery and that people are at the heart of any successful digital transformation. An accomplished programme delivery professional with a reputation for honesty and integrity. Sought after international speaker, keynote speaker at various conferences and public speaking engagements, including at two conferences run by the Australian government. Recognised by Welsh Assembly Government as one of the "top 10 contributors" to transforming public services across Wales in 2016. Rhian won the "Inspirational Leader" award at the 2023 UK industry awards in recognition of innovative approach to leading one of the biggest digital health changes across Wales.

Simon Mansfield

Simon is Head of Value Based Healthcare at Hywel Dda University Health Board. He has previously worked as Service Delivery Manager for Unscheduled Care in Withybush General Hospital, with pan Health Board responsibility for Stroke and Care of the Elderly Services. Prior to working in Hywel Dda University Health Board, he has also worked as Head of Informatics Programmes in Abertawe Bro Morgannwg University Health Board Health Board, as Deputy General Manager in the Princess of Wales Hospital in Bridgend, and as Directorate Manager for the Pathology Directorate in Abertawe Bro Morgannwg University Health Board Health Board. Before working within the NHS, Simon has worked within the private sector as a technology and communications consultant and also as a business development manager within the information security environment. He has also worked extensively as Project Manager and Quality manager for a number of IT Systems Integrators.

Navjot Kalra

Navjot has over two decades of experience in the digital and healthcare industries, specialising in Value Based Healthcare strategies and operations, focusing on enhancing patient outcomes, reducing costs and improving healthcare delivery. Expertise includes leading global digital transformation projects, ensuring regulatory compliance and driving organisational growth in dynamic environments.

Significant experience in delivering complex global business and digital transformation initiatives. She holds an engineering degree in Computer Sciences, MBA with Merit from Henley Business School and is currently pursuing a Doctorate in Business Administration at Swansea University where the research centres on embedding business intelligence in Value Based Healthcare redesign.

As Head of Value-Based Healthcare for a large NHS Wales organisation Navjot leverages her expertise to drive innovation and optimise care. As the Assistant Director for data and analytics for a national program her focus is to embed intelligence for value, collaborating with policymakers and healthcare providers to improve value for the population and the patients served.

Appendix E - Qualitative Semi-Structured Interview Invite Cover Letter and Procedures

Research Protocol

The Name of the Study:	**To what extent does professional value and engagement play in the sustainable delivery of Value Based Healthcare?**
The Study Team:	**Mr. Marc Penny**
The Ethical Approval Document:	**SOM-REC-STAFF 174**
Class of Research:	**Service Review**

The Protocol - Please read this consent document carefully before you decide to participate in this study.

Purpose of the research study

Value Based Healthcare provides a promising approach for driving organisational and process efficiency to achieve greater value for patients, society and taxpayers. However, contemporary discourse overlooks the crucial role of individuals and professionals within this complex socio-technical system, creating a gap in current research and understanding. This gap is particularly notable concerning healthcare professionals, whose involvement the author believes is essential for successful and sustainable implementation.

While some papers acknowledge the need for further research, the current knowledge gap underscores the need for deeper exploration of the professional's role in Value Based Healthcare implementation which is what the authors research aims to contribute towards.

The researcher seeks to answer the research question of 'To what extent does professional value and engagement play in the sustainable delivery of Value Based Healthcare?'

What you will be asked to do in the study

During this study we will interview expert informants. Interviews are expected to last approximately 40 - 60 minutes. All interviews will be recorded using an audio recording device and transcribed for analysis.

The purpose of the expert interviews is to validate the researchers conceptual framework, both the method used in its development and the relational content.

Time required

Approximately 40 - 60 minutes

Risks and Benefits

There are no known risks to participants. There are no expected benefits for individual participants.

Confidentiality

Your identity will be kept confidential to the extent provided by law. Your information will be assigned a code number. The list connecting your name to this number will be kept in a secure file, in a secure server. When the study is completed and the data have been analysed, the list will be destroyed (within 6 months of project closure).

Research Protocol

Your name and a short bio **WILL** be included within the final report referencing you as an expert reviewer, however no feedback or data will be identifiable back to an individual. Please advise the principle researcher if you **DO NOT** wish your name and short bio to be included in the final report.

Voluntary participation

Your participation in this study is completely voluntary. There is no penalty for not participating. In addition, during the interview, you will have the right to waive any question you do not wish to answer.

Right to withdraw from the study

You have the right to withdraw from the study at any time without consequence.
Who to contact if you have questions about the study or wish to withdraw:
Mr Marc Penny.

Principal Researcher: Mr Marc Penny, Swansea School of Management [redacted]

Advisor and Supervisor: Professor Nick Rich, Swansea School of Management, [redacted]

Who to contact about your rights as a research participant in the study:
Dr Carl Cater, Ethical Committee, Swansea School of management. #

Agreement

I have read the procedure described above. I voluntarily agree to participate in the study and I have received a copy of this description.

Participant Name: _____

Participant Signature: _____

Date: _____

Principal Investigator: _____ Date: _____

I agree to having my name and short biography included in the final report detailing me as an expert reviewer (using a cross to select). Yes ☐ No ☐

_____

Marc Penny Research Protocol 2024

Appendix F – Qualitative Semi-Structured Interview Pack

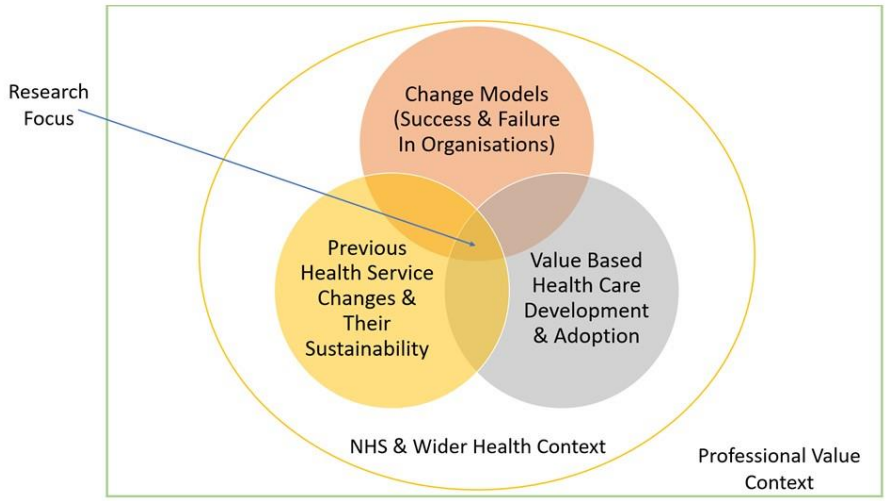
Marc Penny – DBA Conceptual Framework Expert Review

Research Question:
To what extent does professional value and engagement play in the sustainable delivery of Value Based Healthcare?

Sub Questions:

- What lessons can be learnt from current Value Based Healthcare deployments and previous changes implemented in healthcare?
- Do professionals derive value from being involved in and delivering Value Based Healthcare?
- Should there be a specific 'Professional' value domain within Value Based Healthcare?

Authors Spheres of Research



The Literature and Gap – Value Based Healthcare Development and Adoption

Value Based Healthcare provides a promising approach for driving organisational and process efficiency to achieve greater value for patients, society and taxpayers. However, contemporary discourse overlooks the crucial role of individuals and professionals within this complex socio-technical system, creating a gap in current research and understanding. This gap is particularly notable concerning healthcare professionals, whose involvement the author believes is essential for successful and sustainable implementation.

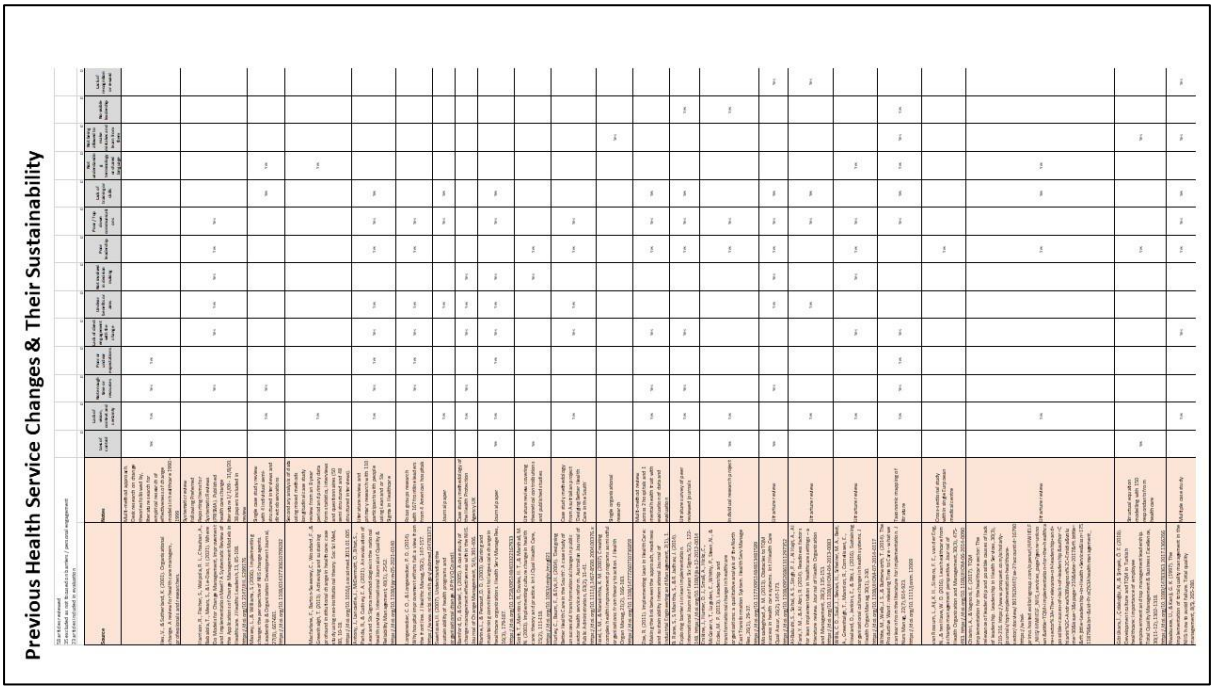
Studies have identified challenges with staff engagement, time constraints, and the failure to integrate Value Based Healthcare into professionals' core responsibilities (Brown & Brown, 2013; Muir Gray, 2004). Additionally, the concept of discretionary effort, where employees exceed their contractual obligations, is vital for sustainable delivery but often overlooked. While some research highlights the importance of understanding healthcare professionals' motivations for successful delivery (Nilsson, Baathe, Andersson, et al., 2017; Nilsson et al., 2018), most studies focus solely on patients and systems, neglecting the professionals' perspectives.

Questions arise regarding the involvement of professionals in co-producing healthcare services and the 'value' Value Based Healthcare brings to them. Despite some recognition of the need for professionals' involvement, barriers to implementing co-production remain largely unaddressed. Enablers such as organisational change management theory (Batalden et al., 2016) are crucial for Value Based Healthcare implementation, emphasising the importance of recognising the role of professionals in driving and sustaining change.

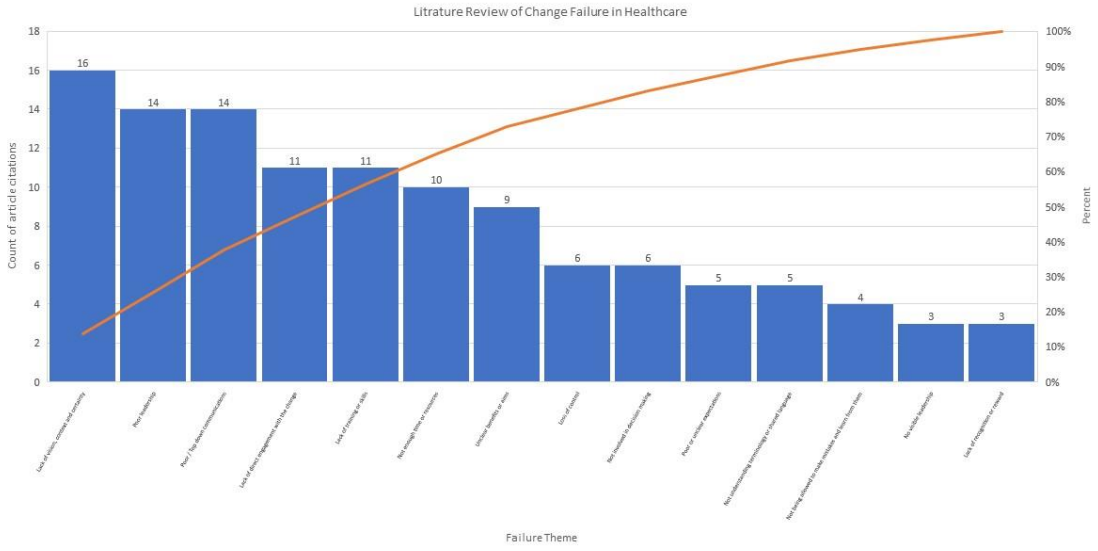
However, professionals' lack of knowledge and understanding of Value Based Healthcare (Nilsson, Baathe, Andersson, et al., 2017; Nilsson, Baathe, Erichsen Andersson, et al., 2017) poses a significant challenge, despite efforts to increase awareness. Considering professionals' perspectives, particularly in terms of rewards and incentives is important (Porter, 2008, 2009, 2010) as their alignment with the goal of delivering value-based care is essential for success.

A culture of Value Based Healthcare, built upon professionals with the right skills and support, is crucial to sustainable change and delivery of benefits. Organisational change emphasises understanding an organisation's current culture before implementing change (Schein, 2017). In conclusion, there's a lack of research and consideration of the professional role in Value Based Healthcare delivery. Despite early 20th-century theories emphasising the human dimension of change, improvement models often overlook this aspect.

While some papers acknowledge the need for further research, the current knowledge gap underscores the need for deeper exploration of the professional's role in Value Based Healthcare implementation which is what the authors research aims to contribute towards.

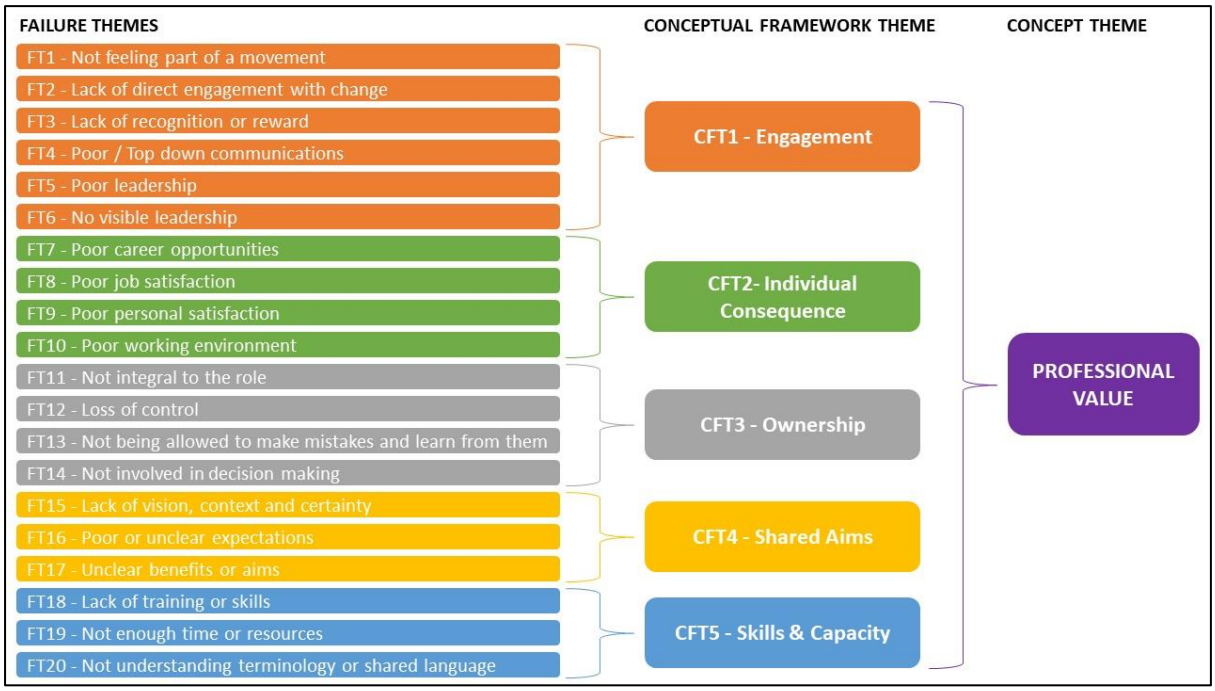


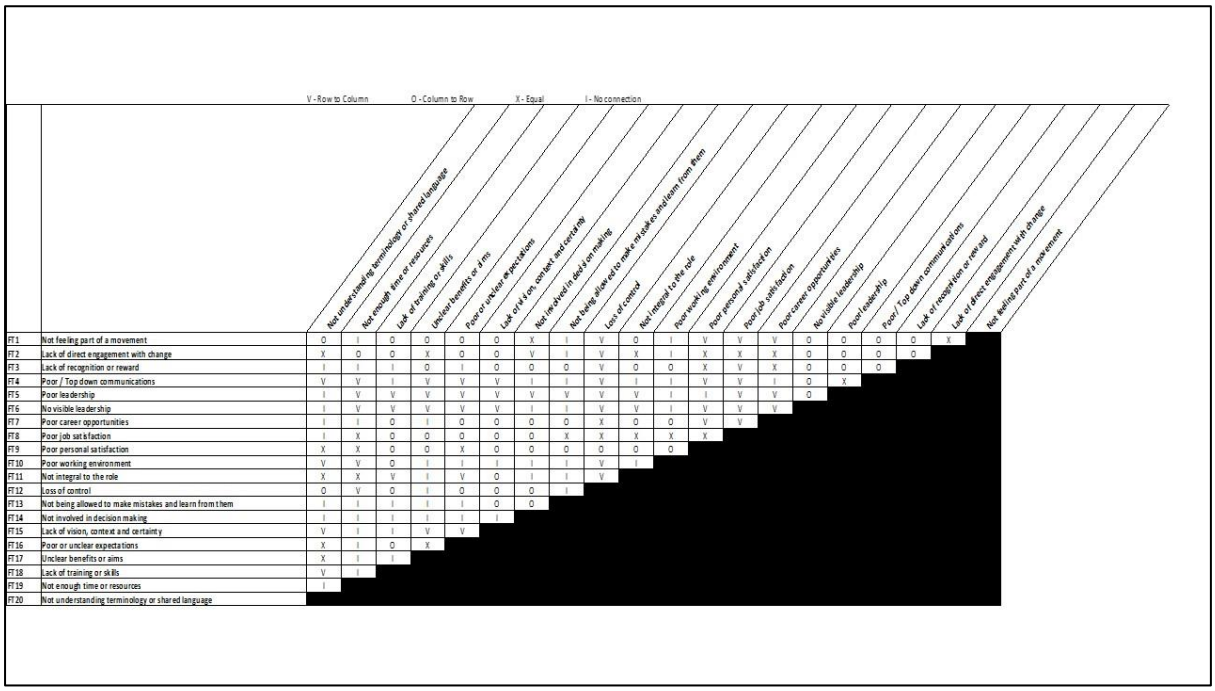
Previous Health Service Changes & Their Sustainability

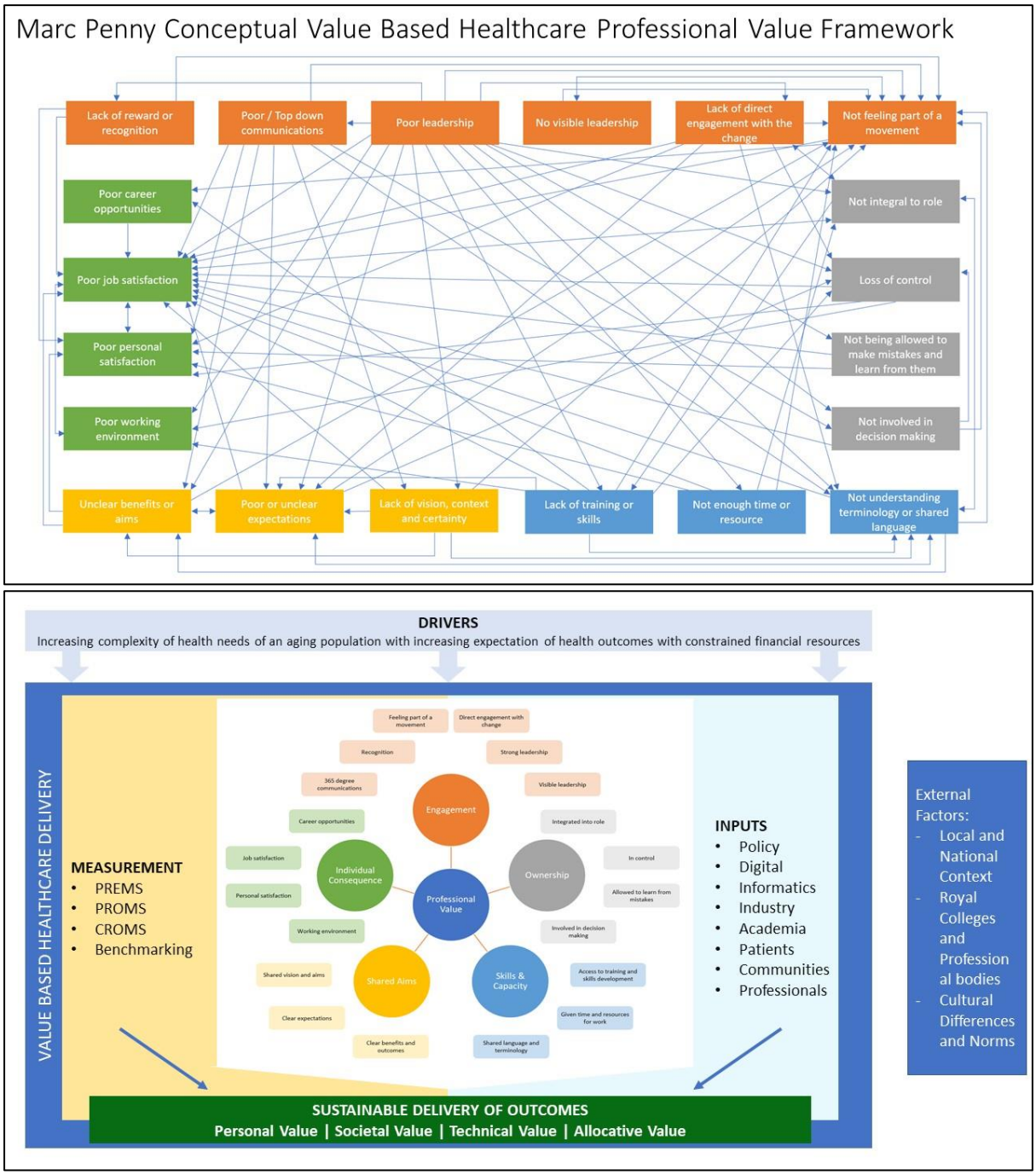


Change Models (Success & Failure in Organisations)

- Individual feeling part of a movement
- Career progression opportunities / development
- Working environment conditions / improvements
- Job satisfaction
- Personal satisfaction
- Integral to the individual's role


FAILURE THEMES
CONCEPTUAL FRAMEWORK THEME
CONCEPT THEME
FT1 - Not feeling part of a movement
FT2 - Lack of direct engagement with change
FT3 - Lack of recognition or reward
FT4 - Poor / Top down communications
FT5 - Poor leadership
FT6 - No visible leadership
FT7 - Poor career opportunities
FT8 - Poor job satisfaction
FT9 - Poor personal satisfaction
FT10 - Poor working environment
FT11 - Not integral to the role
FT12 - Loss of control
FT13 - Not being allowed to make mistakes and learn from them
FT14 - Not involved in decision making
FT15 - Lack of vision, context and certainty
FT16 - Poor or unclear expectations
FT17 - Unclear benefits or aims
FT18 - Lack of training or skills
FT19 - Not enough time or resources
FT20 - Not understanding terminology or shared language
CFT1 - Engagement
CFT2- Individual Consequence
CFT3 - Ownership
CFT4 - Shared Aims
CFT5 - Skills & Capacity
PROFESSIONAL VALUE


V - Row to Column
O - Column to Row
X - Equal
I - No connection
Not understanding terminology or shared language
Not enough time or resources
Lack of training or skills
Unclear benefits or aims
Poor or unclear expectations
Lack of vision, context and certainty
Not involved in decision making
Not being allowed to make mistakes and learn from them
Loss of control
Not integral to the role
Poor working environment
Poor personal satisfaction
Poor job satisfaction
Poor career opportunities
No visible leadership
Poor leadership
Poor / Top down communications
Lack of recognition or reward
Lack of direct engagement with change
Not feeling part of a movement
FT1 Not feeling part of a movement O I O O O O X I V O I V V V O O O O X
FT2 Lack of direct engagement with change X O O X O O V I V X I X X X O O O O
FT3 Lack of recognition or reward I I I O I O O O V O O X V X O O O
FT4 Poor / Top down communications V V I V V V I I V I I V V I O X
FT5 Poor leadership I V V V V V V V V V I I V V O
FT6 No visible leadership I V V V V V I I V V I V V V
FT7 Poor career opportunities I I O I O O O O X O O V V
FT8 Poor job satisfaction I X O O O O O X X X X X
FT9 Poor personal satisfaction X X O O X O O O O O O
FT10 Poor working environment V V O I I I I I V I
FT11 Not integral to the role X X V I V O I I V
FT12 Loss of control O V O I O O O I
FT13 Not being allowed to make mistakes and learn from them I I I I I O O
FT14 Not involved in decision making I I I I I I
FT15 Lack of vision, context and certainty V I I V V
FT16 Poor or unclear expectations X I O X
FT17 Unclear benefits or aims X I I
FT18 Lack of training or skills V I
FT19 Not enough time or resources I
FT20 Not understanding terminology or shared language


Marc Penny Conceptual Value Based Healthcare Professional Value Framework
Lack of reward or recognition
Poor / Top down communications
Poor leadership
No visible leadership
Lack of direct engagement with the change
Not feeling part of a movement
Poor career opportunities
Not integral to role
Poor job satisfaction
Loss of control
Poor personal satisfaction
Not being allowed to make mistakes and learn from them
Poor working environment
Not involved in decision making
Unclear benefits or aims
Poor or unclear expectations
Lack of vision, context and certainty
Lack of training or skills
Not enough time or resource
Not understanding terminology or shared language
DRIVERS
Increasing complexity of health needs of an aging population with increasing expectation of health outcomes with constrained financial resources
VALUE BASED HEALTHCARE DELIVERY
MEASUREMENT
• PREMS
• PROMS
• CROMS
• Benchmarking
Feeling part of a movement
Direct engagement with change
Recognition
Strong leadership
365 degree communications
Visible leadership
Career opportunities
Integrated into role
Engagement
Job satisfaction
Individual Consequence
Ownership
In control
Personal satisfaction
Professional Value
Allowed to learn from mistakes
Working environment
Involved in decision making
Shared vision and aims
Shared Aims
Skills & Capacity
Access to training and skills development
Clear expectations
Given time and resources for work
Clear benefits and outcomes
Shared language and terminology
INPUTS
• Policy
• Digital
• Informatics
• Industry
• Academia
• Patients
• Communities
• Professionals
External Factors:
- Local and National Context
- Royal Colleges and Professional bodies
- Cultural Differences and Norms
SUSTAINABLE DELIVERY OF OUTCOMES
Personal Value | Societal Value | Technical Value | Allocative Value

Appendix G - Quantitative Questionnaire Pilot Questions

Swansea University
Prifysgol Abertawe

1. Survey Introduction

This is a pilot survey and you are being asked to complete it to help inform the questions and ensure the survey makes sense. No data from this pilot will be used in the finalised research. At the end of each section there is a feedback question, please could you provide any feedback via the feedback questions or you can provide directly to [redacted]

Thank you for taking part in this research survey. By completing this survey you consent to your participation in the research.

Anonymity
The survey is anonymous so will not be attributed to any individuals. Where organisational data is collected this is purely to enable categorisation and grouping of responses and upon publication all information presented in any reports or publications will be anonymised and unidentifiable with no individual organisations identified against the data, and will only be shown as 'Organisation 1, Organisation 2, Organisation # etc'.

Who is carrying out the research?
The data is being collected by Marc Penny, Director of Improvement & Innovation Cwm Taf Morgannwg University Health Board Wales as part of his Doctoral studies at Swansea University, College of Human and Health Sciences. He can be contacted at [redacted].

Data Protection Privacy Notice
The data controller for this project will be Swansea University. The University Data Protection Officer provides oversight of university activities involving the processing of personal data, and can be contacted at the Vice Chancellors Office. No personal data is being collected as part of this survey.

At the end of the survey you will be asked if you would be willing to take part in a further face to face / virtual interview. If you agree and provide your email details this will not be linked to you survey responses provided which will remain anonymous.

Thank you for your participation in this study. Your help is very much appreciated.

* 1. What is the name of the organisation you work for?

* 2. What type of role do you have within your organisation?

* 3. Do you deliver health services directly to patients?

- Yes
- No

4. This question is for the pilot only. Does all the information on this page, the questions and answer sets make sense, work and have all the required responses?
Does the introduction make sense and do you understand it?
Do the questions make sense and do you understand what they are asking?
Do the answer responses work, is there anything missing?

2.

This section asks you general questions in relation to Value Based Healthcare and YOUR perspective on it.

Please answer honestly how you view Value Based Healthcare.

Value Based Healthcare Value Definitions:

- Allocative value – ensuring that all available resources are taken into account and distributed in an equitable fashion
- Personal value – ensuring that each individual patient´s values are used as a basis for decision-making in a way that will optimise the benefits for them
- Societal value - ensuring that the intervention in healthcare contributes to connectedness, social cohesion, solidarity, mutual respect, openness to diversity
- Technical value – ensuring that the allocated resources are used optimally (no waste)

Source - Gray, M., How to get better value healthcare. Vol. 3rd Edition. 2017: Oxford Press

* 5. Rank the below Value Based Healthcare benefit areas in order of how you see their importance?

Allocative Value

Personal Value

Societal Value

Technical Value

* 6. What words would you use to describe what Value Based Healthcare means to YOU?

* 7. Does being involved in delivering and or supporting Value Based Healthcare provide you with:

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Personal satisfaction	○	○	○	○	○
Skills development	○	○	○	○	○
Control over your work	○	○	○	○	○
Career development	○	○	○	○	○
Improved working environment	○	○	○	○	○
Improved job satisfaction	○	○	○	○	○
Empowerment to make decisions	○	○	○	○	○
Motivation to do my job	○	○	○	○	○

* 8. Please describe what value you believe being involved in Value Based Healthcare gives you (if any), describe in a few sentences or provide some reflective words.

* 9. I am:

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	N/A
Given the time to undertake Value Based Healthcare activities	○	○	○	○	○	○
Not recognised for the work and effort I put into delivering Value Based healthcare	○	○	○	○	○	○
Involved in decisions relating to Value Based Healthcare activities which affect me	○	○	○	○	○	○
Allowed to make mistakes and learn from them	○	○	○	○	○	○
Recognised for my work and contribution to delivering Value Based Healthcare	○	○	○	○	○	○
Provided with specific objectives relating to Value Based Healthcare	○	○	○	○	○	○
Rewarded for my work and contribution to delivering Value Based Healthcare	○	○	○	○	○	○

* 10. Do you see Value Based Healthcare as part of your job and integral or separate and an additional activity?

Completely seperate	Somewhat seperate	Somewhat integral	Completely integral	N/A
○	○	○	○	○

11. This question is for the pilot only. Does all the information on this page, the questions and answer sets make sense, work and have all the required responses?
Does the introduction make sense and do you understand it?
Do the questions make sense and do you understand what they are asking?
Do the answer responses work, is there anything missing?

3.

This section asks you general questions in relation to Value Based Healthcare and how you view your ORGANISATIONS perspective on it.

Please answer honestly how you view Value Based Healthcare.

Value Based Healthcare Value Definitions:

- Allocative value – ensuring that all available resources are taken into account and distributed in an equitable fashion
- Personal value – ensuring that each individual patient´s values are used as a basis for decision-making in a way that will optimise the benefits for them
- Societal value - ensuring that the intervention in healthcare contributes to connectedness, social cohesion, solidarity, mutual respect, openness to diversity
- Technical value – ensuring that the allocated resources are used optimally (no waste)

Source - Gray, M., How to get better value healthcare. Vol. 3rd Edition. 2017: Oxford Press

* 12. Rank the below Value Based Healthcare benefit areas in order of how you believe your organisation see's their importance?

Allocative Value

Personal Value

Societal Value

Technical Value

13. **This question is for the pilot only. Does all the information on this page, the questions and answer sets make sense, work and have all the required responses?**
Does the introduction make sense and do you understand it?
Do the questions make sense and do you understand what they are asking?
Do the answer responses work, is there anything missing?

Swansea University
Prifysgol Abertawe

4.

This section asks you some specific questions in relation to Value Based Healthcare and how it affects you.

Please answer honestly how you view Value Based Healthcare.

* 14. The following questions relate to leadership

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	N/A
There is clear Value Based Healthcare leadership in my organisation	○	○	○	○	○	○
Leadership strongly encourages involvement in Value Based Healthcare	○	○	○	○	○	○
Managers are personally involved in Value Based Healthcare	○	○	○	○	○	○
Employees feel a strong sense of accountability and ownership for Value Based Healthcare	○	○	○	○	○	○

* 15. The following questions relate to communications

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	N/A
I receive regular communications in relation to Value Based Healthcare	○	○	○	○	○	○
I understand the language used in meetings and discussion around Value Based Healthcare	○	○	○	○	○	○
I can provide feedback on Value Based Healthcare activities	○	○	○	○	○	○
My organisation values my opinion on delivering Value Based Healthcare	○	○	○	○	○	○
I understand why we are undertaking Value Based Healthcare activities	○	○	○	○	○	○
I understand the language used and its terminology in Value Based Healthcare	○	○	○	○	○	○
People in the organisation understand what is meant by Value Based Healthcare	○	○	○	○	○	○
Internal Value Based Healthcare communication is totally open and transparent	○	○	○	○	○	○

* 16. The following questions relate to vision and strategy

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	N/A
I understand my role in supporting delivery of the organisations Value Based Healthcare vision	○	○	○	○	○	○
In our organisation Value Based Healthcare goals, objectives, and strategies are communicated to me	○	○	○	○	○	○
All the members of the team have a clear idea of what is expected of them in relation to Value Based Healthcare, making their contribution to the organisation as beneficial as possible	○	○	○	○	○	○

* 17. The following questions relate to you

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	N/A
I have no ability to input into decisions relating to Value Based Healthcare and my areas of work	○	○	○	○	○	○
My working conditions and environment make it difficult to deliver what's expected of me	○	○	○	○	○	○
Delivering Value Based Healthcare activities takes me away from the important aspects of my job	○	○	○	○	○	○
I feel a sense of pride in delivering Value Based Healthcare	○	○	○	○	○	○
I don't feel involved with Value Based Healthcare activities which affect me	○	○	○	○	○	○
Employees receive						

training to perform Value Based Healthcare activities	○	○	○	○	○	○
There are no opportunities to progress my career within Value Based Healthcare	○	○	○	○	○	○
My manager encourages me / my team to learn from past experiences	○	○	○	○	○	○
I feel I have control and input into the delivery of Value Based Healthcare within my area.	○	○	○	○	○	○
My working environment enables me to deliver at my best	○	○	○	○	○	○
I feel a sense of accomplishment when delivering Value Based Healthcare work	○	○	○	○	○	○
Delivering Value Based Healthcare adds stress to my job	○	○	○	○	○	○
The skills and knowledge I have gained through Value Based Healthcare will benefit me in career progression	○	○	○	○	○	○

* 18. Using any number from 0 to 10, where 0 is not at all and 10 is completely, how much do you feel lack of resource in your area of work is a major source of Value Based Healthcare failure?

	10 Completly	9	8	7	6	5	4	3	2	1	Not at all 0	N/A
.	○	○	○	○	○	○	○	○	○	○	○	○

* 19. Using any number from 0 to 10, where 0 is not at all and 10 is fully, how much do you feel a part of a movement or community of Value Based Healthcare?

	Not at all 0	1	2	3	4	5	6	7	8	9	Fully 10	N/A
.	○	○	○	○	○	○	○	○	○	○	○	○

* 20. Using any number from 0 to 10, where 0 is not at all and 10 is fully, how much is the delivery of Value Based healthcare built into your day to day job??

	No engagement 0	1	2	3	4	5	6	7	8	9	Fully Engaged 10	N/A
.	○	○	○	○	○	○	○	○	○	○	○	○

* 21. Do you believe Value Based Healthcare work is a one off project activity or something which will be continuously delivered within your role?

- ○ One off project
- ○ Continuously delivered within role
- ○ Other (please specify)

22. **This question is for the pilot only. Does all the information on this page, the questions and answer sets make sense, work and have all the required responses?**
Does the introduction make sense and do you understand it?
Do the questions make sense and do you understand what they are asking?
Do the answer responses work, is there anything missing?

Swansea University
Prifysgol Abertawe

5.

As shown previously in this survey Value Based Healthcare currently has 4 Value Definitions:

- Allocative value – ensuring that all available resources are taken into account and distributed in an equitable fashion
- Personal value – ensuring that each individual patient´s values are used as a basis for decision-making in a way that will optimise the benefits for them
- Societal value - ensuring that the intervention in healthcare contributes to connectedness, social cohesion, solidarity, mutual respect, openness to diversity
- Technical value – ensuring that the allocated resources are used optimally (no waste)

Source - Gray, M., How to get better value healthcare. Vol. 3rd Edition. 2017: Oxford Press

* 23. Do you believe there could be a 5th value area within Value Based Healthcare of 'Professional Value' - where undertaking Value Based Healthcare activities provides value to the professional involved in its delivery?

Please provide your reasoning

24. This question is for the pilot only. Does all the information on this page, the questions and answer sets make sense, work and have all the required responses?
Does the introduction make sense and do you understand it?
Do the questions make sense and do you understand what they are asking?
Do the answer responses work, is there anything missing?

6.

Thank you for taking part in this survey, your involvement is very much appreciated.

25. Following on from this survey there will be some further in person / virtual interviews to understand more in depth some of the areas. If you would like to take part in this further research please provide your name, organisation and email address. This information will not be used to attribute your survey responses and again any involvement in further research will be anonymous.

Name	
Organisation	
Email Address	

Appendix H - Quantitative Questionnaire Invite Cover Letter for VBHC Leads

Hello

My name is Marc Penny and I work for Cwm Taf Morgannwg University Health Board in Wales. As part of my doctoral studies being undertaken at Swansea University I am undertaking research into Value Based Healthcare to answer the research question 'To what extent do cultural drivers impact the sustainable delivery of Value Based Healthcare?, and the potential effects culture has (if any) on its delivery and sustainability of benefits. The outputs from the research will hopefully provide a new conceptual framework for VBHC culture as well as inputting into existing change theories.

The research is split into 3 phases:

- Phase 1 of research is a desk exercise and literature review (completed)
- Phase 2 is an online anonymous survey (this request)
- Phase 3 will be face to face / virtual sessions to deep dive any aspects needed from the survey

After completing the NHS Health Research Authority assessment this study is not classified as 'Research' by the NHS and as such does not require REC review. Ethical approval has been provided via Swansea University.

All 7 NHS Wales Health Boards in Wales have been asked to take part as well as one of the NHS Trusts in Wales. Australian Centre for VBHC and Wider Australian health ecosystem are taking part and for wider insights we are asking participation from NHS Scotland and NHS England.

I am keen to understand a number of key aspects which may affect the delivery of Value Based Healthcare and would be most grateful if you would complete the SurveyMonkey questionnaire via the attached link or QR code which should take around 15 minutes to complete.

https://uk.surveymonkey.com/r/KWTPZ92

Please be open and honest with your answers which won't be attributed to identifiable individuals once published based on your views and experience. Where organisational data is collected this is purely to enable categorisation and grouping of responses and upon publication all information presented in any reports or publications will be anonymised and unidentifiable with no individual organisations identified against the data, and will only be shown as 'Organisation 1, Organisation 2, Organisation # etc'.

At the end of the survey you will be asked if you would be willing to take part in a further face to face / virtual interview. If you agree and provide your email details this will not be linked to you survey responses provided which will remain anonymous.

Thank you for your participation in this study. If you know anyone who is involved in Value Based Healthcare please feel free to forward them this email and survey link. Your help is very much appreciated.

Once the research is completed and analysis taken place the research will be published via Swansea University and the Welsh value in Health Centre. No individual data will be published and organisations / regions will be anonymous and not identifiable.

All the best

Marc Penny

Appendix I - Quantitative Questionnaire Procedures

Value Based Healthcare Research Survey

1. Survey Introduction

Thank you for taking part in this research survey. By completing this survey you consent to your participation in the research. This survey is supporting research into Value Based Healthcare and the potential effects culture has (if any) on its delivery and sustainability of benefits. Please be open and honest with your answers which won't be attributed to identifiable individuals once published based on your views and experience.

Anonymity
The survey is anonymous so will not be attributed to any individuals. Where organisational data is collected this is purely to enable categorisation and grouping of responses and upon publication all information presented in any reports or publications will be anonymised and unidentifiable with no individual organisations identified against the data, and will only be shown as 'Organisation 1, Organisation 2, Organisation # etc'.

Ethics
Ethical approval has been received from Swansea University and Health Research Authority processes have been followed.

Who is carrying out the research?
The data is being collected by Marc Penny, Director of Improvement & Innovation Cwm Taf Morgannwg University Health Board Wales as part of his Doctoral studies at Swansea University, College of Human and Health Sciences. He can be contacted at Marc.Penny@Wales.nhs.uk .

Data Protection Privacy Notice
The data controller for this project will be Swansea University. The University Data Protection Officer provides oversight of university activities involving the processing of personal data, and can be contacted at the Vice Chancellors Office. No personal data is being collected as part of this survey.

At the end of the survey you will be asked if you would be willing to take part in a further face to face / virtual interview. If you agree and provide your email details this will not be linked to you survey responses provided which will remain anonymous.

Thank you for your participation in this study. Your help is very much appreciated.

Appendix J - Quantitative Questionnaire Final

Swansea University
Prifysgol Abertawe

Value Based Healthcare Research Survey

1. Survey Introduction

Thank you for taking part in this research survey. By completing this survey you consent to your participation in the research. This survey is supporting research into Value Based Healthcare and the potential effects culture has (if any) on its delivery and sustainability of benefits. Please be open and honest with your answers which won't be attributed to identifiable individuals once published based on your views and experience.

Anonymity
The survey is anonymous so will not be attributed to any individuals. Where organisational data is collected this is purely to enable categorisation and grouping of responses and upon publication all information presented in any reports or publications will be anonymised and unidentifiable with no individual organisations identified against the data, and will only be shown as 'Organisation 1, Organisation 2, Organisation # etc'.

Ethics
Ethical approval has been received from Swansea University and Health Research Authority processes have been followed.

Who is carrying out the research?
The data is being collected by Marc Penny, Director of Improvement & Innovation Cwm Taf Morgannwg University Health Board Wales as part of his Doctoral studies at Swansea University, College of Human and Health Sciences. He can be contacted at Marc.Penny@Wales.nhs.uk .

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At the end of the survey you will be asked if you would be willing to take part in a further face to face / virtual interview. If you agree and provide your email details this will not be linked to you survey responses provided which will remain anonymous.

Thank you for your participation in this study. Your help is very much appreciated.

* 1. What is the name of the organisation you work for?

* 2. What type of role do you have within your organisation?

* 3. Do you deliver health services directly to patients?

- Yes
- No

* 4. How many years experience do you have working in healthcare?

- Have never worked in healthcare
- Less than 3 year
- More than 3 years but less than 10 years
- More than 10 years

* 5. How many years experience do you have of Value Based Healthcare?

- No experience of Value Based Healthcare
- Less than 1 year
- More than 1 year but less than 3 years
- More than 3 years but less than 5 years
- More than 5 years

* 6. How many years leadership experience do you have?

- No experience
- Less than 3 years
- More than 3 years but less than 10 years
- More than 10 years

Swansea University
Prifysgol Abertawe

Value Based Healthcare Research Survey

2.

This section asks you general questions in relation to Value Based Healthcare and YOUR perspective on it.

Please answer honestly how you view Value Based Healthcare.

Value Based Healthcare Value Definitions:

- Allocative value – ensuring that all available resources are taken into account and distributed in an equitable fashion
- Personal value – ensuring that each individual patient´s values are used as a basis for decision-making in a way that will optimise the benefits for them
- Societal value - ensuring that the intervention in healthcare contributes to connectedness, social cohesion, solidarity, mutual respect, openness to diversity
- Technical value – ensuring that the allocated resources are used optimally (no waste)

Source - Gray, M., How to get better value healthcare. Vol. 3rd Edition. 2017: Oxford Press

* 7. Rank the below Value Based Healthcare benefit areas in order of **how you see their importance** with 1 being most important and 4 being least important? You can rank areas equally.

	1 - Most Important	2	3	4 - Least Important
Allocative Value	○	○	○	○
Personal Value	○	○	○	○
Societal Value	○	○	○	○
Technical Value	○	○	○	○

* 8. What SINGLE words would you use to describe what Value Based Healthcare means to YOU?

* 9. Thinking about your involvement in a successful Value Based Healthcare project. **Does being involved** in delivering and or supporting Value Based Healthcare provide you with:

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Personal satisfaction	○	○	○	○	○
Skills development	○	○	○	○	○
Control over your work	○	○	○	○	○
Career development	○	○	○	○	○
Improved working environment	○	○	○	○	○
Improved job satisfaction	○	○	○	○	○
Empowerment to make decisions	○	○	○	○	○
Motivation to do my job	○	○	○	○	○

* 10. **Should being involved** in delivering and or supporting Value Based Healthcare provide you with:

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Personal satisfaction	○	○	○	○	○
Skills development	○	○	○	○	○
Control over your work	○	○	○	○	○
Career development	○	○	○	○	○
Improved working environment	○	○	○	○	○
Improved job satisfaction	○	○	○	○	○
Empowerment to make decisions	○	○	○	○	○
Motivation to do my job	○	○	○	○	○

* 11. Please describe what value you believe being involved in Value Based Healthcare gives you (if any), describe in a few sentences or provide some reflective words.

* 12. I am:

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	N/A
Given the time to undertake Value Based Healthcare activities	○	○	○	○	○	○
Not recognised for the work and effort I put into delivering Value Based healthcare	○	○	○	○	○	○
Involved in decisions relating to Value Based Healthcare activities which affect me	○	○	○	○	○	○
Allowed to make mistakes and learn from them	○	○	○	○	○	○
Recognised for my work and contribution to delivering Value Based Healthcare	○	○	○	○	○	○
Provided with specific objectives relating to Value Based Healthcare	○	○	○	○	○	○
Rewarded for my work and contribution to delivering Value Based Healthcare	○	○	○	○	○	○

* 13. Do you see Value Based Healthcare as part of your job and integral or separate and an additional activity?

Completely seperate	Somewhat seperate	Somewhat integral	Completely integral	N/A
○	○	○	○	○

Swansea University
Prifysgol Abertawe

Value Based Healthcare Research Survey

3.

This section asks you general questions in relation to Value Based Healthcare and how you view your ORGANISATIONS perspective on it.

Please answer honestly how you view your organisation perspective on Value Based Healthcare.

Value Based Healthcare Value Definitions:

- Allocative value – ensuring that all available resources are taken into account and distributed in an equitable fashion
- Personal value – ensuring that each individual patient´s values are used as a basis for decision-making in a way that will optimise the benefits for them
- Societal value - ensuring that the intervention in healthcare contributes to connectedness, social cohesion, solidarity, mutual respect, openness to diversity
- Technical value – ensuring that the allocated resources are used optimally (no waste)

Source - Gray, M., How to get better value healthcare. Vol. 3rd Edition. 2017: Oxford Press

* 14. Rank the below Value Based Healthcare benefit areas in order of **how you believe YOUR ORGANISATION see's their importance** with 1 being most important and 4 being least important? You can rank areas equally.

	1 - Most Important	2	3	4 - Least Important
Allocative Value	○	○	○	○
Personal Value	○	○	○	○
Societal Value	○	○	○	○
Technical Value	○	○	○	○

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Value Based Healthcare Research Survey

4.

This section asks you some specific questions in relation to Value Based Healthcare and how it affects you.

Please answer honestly how you view Value Based Healthcare.

* 15. The following questions relate to leadership

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	N/A
There is clear Value Based Healthcare leadership in my organisation	○	○	○	○	○	○
Leadership strongly encourages involvement in Value Based Healthcare	○	○	○	○	○	○
Managers provide personal leadership for Value Based Healthcare	○	○	○	○	○	○
Managers are personally involved in Value Based Healthcare	○	○	○	○	○	○
Employees feel a strong sense of accountability and ownership for Value Based Healthcare	○	○	○	○	○	○

* 16. The following questions relate to communications

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	N/A
I receive regular communications in relation to Value Based Healthcare	○	○	○	○	○	○
I understand the language used in meetings and discussion around Value Based Healthcare	○	○	○	○	○	○
I can provide feedback on Value Based Healthcare activities	○	○	○	○	○	○
My organisation values my opinion on delivering Value Based Healthcare	○	○	○	○	○	○
I understand why we are undertaking Value Based Healthcare activities	○	○	○	○	○	○
I understand the language used and its terminology in Value Based Healthcare	○	○	○	○	○	○
People in the organisation understand what is meant by Value Based Healthcare	○	○	○	○	○	○
Internal Value Based Healthcare communication is totally open and transparent	○	○	○	○	○	○

* 17. The following questions relate to vision and strategy

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	N/A
I understand my role in supporting delivery of the organisations Value Based Healthcare vision	○	○	○	○	○	○
In our organisation Value Based Healthcare goals, objectives, and strategies are communicated to me	○	○	○	○	○	○
All the members of the team have a clear idea of what is expected of them in relation to Value Based Healthcare, making their contribution to the organisation as beneficial as possible	○	○	○	○	○	○

* 18. The following questions relate to you

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	N/A
I have no ability to input into decisions relating to Value Based Healthcare and my areas of work	○	○	○	○	○	○
My working conditions and environment make it difficult to deliver what's expected of me	○	○	○	○	○	○
Delivering Value Based Healthcare activities takes me away from the important aspects of my job	○	○	○	○	○	○
I feel a sense of pride in delivering Value Based Healthcare	○	○	○	○	○	○
I don't feel involved with Value Based Healthcare activities which affect me	○	○	○	○	○	○
Employees receive						

training to perform Value Based Healthcare activities	○	○	○	○	○	○
There are no opportunities to progress my career within Value Based Healthcare	○	○	○	○	○	○
My manager encourages me / my team to learn from past experiences	○	○	○	○	○	○
I feel I have control and input into the delivery of Value Based Healthcare within my area.	○	○	○	○	○	○
My working environment enables me to deliver at my best	○	○	○	○	○	○
I feel a sense of accomplishment when delivering Value Based Healthcare work	○	○	○	○	○	○
Delivering Value Based Healthcare adds stress to my job	○	○	○	○	○	○
The skills and knowledge I have gained through Value Based Healthcare will benefit me in career progression	○	○	○	○	○	○

* 19. Using any number from 0 to 10, where 0 is not at all and 10 is completely, how much do you feel lack of resource in your area of work is a major source of Value Based Healthcare failure?

	Not at all 0	1	2	3	4	5	6	7	8	9	Completly 10	N/A
.	○	○	○	○	○	○	○	○	○	○	○	○

* 20. Using any number from 0 to 10, where 0 is not at all and 10 is fully, how much do you feel a part of a movement or community of Value Based Healthcare?

	Not at all 0	1	2	3	4	5	6	7	8	9	Fully 10	N/A
.	○	○	○	○	○	○	○	○	○	○	○	○

* 21. Using any number from 0 to 10, where 0 is not at all and 10 is fully, how much is the delivery of Value Based healthcare built into your day to day job??

	No engagement 0	1	2	3	4	5	6	7	8	9	Fully Engaged 10	N/A
.	○	○	○	○	○	○	○	○	○	○	○	○

* 22. Do you believe Value Based Healthcare work is a one off project activity or something which will be continuously delivered within your role?

- ○ One off project
- ○ Continuously delivered within role
- ○ Other (please specify)

Swansea University
Prifysgol Abertawe

Value Based Healthcare Research Survey

5.

As shown previously in this survey Value Based Healthcare currently has 4 Value Definitions:

- Allocative value – ensuring that all available resources are taken into account and distributed in an equitable fashion
- Personal value – ensuring that each individual patient´s values are used as a basis for decision-making in a way that will optimise the benefits for them
- Societal value - ensuring that the intervention in healthcare contributes to connectedness, social cohesion, solidarity, mutual respect, openness to diversity
- Technical value – ensuring that the allocated resources are used optimally (no waste)

Source - Gray, M., How to get better value healthcare. Vol. 3rd Edition. 2017: Oxford Press

* 23. Do you believe there could be a 5th value area within Value Based Healthcare of 'Professional Value' - where undertaking Value Based Healthcare activities provides value to the professional involved in its delivery such as improved job satisfaction, improved working environment, professional development etc?

Please provide your reasoning

Swansea University
Prifysgol Abertawe

Value Based Healthcare Research Survey

6.

Thank you for taking part in this survey, your involvement is very much appreciated.

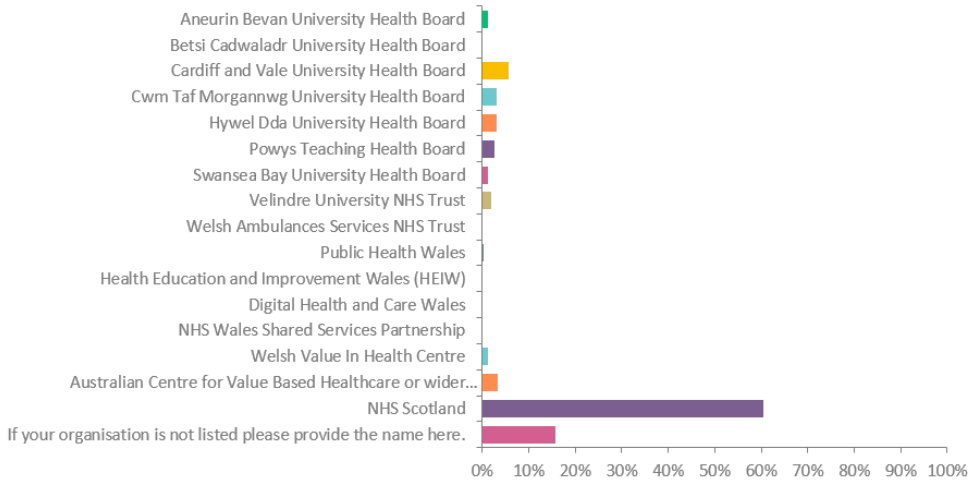
24. Following on from this survey there will be some further in person / virtual interviews to understand more in depth some of the areas covered in this survey. If you would like to take part in this further research please provide your name, organisation and email address. This information will not be used to attribute your survey responses and again any involvement in further research will be anonymous.

Name	
Organisation	
Email Address	

Appendix K - Quantitative Questionnaire Data Tables and Charts

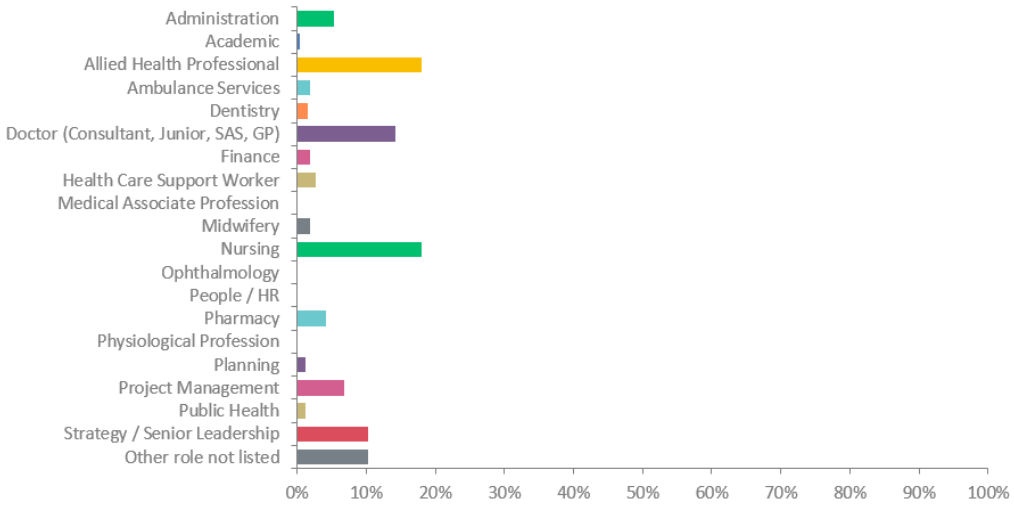
Q1: What is the name of the organisation you work for?

Answered: 261 Skipped: 0



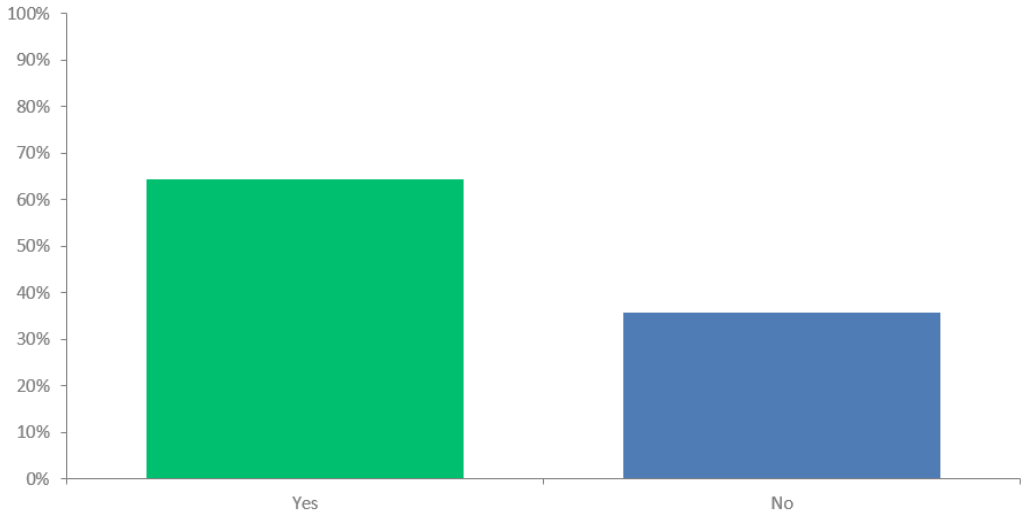
Q2: What type of role do you have within your organisation?

Answered: 261 Skipped: 0



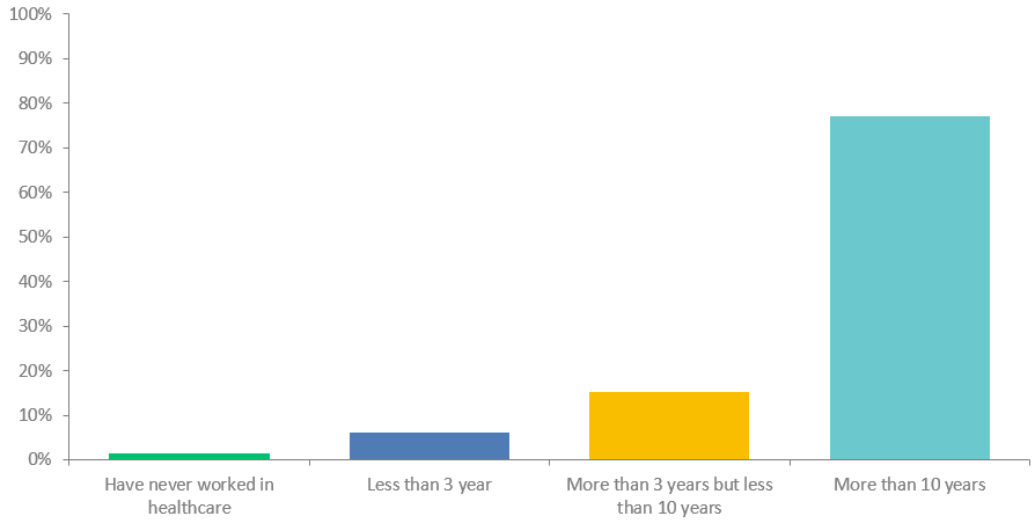
Q3: Do you deliver health services directly to patients?

Answered: 261 Skipped: 0



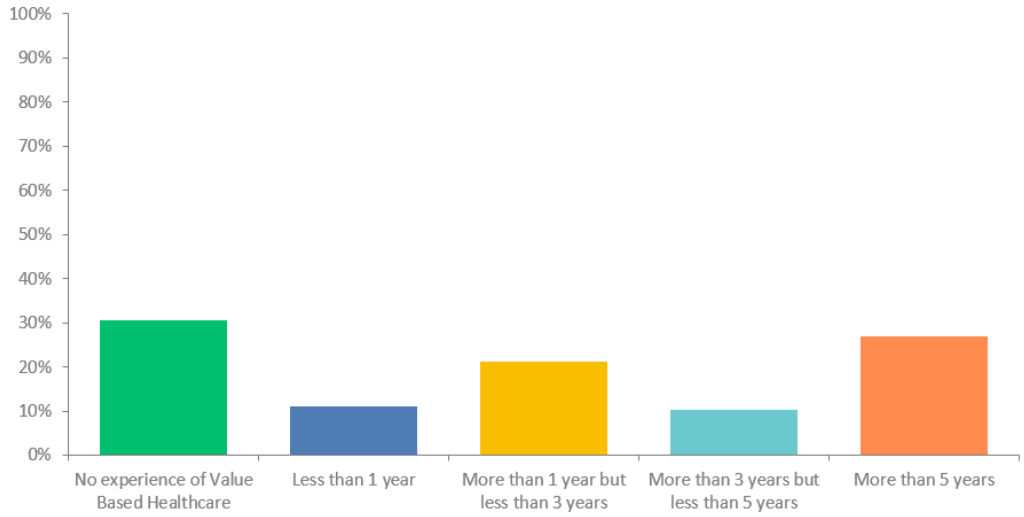
Q4: How many years experience do you have working in healthcare?

Answered: 261 Skipped: 0



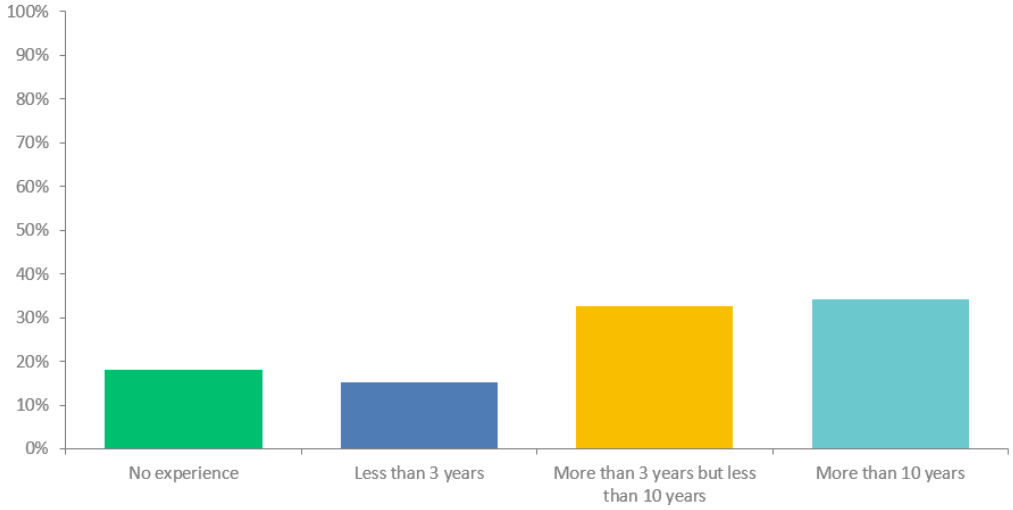
Q5: How many years experience do you have of Value Based Healthcare?

Answered: 261 Skipped: 0



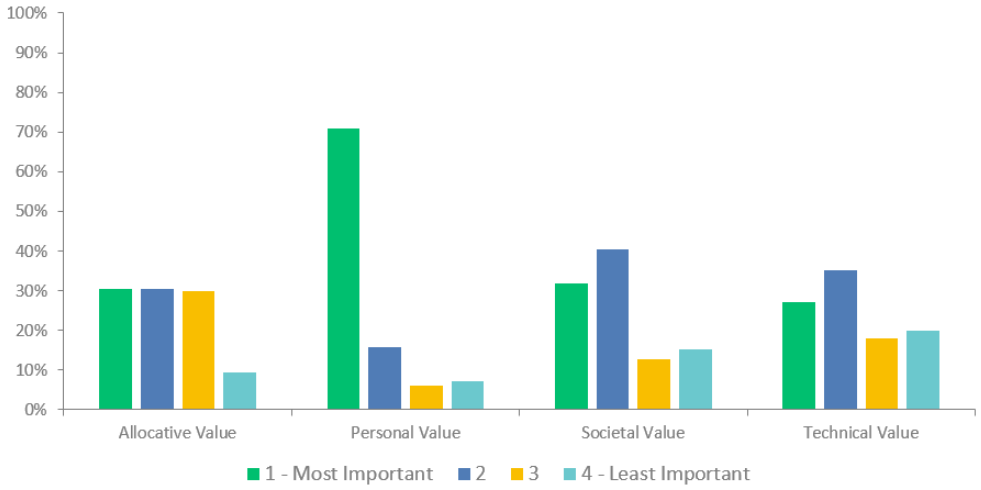
Q6: How many years leadership experience do you have?

Answered: 261 Skipped: 0



Q7: Rank the below Value Based Healthcare benefit areas in order of how you see their importance with 1 being most important and 4 being least important? You can rank areas equally.

Answered: 151 Skipped: 110



	1 - MOST IMPORTANT (1)	2 (2)	3 (3)	4 - LEAST IMPORTANT (4)	TOTAL
Allocative Value	30.46% 46	30.46% 46	29.80% 45	9.27% 14	151
Personal Value	70.86% 107	15.89% 24	5.96% 9	7.28% 11	151
Societal Value	31.79% 48	40.40% 61	12.58% 19	15.23% 23	151
Technical Value	27.15% 41	35.10% 53	17.88% 27	19.87% 30	151

BASIC STATISTICS					
	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Allocative Value	1.00	4.00	2.00	2.18	0.97
Personal Value	1.00	4.00	1.00	1.50	0.90
Societal Value	1.00	4.00	2.00	2.11	1.02
Technical Value	1.00	4.00	2.00	2.30	1.07

Q8 What SINGLE words would you use to describe what Value Based Healthcare means to YOU?

Answered: 151 Skipped: 110

#	RESPONSES	DATE
1	ameliorate	3/19/2024 11:40 AM
2	Core	3/12/2024 5:52 PM
3	equitable	3/12/2024 12:22 PM
4	Equity	3/12/2024 11:43 AM
5	Outcomes	3/12/2024 10:13 AM
6	Outcomes, sustainable, prudent, excellence, quality, meaningful,	3/12/2024 9:58 AM
7	.	3/12/2024 9:32 AM
8	Ensuring that we are utilising all of the available resources inside and outside of health, e.g. third sector, social care, Industry effectively both people and £, providing the best quality service to patients with improved outcomes that matter to them	3/11/2024 4:30 PM
9	Patient Care	3/11/2024 3:54 PM
10	High Quality Care	3/11/2024 3:46 PM
11	efficiency, outcomes, improvement,	3/11/2024 3:42 PM
12	Change	3/11/2024 3:30 PM
13	Person, empowerment, equality, optimising, resources	3/11/2024 1:51 PM
14	Relationships	2/29/2024 8:30 AM
15	Patient-centred	2/22/2024 8:14 AM
16	Outcome, Resources	2/20/2024 9:29 AM
17	optimised, fair, evidence-based	2/20/2024 5:09 AM
18	sustainability	2/19/2024 12:24 PM
19	Equitable	2/16/2024 2:49 PM
20	efficacy	2/16/2024 9:05 AM
21	Health, Accountability, Justice, Sustainability	2/15/2024 10:07 PM
22	Efficiencies outcomes variation improvement Finance savings	2/15/2024 2:23 PM
23	personalised individual person	2/15/2024 5:55 AM
24	Outcome	2/15/2024 4:38 AM
25	Efficiency	2/15/2024 4:22 AM
26	Delivering outcomes that matter to patients	2/15/2024 4:05 AM
27	Optimisation	2/12/2024 5:19 PM
28	Equitable resources for optimal outcomes	2/5/2024 4:45 PM
29	confusing	2/2/2024 1:28 PM
30	Effectiveness	2/1/2024 8:42 AM
31	Authentic, Individualised, Co-design, Meaningful	2/1/2024 7:06 AM
32	Patient-centred, equitable, accessible, optimal	1/31/2024 4:30 PM
33	Ensuring care is delivered in a way that offers most cost effective patient centred benefit.	1/31/2024 12:15 PM

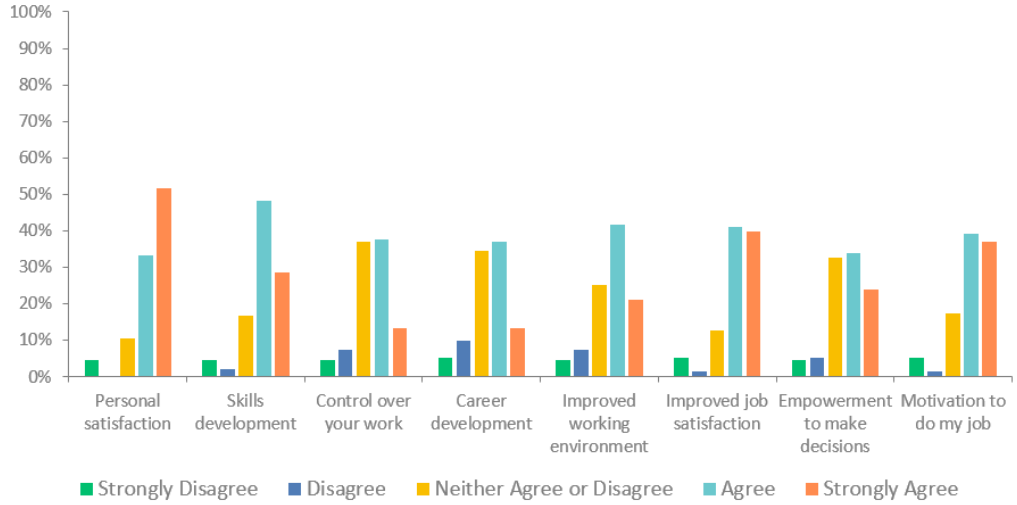
34	value respect care quality	1/31/2024 10:49 AM
35	Efficient, evidence based, Patient-centred	1/30/2024 10:17 AM
36	.	1/30/2024 9:01 AM
37	Respectful	1/29/2024 2:33 PM
38	Patient centred care	1/29/2024 1:05 PM
39	Aim	1/29/2024 10:51 AM
40	Prioritise Shared realistic	1/29/2024 10:14 AM
41	Individuality	1/26/2024 9:28 AM
42	outcomes person centred	1/25/2024 11:16 AM
43	Responsible	1/25/2024 10:00 AM
44	cost-saving improvement value Integration Patient centred	1/25/2024 9:11 AM
45	Fairness	1/24/2024 5:37 PM
46	fair sustainable	1/24/2024 4:38 PM
47	person-centred realistic prioritised considered evidence-based manageable optimised thoughtful	1/24/2024 3:49 PM
48	best quality care	1/24/2024 3:48 PM
49	Person-centred	1/24/2024 11:51 AM
50	Don't have any experience of this term until now. Do put patients at the centre of the care I provide and ensure they are an equal partner in decision.	1/24/2024 11:19 AM
51	Goals	1/23/2024 5:07 PM
52	sustainable resources	1/23/2024 5:00 PM
53	integrated	1/23/2024 3:51 PM
54	person centred, diversity, partnership	1/23/2024 9:16 AM
55	meaningful centre based	1/23/2024 9:12 AM
56	Equity	1/23/2024 1:49 AM
57	Collaborative, Innovative, Outcome-focused	1/22/2024 9:13 PM
58	Respect Sustainability Solidarity Continuous	1/22/2024 7:34 PM
59	Unrealistic in the current culture	1/22/2024 5:05 PM
60	what matters to me	1/22/2024 3:49 PM
61	coproduction	1/22/2024 3:24 PM
62	gamechanger	1/22/2024 3:17 PM
63	Personal Outcomes, quality, Best practice, Effectiveness, Evidenced-based, relationship-based care	1/22/2024 12:15 PM
64	Person-centred	1/22/2024 12:06 PM
65	fundamental	1/22/2024 11:11 AM
66	Person centred effective	1/22/2024 10:42 AM
67	equitable	1/22/2024 10:39 AM
68	restrictive costcutting impersonal	1/22/2024 10:31 AM
69	fairness	1/22/2024 10:17 AM
70	Prioritisation	1/22/2024 10:10 AM
71	empowerment	1/22/2024 8:44 AM
72	Equity	1/21/2024 10:44 PM

73	Choice, understanding, equality, value.	1/20/2024 9:00 AM
74	Health Outcomes, Shared-decision making, Co-design, Patient-centered care, equity in care	1/19/2024 11:50 PM
75	Best use of finite resources for the optimal outcomes that matter most to individual patients	1/19/2024 3:38 PM
76	efficient, effective, safe, value	1/19/2024 1:35 PM
77	Value	1/19/2024 11:02 AM
78	inclusion honesty fairness non-judgement respect equity group	1/19/2024 10:51 AM
79	Efficacy efficiency	1/19/2024 9:22 AM
80	optimalisation	1/19/2024 9:21 AM
81	Appropriate	1/19/2024 9:15 AM
82	Efficiency	1/19/2024 5:57 AM
83	Outcomes, importance, person-centred	1/19/2024 1:12 AM
84	efficiency, equity, value, worth	1/18/2024 11:44 PM
85	a	1/18/2024 8:29 PM
86	Just, fair, proportional	1/18/2024 5:54 PM
87	fair, timely, proportionate, right, prudent,	1/18/2024 4:00 PM
88	Optimal	1/18/2024 3:27 PM
89	Care, Competency, Trust, efficiency, fairness, mutual respect shared decision making, resourced	1/18/2024 3:12 PM
90	Excellent Logical Fair	1/18/2024 2:47 PM
91	Single words??	1/18/2024 2:42 PM
92	Kindness	1/18/2024 11:04 AM
93	fair	1/18/2024 10:25 AM
94	Personal	1/18/2024 9:43 AM
95	optimal outcomes	1/18/2024 1:23 AM
96	Sustainable	1/17/2024 7:33 PM
97	Fairness Quality Justice Equality Safety	1/17/2024 5:59 PM
98	Personal Efficient Resourceful	1/17/2024 4:29 PM
99	Patient-centric	1/17/2024 4:28 PM
100	Potential for conflict	1/17/2024 4:13 PM
101	holistic patient important rewarding	1/17/2024 4:06 PM
102	meeting outcomes that matter most to me and my lifestyle	1/17/2024 11:49 AM
103	outcomes	1/17/2024 2:56 AM
104	Values; beliefs; choice; involvement; empowerment; collaboration; engagement; outcomes; commitment; effectiveness; care; individual; community; positivity; integration; embedded; communication; participation	1/17/2024 1:51 AM
105	person-centred	1/16/2024 11:38 PM
106	Sustainability	1/16/2024 4:31 PM
107	Sustainable	1/16/2024 4:23 PM
108	Sustainable	1/16/2024 3:25 PM
109	Individualised	1/16/2024 12:30 PM
110	Equity Evidence-based Patient-centred Supportive Transformational Sustainable Transparent Effective Efficient	1/16/2024 12:14 PM
111	listening, cooperation, empowering	1/16/2024 12:06 PM

112	Person-centred Relevant Achievable	1/16/2024 9:24 AM
113	Optimal outcomes for the greater good	1/16/2024 8:39 AM
114	Health Care that meets your physical, economical and social needs	1/16/2024 7:14 AM
115	equitable	1/16/2024 5:19 AM
116	Quality Efficiency Access Patient-Centred Prevention	1/16/2024 4:30 AM
117	Meaningful outcomes, efficiently.	1/16/2024 3:52 AM
118	Sustainable, equitable, importance, outcomes	1/16/2024 3:49 AM
119	Sustainability	1/16/2024 3:20 AM
120	Impactful	1/16/2024 3:13 AM
121	Patient centred	1/16/2024 3:05 AM
122	value in what we deliver and best care	1/15/2024 8:05 PM
123	collaborative, co-designed, equity, compassion, empathic, honest, clear, planned and enabling	1/15/2024 9:19 AM
124	Effectiveness	1/12/2024 4:46 PM
125	allocation important shared	1/12/2024 2:57 PM
126	rebranding of an old idea	1/12/2024 12:17 PM
127	person centered	1/12/2024 9:10 AM
128	improvement	1/12/2024 8:24 AM
129	equitable access	1/11/2024 5:45 PM
130	person-centred	1/11/2024 3:47 PM
131	Best quality timely outcomes for patients	1/11/2024 3:19 PM
132	Beneficial	1/11/2024 2:31 PM
133	maximising	1/11/2024 1:29 PM
134	Timely, high quality service	1/11/2024 12:02 PM
135	Efficiency	1/11/2024 8:13 AM
136	Another stupid idea to make people feel important but not actually provide proper patient care	1/11/2024 8:07 AM
137	impact	1/10/2024 9:36 PM
138	Optimal Effective Wise Sustainable	1/10/2024 4:20 PM
139	Outcome	1/10/2024 10:03 AM
140	Patient centred Valuable cost-effective efficient equitable	1/8/2024 4:02 PM
141	Patient centred	1/8/2024 4:21 AM
142	outcomes that matter to people and communities across the full pathway of care equitable, sustainable, transparent and appropriate use of resources Equity, sustainability, outcome focused, place-based	1/7/2024 10:21 PM
143	sustainable, equitable, prudent	1/3/2024 10:41 AM
144	Positivity	1/2/2024 3:12 PM
145	gv	1/2/2024 2:57 PM
146	people	1/2/2024 12:36 PM
147	Better care through best use of money	1/2/2024 10:59 AM
148	It is what health care is all about	12/28/2023 10:31 AM
149	effective	12/28/2023 9:38 AM
150	holistic intelligent powerful	12/27/2023 11:22 AM
151	Patient, Focus, Personal	12/15/2023 12:23 PM

Q9: Thinking about your involvement in a successful Value Based Healthcare project. Does being involved in delivering and or supporting Value Based Healthcare provide you with:

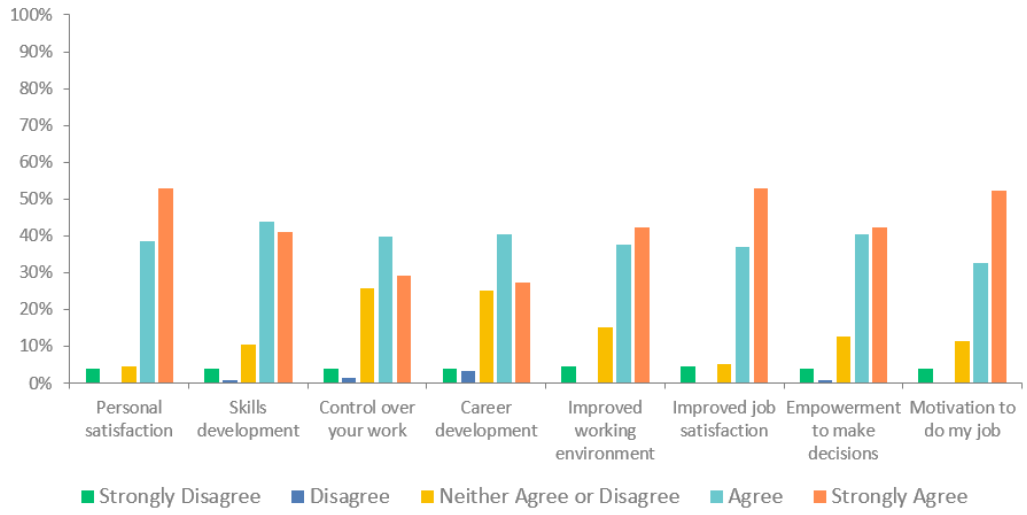
Answered: 151 Skipped: 110



	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE	STRONGLY AGREE	TOTAL	WEIGHTED AVERAGE
Personal satisfaction	4.64% 7	0.00% 0	10.60% 16	33.11% 50	51.66% 78	151	4.27
Skills development	4.64% 7	1.99% 3	16.56% 25	48.34% 73	28.48% 43	151	3.94
Control over your work	4.64% 7	7.28% 11	37.09% 56	37.75% 57	13.25% 20	151	3.48
Career development	5.30% 8	9.93% 15	34.44% 52	37.09% 56	13.25% 20	151	3.43
Improved working environment	4.64% 7	7.28% 11	25.17% 38	41.72% 63	21.19% 32	151	3.68
Improved job satisfaction	5.30% 8	1.32% 2	12.58% 19	41.06% 62	39.74% 60	151	4.09
Empowerment to make decisions	4.64% 7	5.30% 8	32.45% 49	33.77% 51	23.84% 36	151	3.67
Motivation to do my job	5.30% 8	1.32% 2	17.22% 26	39.07% 59	37.09% 56	151	4.01

Q10: Should being involved in delivering and or supporting Value Based Healthcare provide you with:

Answered: 151 Skipped: 110



	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE	STRONGLY AGREE	TOTAL	WEIGHTED AVERAGE
Personal satisfaction	3.97% 6	0.00% 0	4.64% 7	38.41% 58	52.98% 80	151	4.36
Skills development	3.97% 6	0.66% 1	10.60% 16	43.71% 66	41.06% 62	151	4.17
Control over your work	3.97% 6	1.32% 2	25.83% 39	39.74% 60	29.14% 44	151	3.89
Career development	3.97% 6	3.31% 5	25.17% 38	40.40% 61	27.15% 41	151	3.83
Improved working environment	4.64% 7	0.00% 0	15.23% 23	37.75% 57	42.38% 64	151	4.13
Improved job satisfaction	4.64% 7	0.00% 0	5.30% 8	37.09% 56	52.98% 80	151	4.34
Empowerment to make decisions	3.97% 6	0.66% 1	12.58% 19	40.40% 61	42.38% 64	151	4.17
Motivation to do my job	3.97% 6	0.00% 0	11.26% 17	32.45% 49	52.32% 79	151	4.29

Q11 Please describe what value you believe being involved in Value Based Healthcare gives you (if any), describe in a few sentences or provide some reflective words.

Answered: 151 Skipped: 110

#	RESPONSES	DATE
1	A chance to think and do differently. to review what's strong, what's wrong and not default to the way we have always done things.	3/19/2024 11:40 AM
2	Satisfaction. Care needs to reflect individual needs & values & can result in better allocation of resources & reduced waste thereby creating a more sustainable system.	3/12/2024 5:52 PM
3	I'm not sure I understand the question	3/12/2024 12:22 PM
4	Assurance that patient centred care is being delivered in a sustainable way	3/12/2024 11:43 AM
5	Being able to support teams to implement PROMs can often feeling like	3/12/2024 10:13 AM
6	More focus on the patient	3/12/2024 9:58 AM
7	.	3/12/2024 9:32 AM
8	The ability to improve lives for the people of Wales The ability to ensure that we are doing the right thing at the right time, using appropriate resources The ability to understand what patients want from our services The ability to influence how we use of resources whilst improving health care models and pathways of care	3/11/2024 4:30 PM
9	I am unsure what my role is in the team therefore don't feel particularly valued	3/11/2024 3:54 PM
10	Contributing more towards healthcare with high value	3/11/2024 3:46 PM
11	I feel that its the closest I can be to improving a patients outcomes without being clinical and that feels like Im with the patients	3/11/2024 3:42 PM
12	Opportunity to make a difference for our patients	3/11/2024 3:30 PM
13	Empowering people to make the decisions they wish to make rather than being told what would be best for them. This makes outcomes a success for the persons point of view but not necessarily from the systems point of view.	3/11/2024 1:51 PM
14	It gives me hope that we are moving in the right direction towards promoting responsibility to ones own health and promptly providing the care people really need and moving away from the expectations that the health service is there to fix everything.	2/29/2024 8:30 AM
15	The only reason we have a job in a public health system is because of patients. Staff sometimes forget this and forget that true VBHC can only be achieved through full accountability to patient outcome and when all decisions are made with the patient central to achieving optimal outcomes for an individual.	2/22/2024 8:14 AM
16	Comprehension, systems learning and understanding	2/20/2024 9:29 AM
17	I am a research coordinator with a focus on secondary use of registry/clinical data and outcomes research to inform decision-making in cardiac surgery. Value-based healthcare and perhaps more descriptively the Learning Health System is what I try to support and encourage in the coalface clinical environment. When input from my work manages to influence how patient care is managed or improved, I receive a great sense of satisfaction in having contributed to slightly bettering the health system for society	2/20/2024 5:09 AM
18	ownership personal / professional development confidence satisfaction	2/19/2024 12:24 PM
19	ENSURING THAT EVERYONE HAS EQUAL ACCESS TO A HIGH STANDARD OF HEALTHCARE WHEN NEEDED, AND RESOURCES ARE USED WISELY WITH NO WASTE.	2/16/2024 2:49 PM
20	make best use of resources as a guardian of the public purse	2/16/2024 9:05 AM
21	Helps us understand if we are doing a good job, and where we can improve. Helps us work together.	2/15/2024 10:07 PM

22	Satisfaction that the limited NHS resources are being used to the maximum benefit of the population that we serve. Allows a focus on prevention and improving outcomes. Allows us to challenge current practice and highlight unacceptable variation.	2/15/2024 2:23 PM
23	ethical congruent	2/15/2024 5:55 AM
24	Excitement	2/15/2024 4:38 AM
25	To improve cost-efficiencies and effectiveness.	2/15/2024 4:22 AM
26	Satisfaction that what I am doing is contributing to delivering the outcomes and experiences that really matter to patients	2/15/2024 4:05 AM
27	Knowing that we are benefiting individuals and society to the best our ability with judicious use of a limited resource.	2/12/2024 5:19 PM
28	I think it gives me a sense of purpose.	2/5/2024 4:45 PM
29	not applicable	2/2/2024 1:28 PM
30	Challenge. Changing embedded practice in a risk averse profession (plus risk averse patients) is a challenge!	2/1/2024 8:42 AM
31	Offers me the opportunity to undertake purposeful, meaningful work that is able to authentically meet the needs of the vulnerable families that I work with. The work is freeing in that it is not restricted by clinician expectations, organisational historical models (eg ABF) and enables raw reflection.	2/1/2024 7:06 AM
32	Motivated to connect better with patients and colleagues, enthusiastic about finding optimal solutions that are patient-centric	1/31/2024 4:30 PM
33	It gives a sensible fair structure to care delivery that can therefore give equitable and fair aims to drive towards in a chaotic and poorly organised NHS.	1/31/2024 12:15 PM
34	enables me to provide person centred care allows time with people to listen to their needs and provide informed information support to assist them with the health needs they are experiencing	1/31/2024 10:49 AM
35	Direction Project planning Best practice	1/30/2024 10:17 AM
36	.	1/30/2024 9:01 AM
37	The value this gives me is that VBH&C delivers the care that patients value most, making my work of more value to them.	1/29/2024 2:33 PM
38	person centred care	1/29/2024 1:05 PM
39	The opportunity to provide gold standard patient care with a maximum benefit to patient and society.	1/29/2024 10:51 AM
40	A focus on shared decision making, putting the patient at the heart of what you're doing	1/29/2024 10:14 AM
41	in a complex, ambiguous healthcare system it gives an opportunity to deliver healthcare that is meaningful to individuals	1/26/2024 9:28 AM
42	-	1/25/2024 11:16 AM
43	I feel that I don't understand what Value Based Healthcare means enough to answer this question. My initial feel is that it creates hard work for me: I have to consider all the aspects stated in the above definition of Value Based Healthcare and adjust my way of working to it, even if that means it is to an disadvantage to me. A possibly banal example: we have a policy of only printing black and white. I work with children. Colour is a lot more engaging. I need to adjust my working to the black and white printing. I don't feel valued in the Value Based Healthcare definition.	1/25/2024 10:00 AM
44	Job satisfaction knowing you have provided person-centred care while ensuring that value in the health care is improved.	1/25/2024 9:11 AM
45	I think people worry that they don't have enough resources to provide personal value & struggle to provide allocative value because it's hard to prioritise and those who shout loudest often get their needs met over those who just accept what's on offer. Everyone would surely like to provide economic value. When services are so stretched societal value may also be a challenge to deliver.	1/24/2024 5:37 PM
46	An opportunity to work collaboratively with like minded people, with shared values and a common aim of doing the best we can with what we have, using transparent and sensible approaches to make decisions that our population can understand and buy in to	1/24/2024 4:38 PM

47	Real job satisfaction and sense of worth, personal development of skills and knowledge, shared decision-making, improved communication with MDT and patients, team-working, improved patient care	1/24/2024 3:49 PM
48	improved job satisfaction improved working skills development	1/24/2024 3:48 PM
49	The importance of knowing that patient are being delivered a service that is appropriate to them, not just what the service, or managers believe we can or should be offering. Patients/ individuals should always be the driving force behind the information and services we deliver. This sometimes requires increased education of a certain condition or service, in order that they are aware of their options	1/24/2024 11:51 AM
50	I feel motivated to do my job and get a lot of job satisfaction from listening to patients and responding to their individual needs.	1/24/2024 11:19 AM
51	patient satisfaction, patient feels listened to	1/23/2024 5:07 PM
52	contributing to NHS scotland and the healthcare service	1/23/2024 5:00 PM
53	worth	1/23/2024 3:51 PM
54	working in partnership, cohesively, focusing on person, individual	1/23/2024 9:16 AM
55	job satisfaction feeling I have made a difference	1/23/2024 9:12 AM
56	Involvement in VBHC provides a sense of equitable access and outcomes to any person regardless of postcode. The dollar does not drive the action rather the outcome of the individual drive the behaviour of provider and funder.	1/23/2024 1:49 AM
57	Being an engineer by training it emphasises the importance of efficiency and effectiveness in healthcare delivery which resonates with my engineering background. Involvement in VBHC also allows me to leverage my experience in fostering collaborations and synergies between healthcare entities, from governments to local health systems. People make the changes.	1/22/2024 9:13 PM
58	Accountability. This value reminds me of my responsibility in delivering a high standard of patient care while taking care of myself and looking after my colleagues.	1/22/2024 7:34 PM
59	I have not been involved Value Based Healthcare	1/22/2024 5:05 PM
60	making a difference with what we have - reducing waste,harm and (inappropriate) variation	1/22/2024 3:49 PM
61	Opportunity to introduce an integrated approach to service development truly involves people..	1/22/2024 3:24 PM
62	Support to know that the proposal is valid and will provide value, the ability to properly evaluate the work.	1/22/2024 3:17 PM
63	Satisfaction in improving patient care	1/22/2024 12:15 PM
64	It creates a sense of satisfaction when working collaboratively with people to come up with solutions to problems that fit their needs and personal circumstance. It provides me with opportunities to use my expertise and explore how what I have learned as a clinician can be used practically to help people manage health conditions, re-integrate socially, increase confidence and self-efficacy, and create a more empowered community.	1/22/2024 12:06 PM
65	focus, fairness, perspective. Ability to challenge morally questionable decisions within large organisations.	1/22/2024 11:11 AM
66	Personal satisfaction that patients feel valued and cared for	1/22/2024 10:42 AM
67	it provides guiding principles to enable you to understand what is important when caring and supporting individuals. Value based care sits alongside evidence based practice in supporting clinical judgement.	1/22/2024 10:39 AM
68	based on cost-benefit ratio and not on right to rehab or rehab needs may see some specialist patients (dementia/mental health) have a premature ceiling put on their care reduces clinical reasoning and decision making skills	1/22/2024 10:31 AM
69	n/a	1/22/2024 10:17 AM
70	Satisfaction of a job well done. Patient welfare/care is optimised and the the correct skills mix/experience utilised.	1/22/2024 10:10 AM
71	The satisfaction of knowing that you have enabled a person to take back some control over their health and improved their health related quality of life. The joy in seeing someone get	1/22/2024 8:44 AM

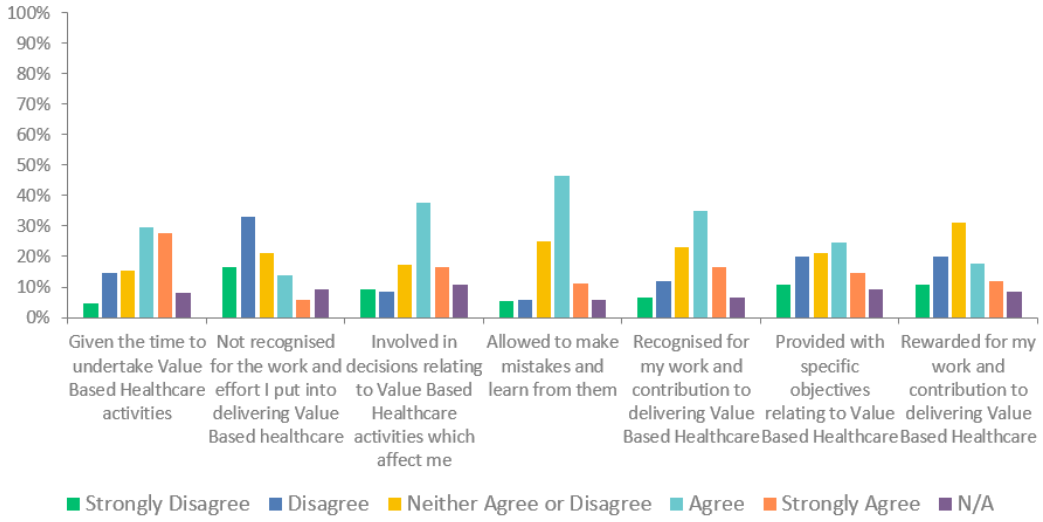
	stronger physiologically and emotionally and living their life at its optimal level.	
72	Improved outcomes for patients. Better utilization of scarce resources	1/21/2024 10:44 PM
73	Value knowing that we are aiming to utilise resources appropriately thus trying to sustain safe health care services for all.	1/20/2024 9:00 AM
74	I believe there is a sense of personal satisfaction knowing that care planned and delivered is based on patient needs. Importance of co-designing care plans with patients empowers patients moving beyond the traditional biomedical model to a truly patient centered care model supported by shared -decision making.	1/19/2024 11:50 PM
75	Personal contribution to enabling effective change to be adopted for health systems to deliver optimal outcomes that matter to patients	1/19/2024 3:38 PM
76	reduce waste, improve efficiency, increase access to healthcare	1/19/2024 1:35 PM
77	Personal satisfaction- to give full value to patients	1/19/2024 11:02 AM
78	self worth, respect in the workplace, giving a good service creating a safe space value for both staff and patient experience	1/19/2024 10:51 AM
79	Frustration with the barriers	1/19/2024 9:22 AM
80	being able to participate in something that is potentially revolutionary for the way we do health care	1/19/2024 9:21 AM
81	Knowing that we are using resources efficiently and effectively to achieve the outcomes that patients care about.	1/19/2024 9:15 AM
82	it allows a framework for helping clinical teams to make decisions around what is best for patients and progress towards implementing change with a structure	1/19/2024 5:57 AM
83	Being part of the probable future of health care delivery	1/19/2024 1:12 AM
84	Insight into current and innovative strategy and planning approaches to health care delivery and policy. Hope for improvement in health system efficiency, patient and societal outcomes	1/18/2024 11:44 PM
85	a	1/18/2024 8:29 PM
86	Satisfying	1/18/2024 5:54 PM
87	purpose, satisfaction,	1/18/2024 4:00 PM
88	Any care delivered has optimal benefits to patients and uses available resources in the most effective way	1/18/2024 3:27 PM
89	Satisfied with a job well done	1/18/2024 3:12 PM
90	Ability to deliver truly person centred care. No postcode lottery. Empowerment to adapt to local circumstances.	1/18/2024 2:47 PM
91	See no value at present.	1/18/2024 2:42 PM
92	creativity to undertake training within my job	1/18/2024 11:04 AM
93	n/a	1/18/2024 10:25 AM
94	Working with patients beliefs and educating them to make joint decisions about their medications and health.	1/18/2024 9:43 AM
95	bringing together patients, those who care for them, the institutions in which care occurs and those who make care policy to get the best health outcomes we can and improve efficiency of the system	1/18/2024 1:23 AM
96	More engaged and empowered to shape change and make decisions	1/17/2024 7:33 PM
97	Provides a healthcare system that meets the needs of the population and is fair to everyone.	1/17/2024 5:59 PM
98	Without labelling it, I feel I have always worked in a values based way, but have been frustrated by the environment. Seeing it formalised in this way, helps me have hope for being able to give a quality service that works with efficiency and the patient at the centre of decision making.	1/17/2024 4:29 PM
99	Providing most appropriate care whilst cogniscent of totality of resource availability.	1/17/2024 4:28 PM

100	None - it's a new buzz term that will be used to ration treatment.	1/17/2024 4:13 PM
101	Feeling empowered that I have managed get to the souce of a patients needs and values to have te biggest impact on their management/recovery. Improve therapeutic alliance as they will feel heard and their problems addressed when probably haven't had this experience before	1/17/2024 4:06 PM
102	learning from patients, shared decisions, holistic approach, helping to do the right thing	1/17/2024 11:49 AM
103	trying to create a better health system focussed on patient and not on funding	1/17/2024 2:56 AM
104	See question 8	1/17/2024 1:51 AM
105	N/A	1/16/2024 11:38 PM
106	When I think about it - my role is heavily focused on value based healthcare - collaborating with health and social care partners to build pathways that provide patients with the right care, in the right place, at the right time, the first time. There's a lot of satisfaction in looking at a problem from all perspectives, and then working together to resolve it as a team! I feel a strong sense of connection to my NHSS colleagues, and a shared responsibility to improve patient experience. It's great to reflect on how much we have achieved with the development of urgent care pathways over the last couple of years. There is much work still to be done!	1/16/2024 4:31 PM
107	Skills development Contribute to a more sustainable future service	1/16/2024 4:23 PM
108	Knowing what the public money is being sent on is wisely apportioned. Knowing that what matters to people is prioritised.	1/16/2024 3:25 PM
109	It gives me a deeper appreciation and understanding of the personal and widerimpact of the care I provide.	1/16/2024 12:30 PM
110	An opportunity to avoid moral distress	1/16/2024 12:14 PM
111	Delivering the care that healthcare users value, handing the control of care back to the patient. Reducing the waste of investigations and treatments that patients don't value and measuring outcomes based on whats important to the public not research primary/secondary outcomes	1/16/2024 12:06 PM
112	Improved job satisfaction and being able to witness the positive impact on people's lives	1/16/2024 9:24 AM
113	Delivering care with optimal efficiency and effectiveness to improve outcomes for the greater number should be a goal for all clinicians. Sometimes bureaucratic processes are the major barrier to achieving this and clinicians are left exhausted trying to advocate for common sense spending within executive structures that have key performance indicators meant to track safety and quality of patient care that don't actually reflect meaningful clinical risks and outcomes. VBHC should help provide a shared language for discussion of barriers and enablers of improvement	1/16/2024 8:39 AM
114	Extremely valuable and useful in supporting a value based solution to providing holistic health care	1/16/2024 7:14 AM
115	pride	1/16/2024 5:19 AM
116	Being involved in VBHC assists me in fulfilling my passion which is improving access to high quality care.	1/16/2024 4:30 AM
117	Having an understanding of what value based healthcare means in a specific project context enables me to optimise my planning and evaluation. It is about doing things and measuring things that matter.	1/16/2024 3:52 AM
118	A purpose, client driven	1/16/2024 3:49 AM
119	I believe that there is an increase in the acceptability and implementation of VBHC which means that my employability is likely to increase and organisations will be seeking my skills.	1/16/2024 3:20 AM
120	Ensuring that the care that is purchased or provided is a result of what the client needs and results in a positive and measurable impact to the patient, their family, health care team, the broader community, funders, so that we can continue to have a universal healthcare system.	1/16/2024 3:13 AM
121	Knowing that there is a contribution of value to greater health system and community	1/16/2024 3:05 AM
122	Job satisfaction	1/15/2024 8:05 PM

123	Professional enablement, deeper collaborative relationships and self permission to prioritise work that you know will lead to improved outcomes for individuals and their families. This leads to great satisfaction of making a difference that matters and can pave the way for the next change you want to make with the new contacts you have made.	1/15/2024 9:19 AM
124	A framework to implement meaningful and positive change	1/12/2024 4:46 PM
125	It should give you the access to a world of supported change that is a step forward from other change approaches used in the past.	1/12/2024 2:57 PM
126	I'm on the fence - as with many QI initiatives, clinicians can spend a lot of time, see their work go to waste and become understandably cynical, so needs major organisational prioritisation (this could waste a lot of resource, not pitched at the right level)	1/12/2024 12:17 PM
127	Awareness Engagement Confidence and trust gained through sharing patient stories	1/12/2024 9:10 AM
128	equitable care, optimal and transparent use of resources, extension and context to person centred care	1/12/2024 8:24 AM
129	job satisfaction that resources are allocated fairly	1/11/2024 5:45 PM
130	Contributing to a better patient/person experience which results in empowerment and better health outcomes; and in turn provides a more satisfying work experience, the opportunity to upskill and progress in career.	1/11/2024 3:47 PM
131	Transformational change in strategic direction to influence both clinical patient pathways and support staff in career pathway journey	1/11/2024 3:19 PM
132	Additional knowledge on alternative healthcare and new models of care	1/11/2024 2:31 PM
133	worthwhile, positive, necessary, constructive solution	1/11/2024 1:29 PM
134	Personal satisfaction & Motivation	1/11/2024 12:02 PM
135	Depends on definition of being involved with. Trying to promote VBHC is really difficult in our current climate, service being propped up with a series of rotating locum consultants.	1/11/2024 8:13 AM
136	None a waste of time pretending to do work and promoting mediocracy and poor care within the nhs instead of proper care	1/11/2024 8:07 AM
137	treating others thru better use of resource	1/10/2024 9:36 PM
138	Meaning and purpose Makes me a net contributor	1/10/2024 4:20 PM
139	Compassion Influence Community Kindness Optimism Leadership	1/10/2024 10:03 AM
140	Providing a real difference to patients lives in supporting them in what they need at the best time, to provide the best outcomes but in the most economical way	1/8/2024 4:02 PM
141	Increased job satisfaction, contribute to reduced healthcare costs	1/8/2024 4:21 AM
142	VBHC enables me to take a whole system view. To understand how people move through the health system and identify the areas for improvement. It enables me to connect and learn with people beyond my silo to improve the experience and outcomes of people interacting with the health system.	1/7/2024 10:21 PM
143	Altruism. Doing a job that is wirthwhile and better for service users	1/3/2024 10:41 AM
144	Hope for the future of the population and the NHS.	1/2/2024 3:12 PM
145	de	1/2/2024 2:57 PM
146	understanding of health impact that care and treatment is having on patients as they are living their lives.	1/2/2024 12:36 PM
147	None	1/2/2024 10:59 AM
148	It is the way health care should be delivered and therefore very satisfying	12/28/2023 10:31 AM
149	Motivation to refocus and make services collaborative between health care professionals and patients.	12/28/2023 9:38 AM
150	Ability to contribute to systemic change. Greater scale of impact.	12/27/2023 11:22 AM
151	.	12/15/2023 12:23 PM

Q12: I am:

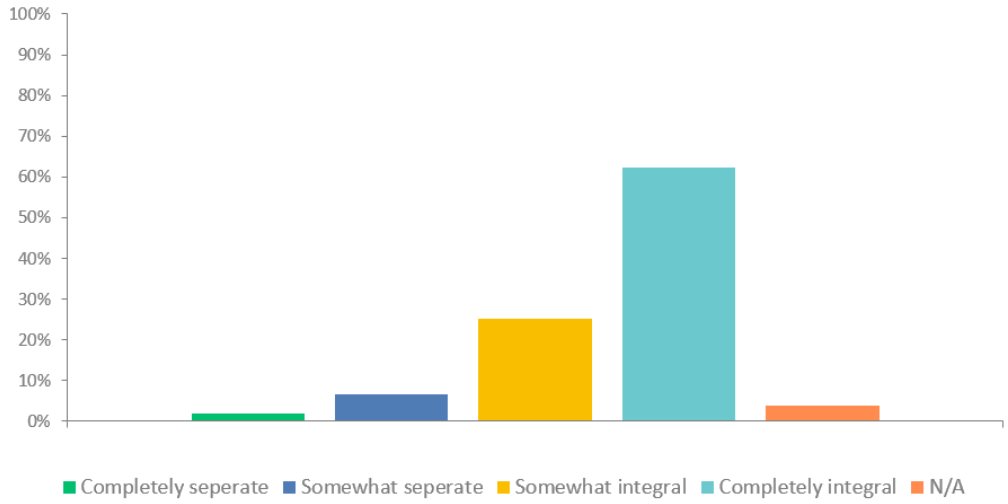
Answered: 151 Skipped: 110



	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE	STRONGLY AGREE	N/A	TOTAL	WEIGHTED AVERAGE
Given the time to undertake Value Based Healthcare activities	4.64% 7	14.57% 22	15.23% 23	29.80% 45	27.81% 42	7.95% 12	151	3.67
Not recognised for the work and effort I put into delivering Value Based healthcare	16.56% 25	33.11% 50	21.19% 32	13.91% 21	5.96% 9	9.27% 14	151	2.55
Involved in decisions relating to Value Based Healthcare activities which affect me	9.27% 14	8.61% 13	17.22% 26	37.75% 57	16.56% 25	10.60% 16	151	3.49
Allowed to make mistakes and learn from them	5.30% 8	5.96% 9	25.17% 38	46.36% 70	11.26% 17	5.96% 9	151	3.56
Recognised for my work and contribution to delivering Value Based Healthcare	6.62% 10	11.92% 18	23.18% 35	35.10% 53	16.56% 25	6.62% 10	151	3.46
Provided with specific objectives relating to Value Based Healthcare	10.60% 16	19.87% 30	21.19% 32	24.50% 37	14.57% 22	9.27% 14	151	3.14
Rewarded for my work and contribution to delivering Value Based Healthcare	10.60% 16	19.87% 30	31.13% 47	17.88% 27	11.92% 18	8.61% 13	151	3.01

Q13: Do you see Value Based Healthcare as part of your job and integral or separate and an additional activity?

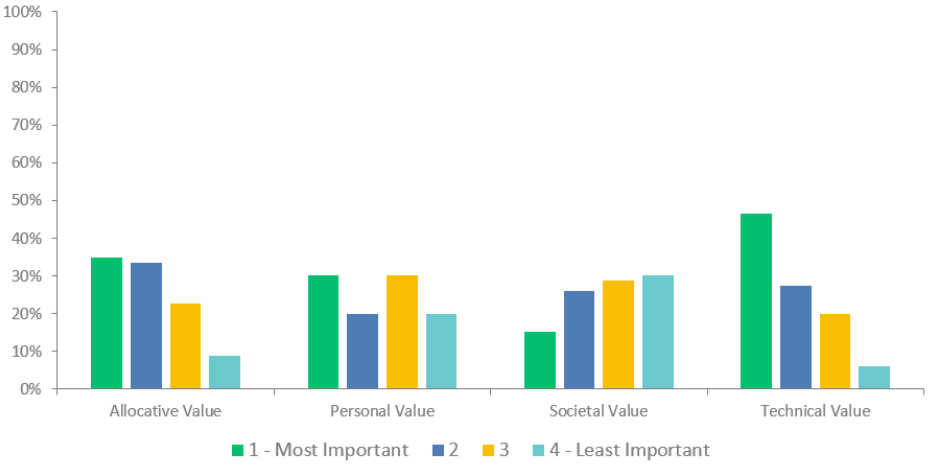
Answered: 151 Skipped: 110



	COMPLETELY SEPERATE	SOMEWHAT SEPERATE	SOMEWHAT INTEGRAL	COMPLETELY INTEGRAL	N/A	TOTAL	WEIGHTED AVERAGE
(no label)	1.99% 3	6.62% 10	25.17% 38	62.25% 94	3.97% 6	151	3.54

Q14: Rank the below Value Based Healthcare benefit areas in order of how you believe YOUR ORGANISATION see's their importance with 1 being most important and 4 being least important? You can rank areas equally.

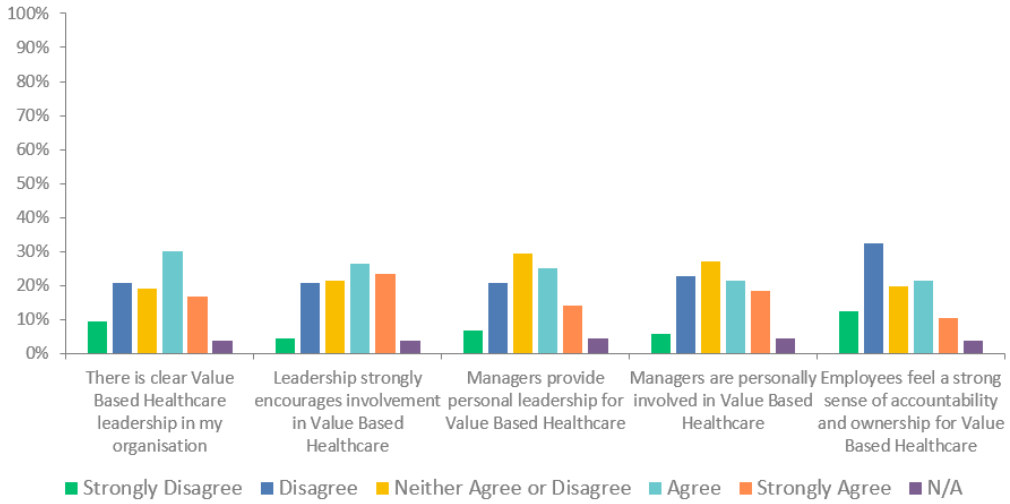
Answered: 146 Skipped: 115



	1 - MOST IMPORTANT	2	3	4 - LEAST IMPORTANT	TOTAL
Allocative Value	34.93% 51	33.56% 49	22.60% 33	8.90% 13	146
Personal Value	30.14% 44	19.86% 29	30.14% 44	19.86% 29	146
Societal Value	15.07% 22	26.03% 38	28.77% 42	30.14% 44	146
Technical Value	46.58% 68	27.40% 40	19.86% 29	6.16% 9	146

Q15: The following questions relate to leadership

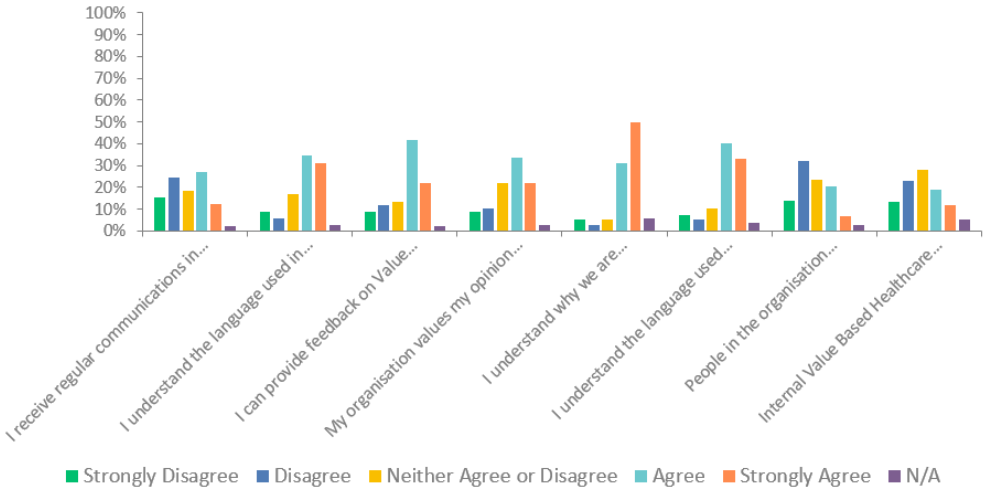
Answered: 136 Skipped: 125



	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE	STRONGLY AGREE	N/A	TOTAL	WEIGHTED AVERAGE
There is clear Value Based Healthcare leadership in my organisation	9.56% 13	20.59% 28	19.12% 26	30.15% 41	16.91% 23	3.68% 5	136	3.25
Leadership strongly encourages involvement in Value Based Healthcare	4.41% 6	20.59% 28	21.32% 29	26.47% 36	23.53% 32	3.68% 5	136	3.46
Managers provide personal leadership for Value Based Healthcare	6.62% 9	20.59% 28	29.41% 40	25.00% 34	13.97% 19	4.41% 6	136	3.20
Managers are personally involved in Value Based Healthcare	5.88% 8	22.79% 31	27.21% 37	21.32% 29	18.38% 25	4.41% 6	136	3.25
Employees feel a strong sense of accountability and ownership for Value Based Healthcare	12.50% 17	32.35% 44	19.85% 27	21.32% 29	10.29% 14	3.68% 5	136	2.84

Q16: The following questions relate to communications

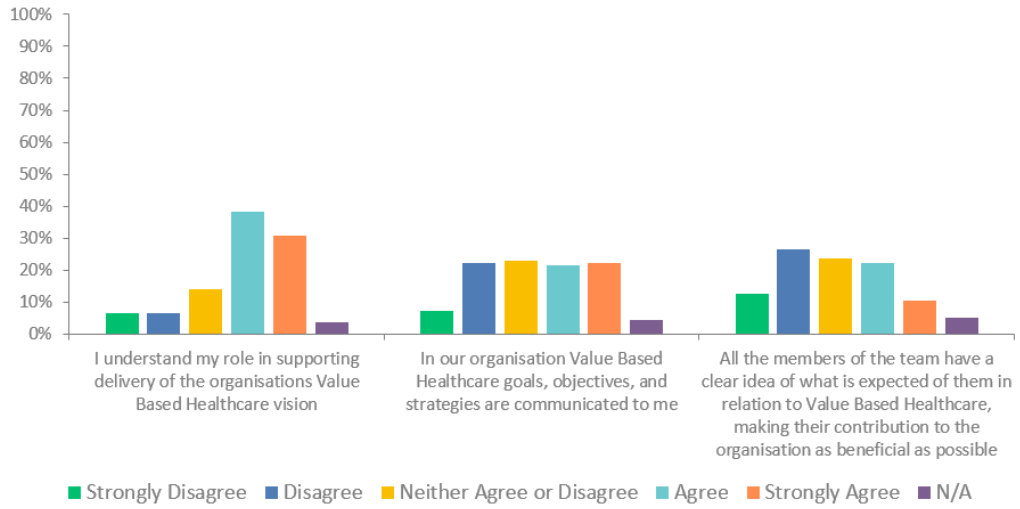
Answered: 136 Skipped: 125



	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE	STRONGLY AGREE	N/A	TOTAL	WEIGHTED AVERAGE
I receive regular communications in relation to Value Based Healthcare	15.44% 21	24.26% 33	18.38% 25	27.21% 37	12.50% 17	2.21% 3	136	2.97
I understand the language used in meetings and discussion around Value Based Healthcare	8.82% 12	5.88% 8	16.91% 23	34.56% 47	30.88% 42	2.94% 4	136	3.75
I can provide feedback on Value Based Healthcare activities	8.82% 12	11.76% 16	13.24% 18	41.91% 57	22.06% 30	2.21% 3	136	3.58
My organisation values my opinion on delivering Value Based Healthcare	8.82% 12	10.29% 14	22.06% 30	33.82% 46	22.06% 30	2.94% 4	136	3.52
I understand why we are undertaking Value Based Healthcare activities	5.15% 7	2.94% 4	5.15% 7	30.88% 42	50.00% 68	5.88% 8	136	4.25
I understand the language used and its terminology in Value Based Healthcare	7.35% 10	5.15% 7	10.29% 14	40.44% 55	33.09% 45	3.68% 5	136	3.90
People in the organisation understand what is meant by Value Based Healthcare	13.97% 19	32.35% 44	23.53% 32	20.59% 28	6.62% 9	2.94% 4	136	2.73
Internal Value Based Healthcare communication is totally open and transparent	13.24% 18	22.79% 31	27.94% 38	19.12% 26	11.76% 16	5.15% 7	136	2.93

Q17: The following questions relate to vision and strategy

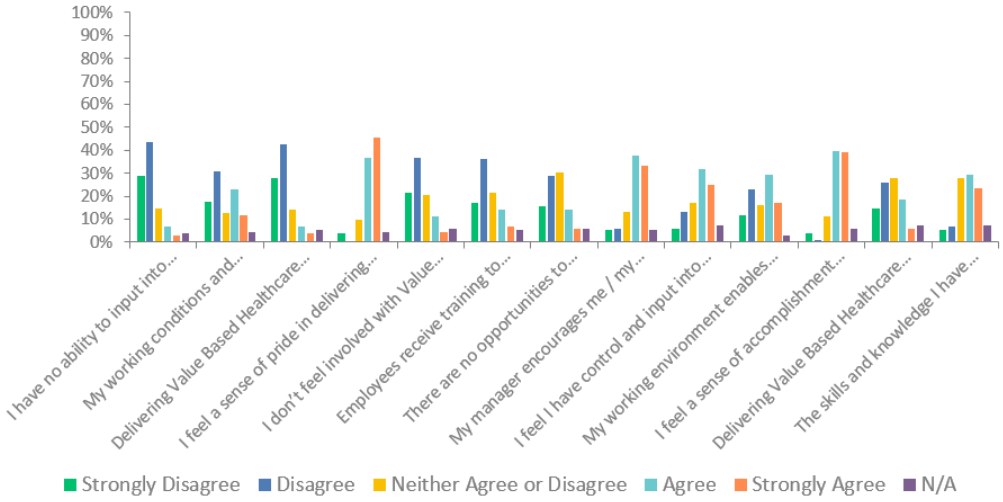
Answered: 136 Skipped: 125



	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE	STRONGLY AGREE	N/A	TOTAL	WEIGHTED AVERAGE
I understand my role in supporting delivery of the organisations Value Based Healthcare vision	6.62% 9	6.62% 9	13.97% 19	38.24% 52	30.88% 42	3.68% 5	136	3.83
In our organisation Value Based Healthcare goals, objectives, and strategies are communicated to me	7.35% 10	22.06% 30	22.79% 31	21.32% 29	22.06% 30	4.41% 6	136	3.30
All the members of the team have a clear idea of what is expected of them in relation to Value Based Healthcare, making their contribution to the organisation as beneficial as possible	12.50% 17	26.47% 36	23.53% 32	22.06% 30	10.29% 14	5.15% 7	136	2.91

Q18: The following questions relate to you

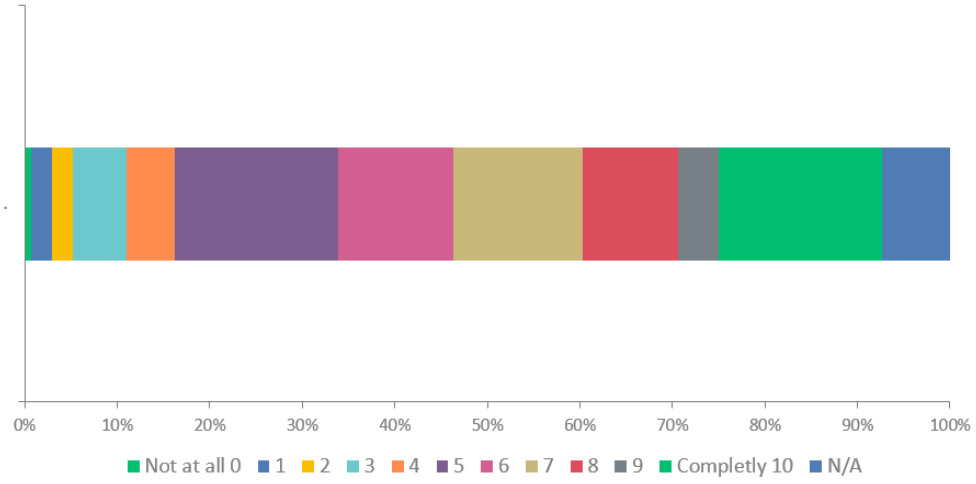
Answered: 136 Skipped: 125



	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE	STRONGLY AGREE	N/A	TOTAL	WEIGHTED AVERAGE
I have no ability to input into decisions relating to Value Based Healthcare and my areas of work	28.68% 39	43.38% 59	14.71% 20	6.62% 9	2.94% 4	3.68% 5	136	2.08
My working conditions and environment make it difficult to deliver what's expected of me	17.65% 24	30.88% 42	12.50% 17	22.79% 31	11.76% 16	4.41% 6	136	2.79
Delivering Value Based Healthcare activities takes me away from the important aspects of my job	27.94% 38	42.65% 58	13.97% 19	6.62% 9	3.68% 5	5.15% 7	136	2.11
I feel a sense of pride in delivering Value Based Healthcare	3.68% 5	0.00% 0	9.56% 13	36.76% 50	45.59% 62	4.41% 6	136	4.26
I don't feel involved with Value Based Healthcare activities which affect me	21.32% 29	36.76% 50	20.59% 28	11.03% 15	4.41% 6	5.88% 8	136	2.37
Employees receive training to perform Value Based Healthcare activities	16.91% 23	36.03% 49	21.32% 29	13.97% 19	6.62% 9	5.15% 7	136	2.55
There are no opportunities to progress my career within Value Based Healthcare	15.44% 21	28.68% 39	30.15% 41	13.97% 19	5.88% 8	5.88% 8	136	2.64
My manager encourages me / my team to learn from past experiences	5.15% 7	5.88% 8	13.24% 18	37.50% 51	33.09% 45	5.15% 7	136	3.92
I feel I have control and input into the delivery of Value Based Healthcare within my area.	5.88% 8	13.24% 18	16.91% 23	31.62% 43	25.00% 34	7.35% 10	136	3.61
My working environment enables me to deliver at my best	11.76% 16	22.79% 31	16.18% 22	29.41% 40	16.91% 23	2.94% 4	136	3.17
I feel a sense of accomplishment when delivering Value Based Healthcare work	3.68% 5	0.74% 1	11.03% 15	39.71% 54	38.97% 53	5.88% 8	136	4.16
Delivering Value Based Healthcare adds stress to my job	14.71% 20	25.74% 35	27.94% 38	18.38% 25	5.88% 8	7.35% 10	136	2.73
The skills and knowledge I have gained through Value Based Healthcare will	5.15% 7	6.62% 9	27.94% 38	29.41% 40	23.53% 32	7.35% 10	136	3.64

Q19: Using any number from 0 to 10, where 0 is not at all and 10 is completely, how much do you feel lack of resource in your area of work is a major source of Value Based Healthcare failure?

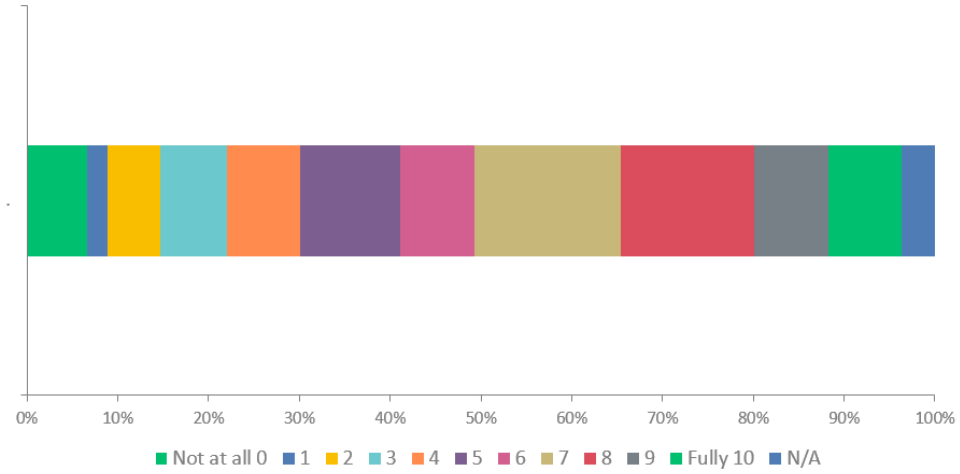
Answered: 136 Skipped: 125



	NOT AT ALL 0	1	2	3	4	5	6	7	8	9	COMPLETLY 10	N/A
.	0.74% 1	2.21% 3	2.21% 3	5.88% 8	5.15% 7	17.65% 24	12.50% 17	13.97% 19	10.29% 14	4.41% 6	17.65% 24	7.35% 10

Q20: Using any number from 0 to 10, where 0 is not at all and 10 is fully, how much do you feel a part of a movement or community of Value Based Healthcare?

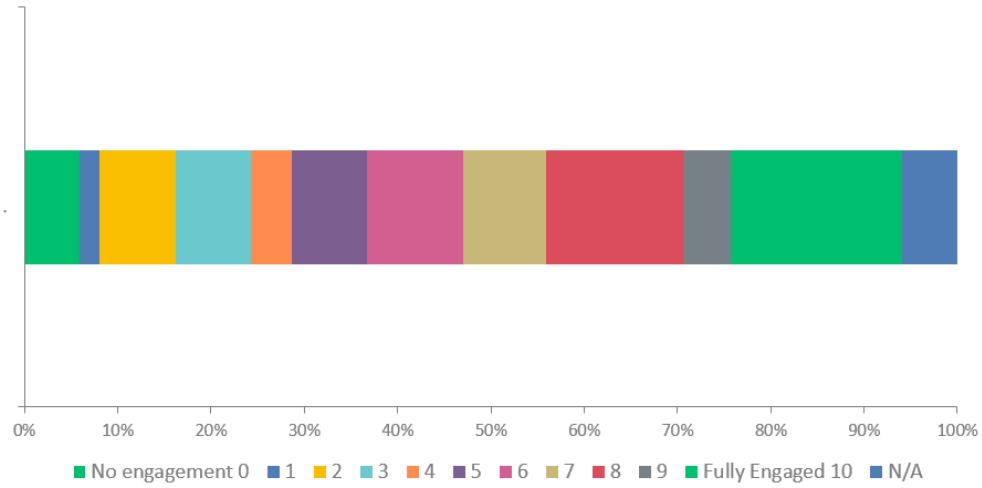
Answered: 136 Skipped: 125



	NOT AT ALL 0	1	2	3	4	5	6	7	8	9	FULLY 10	N/A	TOTAL
.	6.62% 9	2.21% 3	5.88% 8	7.35% 10	8.09% 11	11.03% 15	8.09% 11	16.18% 22	14.71% 20	8.09% 11	8.09% 11	3.68% 5	13(

Q21: Using any number from 0 to 10, where 0 is not at all and 10 is fully, how much is the delivery of Value Based healthcare built into your day to day job??

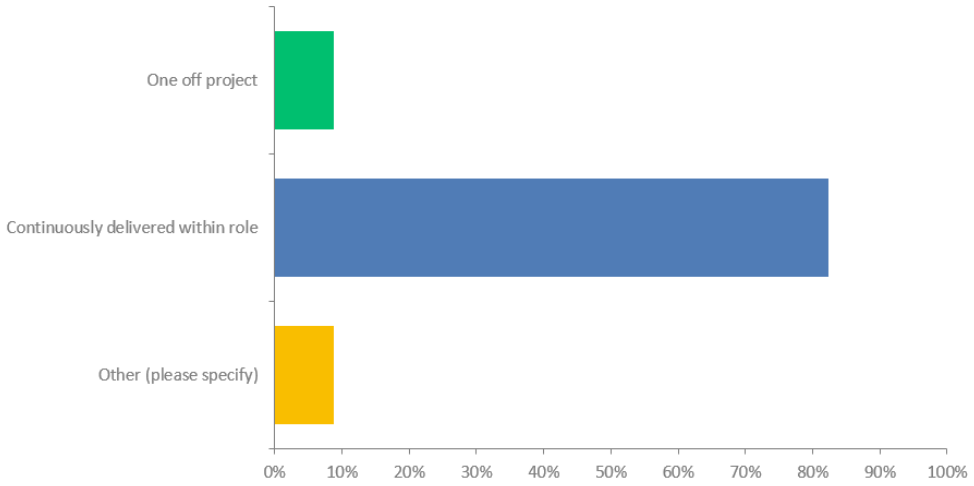
Answered: 136 Skipped: 125



	NO ENGAGEMENT 0	1	2	3	4	5	6	7	8	9	FULLY ENGAGED 10	N/A
.	5.88% 8	2.21% 3	8.09% 11	8.09% 11	4.41% 6	8.09% 11	10.29% 14	8.82% 12	14.71% 20	5.15% 7	18.38% 25	5.88

Q22: Do you believe Value Based Healthcare work is a one off project activity or something which will be continuously delivered within your role?

Answered: 136 Skipped: 125

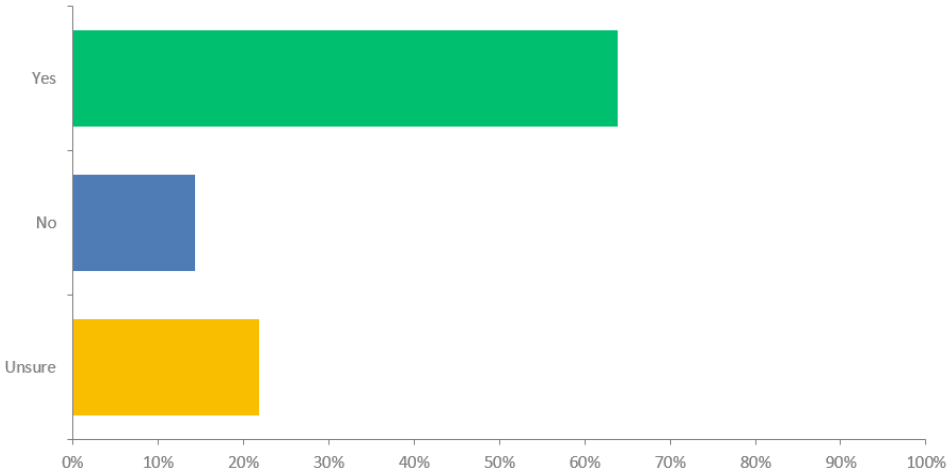


ANSWER CHOICES	RESPONSES	
One off project	8.82%	12
Continuously delivered within role	82.35%	112
Other (please specify)	8.82%	12
TOTAL		136

#	OTHER (PLEASE SPECIFY)	DATE
1	Call me a cynic but hard not to see this as the latest buzz words which will eventually be replaced with something else	1/24/2024 5:42 PM
2	unsure	1/23/2024 5:10 PM
3	VBHC is not designed in to the fabric of clinical boards mindsets resulting in lack organisational alignment to CLinical Boards. Seen as separate Projects under VBHC Programme Broad not integrated to the mainstream.	1/22/2024 3:32 PM
4	continously delivered but based on personally valuing it not because it is built in	1/22/2024 11:17 AM
5	Values based healthcare is still viewed as a personal responsibility and few practitioners are working to this agenda. This makes my job harder because I end up intervening where other members of staff have not worked to a values based model.	1/22/2024 10:47 AM
6	not used in practice	1/22/2024 10:35 AM
7	As a time limited research project this is not applicable	1/19/2024 1:20 AM
8	Should be continuous but tends to be one off, depending on political influence and inclination	1/18/2024 11:49 PM
9	I think that often VBH depends on staff and their beliefs and values and also how time poor they are at work and how much committment they have for change and the change process and of giving patients power and control over decisions relating to their health care. Health care continues to be authoritarian and autocratic	1/17/2024 2:02 AM
10	Not currently used	1/16/2024 11:42 PM
11	My role is to embed realistic medicine/VBH&C across the organisation though	1/11/2024 1:35 PM
12	Waste of time promoting mediocre care	1/11/2024 8:09 AM

Q23: Do you believe there could be a 5th value area within Value Based Healthcare of 'Professional Value' - where undertaking Value Based Healthcare activities provides value to the professional involved in its delivery such as improved job satisfaction, improved working environment, professional development etc?

Answered: 133 Skipped: 128



ANSWER CHOICES	RESPONSES	
Yes	63.91%	85
No	14.29%	19
Unsure	21.80%	29
TOTAL		133

#	PLEASE PROVIDE YOUR REASONING	DATE
1	I think we do Value Based Health Care to deliver better care with the current finite resource available. The improvement in job satisfaction etc is a by-product of delivering Value not the definition. You can achieve Professional Value without delivering VBHC.	3/19/2024 11:53 AM
2	I think there could be but I'm not sure it should be a focus, only a secondary outcome of achieving the others. Sometimes what a professional wants/values is not of ultimate benefit to the patient/system. But perhaps you could argue the same for technical value & professional should trump that?	3/12/2024 5:59 PM
3	that would be one of many benefits of a VBHC system, workforse is already part of the quardruple aim, I don't see the need to add it	3/12/2024 12:28 PM
4	It would be good to see how the implementing of VBHC principles can positively impact the staff we work with	3/12/2024 10:18 AM
5	I don't think many professionals see it this way	3/12/2024 10:09 AM
6	Evidencing Value through your own personal work not only gives job satisfaction etc., but cements the reason for working as part of the NHS in Wales in wanting to provide quality services to patients and receive the best care on things that matter to me as a patient	3/11/2024 4:34 PM
7	The staff needs to be listened to more	3/11/2024 3:58 PM
8	Just as above - I feel increased job satisfaction when applying Value Based Care in my role.	2/29/2024 8:34 AM
9	Happy / confident / content staff = better patient health care interactions	2/22/2024 8:14 AM

10	Keeps employees more engaged	2/20/2024 9:35 AM
11	There are a number of models such as the Quadruple aim which align with VBHC where the importance of professional needs are recognised. Without satisfied staff healthcare will gradually lose appeal and become untenable	2/20/2024 5:17 AM
12	question assumes you subscribe to Grays descriptors as preferred value theory	2/16/2024 9:10 AM
13	Health care is a partnership between patient and clinician	2/15/2024 10:14 PM
14	Workforce is critial in values baed health care delivery and it done well has the power to aid retention	2/15/2024 4:41 AM
15	Sustainability value also needs to be considered.	2/15/2024 4:25 AM
16	It provides lots of job satisfaction	2/15/2024 4:09 AM
17	Effective use of limited resource is a professional responsibility.	2/12/2024 5:25 PM
18	The quadruple aim	2/5/2024 4:49 PM
19	It is difficultto imagin the other 4 not being impacted by this 5th	2/2/2024 1:35 PM
20	The ideal number is three.	2/1/2024 8:49 AM
21	I think it is important to consider what VBHC offers to professionals, as these individual factors are key to the culture of VBHC	2/1/2024 7:13 AM
22	To maintain engagement in a very difficult work setting we must not forget the needs of the workforce.	1/31/2024 12:21 PM
23	if you are achieving person centred care and offering value based healthcare you will be able to spend time with people undertand their needs and goals in life and be able to support them to gain skills and improve their quality of life, this will provide job satisfaction	1/31/2024 10:56 AM
24	Increases job satisfaction, enabling changes, increasing morale, encourages teams to develop between finances/ops/clinicians.	1/30/2024 10:23 AM
25	Job satisfaction will be enhanced if staff believe they are providing care of value to patients	1/29/2024 2:41 PM
26	If this were part of the values it would add to revalidation expectations and improved interest and involvement in VBHC	1/29/2024 10:58 AM
27	It would at least suggest that we value/have esteem for the professional equally to the service user the the practical elements of the job	1/25/2024 10:07 AM
28	While professional value is important, I worry it would distract from the other aspects already in the definition. I think it a pear and the others are varieties of apple	1/24/2024 4:50 PM
29	making a difference to patient's quality of life and treatments consistently	1/24/2024 3:55 PM
30	Imorved working environments help sstaff morale, teamwork, leadership and effectiveness, giving them the time and space to be able to integrate these values into their work.	1/24/2024 11:58 AM
31	will likely aid staff retention	1/23/2024 5:10 PM
32	I am employed to undertake a role. Job satisfaction affects how well I do that. But for working environment and development, these are not expectations of my role.	1/23/2024 3:57 PM
33	By aligning their work with Value Based Healthcare principles, professionals can experience enhanced job satisfaction, a more positive working environment, and opportunities for professional development. This aligns with the notion that when healthcare providers feel valued and see the tangible impact of their work, it can lead to improved performance, higher levels of engagement, and a deeper commitment to patient care.	1/22/2024 9:19 PM
34	As employees of an organisation, there are expectations that should be met doing a job or being in service. One of which is ensuring professional competency and development to continue to improve through evidence-based practices. Also, receiving trainings on new roles given like being a mentor to students of newly qualified colleagues.	1/22/2024 7:47 PM
35	If the Healthcare System (NHS) truly believes that healthcare staff are integral to Value Based Healthcare.	1/22/2024 5:10 PM
36	I putthis under personal value and we have evidenced it on many ocassions in professionals deliverung services - always a danger of too many areas !!!	1/22/2024 3:55 PM
37	If structure and integrated in to Health Board mentality. But it can be very frustrating if your	1/22/2024 3:33 PM

	organisation where ideas are not aligned.	
38	personal experience	1/22/2024 3:20 PM
39	Just makes sense	1/22/2024 12:23 PM
40	without it contributing to self development, it is unlikely to be sustained or prioritised.	1/22/2024 11:18 AM
41	Maybe more staff would take on this model if this were the case.	1/22/2024 10:47 AM
42	would enhance job satisfaction	1/22/2024 10:46 AM
43	More satisfaction, less frustration	1/22/2024 10:15 AM
44	Workforce culture and capability are imperative to delivering vbhc	1/21/2024 10:48 PM
45	Our work should always improve job satisfaction and professional development	1/20/2024 9:04 AM
46	Important to capture clinician's value in conjunction with patient's value	1/19/2024 11:59 PM
47	I think we should focus on achieving demonstrated success in the Four Pillars version first, before any expansion.	1/19/2024 3:47 PM
48	This would help everyone to appreciate and understand that it is everyone's role to ensure we work within a diverse and respectful health care setting	1/19/2024 10:54 AM
49	usually we consider benefits to staff members as either part of personal, allocative or societal value - depending on the kind of work we are doing	1/19/2024 9:26 AM
50	not sure of the value of this	1/19/2024 6:02 AM
51	There won't be engagement or take up unless there are tangible benefits to staff	1/19/2024 1:21 AM
52	Absolutely, this aligns with the quadruple aim although it may be hard to measure.	1/18/2024 11:50 PM
53	without staff sustainability nothing will last.	1/18/2024 4:05 PM
54	We all have a role in health to protect the resources we have	1/18/2024 3:32 PM
55	Completely understand the concept, however there is no change within the organisation. Just another thing to add stress and impact on Mental Health,. lots of teaching, speaking about it, but often lacks in action. Same issues are still arising with people now avoiding managerial responsibility ecause 'lets talk about it' is so much better. It ahs really taken people away from the resonsibility of their roles.	1/18/2024 11:30 AM
56	It is rewarding to work with patients and help educate them and make decisions together.	1/18/2024 9:45 AM
57	clinical buy in is essential to any clinical practice change and this would encourage it	1/18/2024 1:26 AM
58	It is important clinicians see themselves as providing care to an entire population, not just patients under their direct care at a given point in time and not caring about everyone else.	1/17/2024 6:03 PM
59	Working as individuals will have little impact and may induce frustrations at paucity of whole system approaches to Value Based thinking and actions . Poor interfaces / pathways and under-resourcing and acknowledgement of Primary Care (proven track record of value efficient care) will restrict Value Based Healthcare at a societal , technical and allocative level unless recognised and resolved . No matter how much effort is going into this work ,until our Health Service has a change in Culture to being more Community care focussed and much better integrated then we will struggle to make sizeable progress in Value Based care .	1/17/2024 4:53 PM
60	as it is important we also address workforce and improve retention with new ways of working adding value to their roles	1/17/2024 4:11 PM
61	experiential learning suggest that where there is professional value morale and innovation improves engagement and drive for success	1/17/2024 11:56 AM
62	overkill	1/17/2024 2:59 AM
63	Providing all health care workers with a sense of worth and importance and the provision of explicit rewards may encourage the use of VBH	1/17/2024 2:06 AM
64	Not familiar enough with value based healthcare	1/16/2024 11:42 PM
65	This is vital in a time where NHS employees and health professionals feel undervalued and overworked. This needs to be considered when we think about workforce retention.	1/16/2024 4:36 PM
66	Upskilling the workforce is a necessity	1/16/2024 4:26 PM

67	I have been incorporating it into Allocative value as it stands with al workforce elements as you have described being incorporated into that. I think we would need to be clear on how you would measure that value and what would be the link with outcome/resource = value and the theory behind value.	1/16/2024 3:36 PM
68	It is all interlinked, if you have colleagues who have improved job satisfaction etc. they will be more enagaged.	1/16/2024 12:35 PM
69	Given the significant international workforce challenges in healthcare, actively examinining professional value would be incredibly beneficial in attracting and retaining staff	1/16/2024 12:21 PM
70	undertaking high burden treatment for low yield results is professionally and morally injurious	1/16/2024 12:13 PM
71	Staff morale is at an alltime low and any activities which improve job satisfaction and morale should be widely encouraged.	1/16/2024 9:29 AM
72	I think that this Professional Value will encourage workforce to continually work to acheive optimal care within both outcome and funding availability	1/16/2024 7:19 AM
73	this value leads to reduced staff turnover, more skilled workforce and staff wellbeing that interconect and contribute to the other values	1/16/2024 5:26 AM
74	Referring to the quadruple aim of healthcare, clinician experience must be considered when evaluating value. Without improvements for clinicians, there is a lack of incentive to get them onboard these projects	1/16/2024 4:50 AM
75	Each of the other four values align with the Quintuple Aim of Healthcare Improvement. Enhancing the health professional experience is the only one left out.	1/16/2024 4:00 AM
76	Would help get provider buy in and engagement	1/16/2024 3:54 AM
77	I believe that adding too many additional values will dilute the message and make it potentially more confusing and overwhelming for organisations. I believe this is already covered by the provider experience.	1/16/2024 3:27 AM
78	I am not sure as this may already be something people would expect to come under the pillar of provider expereince.	1/16/2024 3:18 AM
79	You are completing the relationship dynamic by adding the 5th element to have individual, organisation and caregiver needs represented. We have to find a way to enable organisations and professions to communicate the value of this to the clinician and all of the support workers that satellite around the individual we are caring for. There has to be a two way relationship benefit, its not all about the pay packet.	1/15/2024 9:32 AM
80	Perhaps as a by-product but I wouldn't understand it as central	1/12/2024 4:50 PM
81	I think the parameteres of what it adds. If that is happiness in work rather than professional developement.	1/12/2024 3:05 PM
82	if you want to continue to dissect descriptives of what people do	1/12/2024 12:23 PM
83	There is value to the staff member's experiences, knowledge/skills, and professional development.	1/11/2024 4:01 PM
84	Potentially less stress for the professional when able to provide better healthcare and resolutions for the patient therefore increasing positive outcomes	1/11/2024 2:45 PM
85	Whilst this might be true, I think the landscape around this is 'busy' enough and it would be detrimental to dilute it any further.	1/11/2024 1:36 PM
86	by impacting improvements where they count proprtionately to the clinical need	1/10/2024 9:41 PM
87	Want to avoid overcomplicating these concepts. But delivering VBH&C is part of being a health and care professional	1/10/2024 4:23 PM
88	This is an outcome from practicing VBHC	1/10/2024 10:08 AM
89	I think this could be important especially if you see the results of the VBHC projects rewarded ie continued funding if was a project and becomes business as usual or scaling up initiatives across Wales	1/8/2024 4:10 PM
90	Cannot be separate to the role or job	1/8/2024 4:25 AM
91	Absolutely - what we hear when speaking to people in Australia is that the increasing bureaucracy and workloads is leading people to feel disengaged and undervalued. VBHC provides a framework for putting people and communities at the center of all healthcare decision making an as such can enable people to reconnect with their purpose as healers	1/7/2024 10:32 PM

	improving job satisfaction, creating a shared goal for teams to work towards together and enabling people to reach across silos and professions to learn and develop as professionals.	
92	The current definitions are related to the patient and the system, not the professional.	1/2/2024 3:15 PM
93	t	1/2/2024 2:58 PM
94	we all need to feel valued that includes staff and patients	1/2/2024 12:48 PM
95	You could apply that definition to any aspect of the job	1/2/2024 11:05 AM
96	It should be about patients The 4 values are suitable and if applied provide professionals value without needing a separate criterion	12/28/2023 10:35 AM
97	the skills and experience of the project i am involved with has fast tracked my personal development	12/28/2023 9:43 AM
98	Will lead to improved confidence in decision making	12/27/2023 11:36 AM

Appendix L – Quantitative Questionnaire Demographic Data

Q1: What is the name of the organisation you work for?

ANSWER CHOICES	RESPONSES	
Aneurin Bevan University Health Board	1.15%	3
Betsi Cadwaladr University Health Board	0.00%	0
Cardiff and Vale University Health Board	5.75%	15
Cwm Taf Morgannwg University Health Board	3.07%	8
Hywel Dda University Health Board	3.07%	8
Powys Teaching Health Board	2.68%	7
Swansea Bay University Health Board	1.15%	3
Velindre University NHS Trust	1.92%	5
Welsh Ambulances Services NHS Trust	0.00%	0
Public Health Wales	0.38%	1
Health Education and Improvement Wales (HEIW)	0.00%	0
Digital Health and Care Wales	0.00%	0
NHS Wales Shared Services Partnership	0.00%	0
Welsh Value In Health Centre	1.15%	3
Australian Centre for Value Based Healthcare or wider Australian Healthcare Organisation	3.45%	9
NHS Scotland	60.54%	158
If your organisation is not listed please provide the name here.	15.71%	41
TOTAL		261

Q2: What type of role do you have within your organisation?

ANSWER CHOICES	RESPONSES	
Administration	5.36%	14
Academic	0.38%	1
Allied Health Professional	18.01%	47
Ambulance Services	1.92%	5
Dentistry	1.53%	4
Doctor (Consultant, Junior, SAS, GP)	14.18%	37
Finance	1.92%	5
Health Care Support Worker	2.68%	7
Medical Associate Profession	0.00%	0
Midwifery	1.92%	5
Nursing	18.01%	47
Ophthalmology	0.00%	0
People / HR	0.00%	0
Pharmacy	4.21%	11
Physiological Profession	0.00%	0
Planning	1.15%	3
Project Management	6.90%	18
Public Health	1.15%	3
Strategy / Senior Leadership	10.34%	27
Other role not listed	10.34%	27
TOTAL		261

Q3: Do you deliver health services directly to patients?

ANSWER CHOICES	RESPONSES	
Yes	64.37%	168
No	35.63%	93
TOTAL		261

Q4: How many years' experience do you have working in healthcare?

ANSWER CHOICES	RESPONSES	
Have never worked in healthcare	1.53%	4
Less than 3 year	6.13%	16
More than 3 years but less than 10 years	15.33%	40
More than 10 years	77.01%	201
TOTAL		261

Q5: How many years' experience do you have of Value Based Healthcare?

ANSWER CHOICES	RESPONSES	
No experience of Value Based Healthcare	30.65%	80
Less than 1 year	11.11%	29
More than 1 year but less than 3 years	21.07%	55
More than 3 years but less than 5 years	10.34%	27
More than 5 years	26.82%	70
TOTAL		261

Q6: How many years leadership experience do you have?

ANSWER CHOICES	RESPONSES	
No experience	18.01%	47
Less than 3 years	15.33%	40
More than 3 years but less than 10 years	32.57%	85
More than 10 years	34.10%	89
TOTAL		261

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