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# An Introduction and Background to Value in Healthcare

# Summary

This briefing has been written to provide an introduction and background to some of the main ideas and themes around value in healthcare. It summarises the key academic papers on value, explains the main concepts and gives examples of how NHS organisations are working to improve value in their own organisations.

The definition of value is generally understood to be the health outcomes achieved that matter to patients relative to the cost of achieving those outcomes. However, the difficulty in measuring and, therefore, improving value, comes from inaccuracies in measuring outcomes and costs. The majority of the work taking place on value in healthcare at the moment is to develop more accurate costing systems and measurement of outcomes that matter to patients, alongside developing methods for improving value in practice.

Value must also be measured in relation to the whole cycle of a patient's care, rather than individual episodes across several organisations.

This briefing is an introduction to selected ideas around value. It contains links to several papers and web-based resources that can provide greater understanding of a topic that is growing in importance.

# Introduction

HFMA's Healthcare Costing for Value Institute was established with the intention of being a leader in developing the concept and application of improving value in healthcare.

The Institute builds on the success of HFMA's work to produce nationally recognised standards for costing in the NHS. It is a natural progression for NHS finance practitioners to use the intelligence gathered during the costing process to stimulate debate within and across organisations about the consistency and quality of the approach to commissioning and providing healthcare.

This document provides an introduction and background to value in healthcare by drawing on the existing literature and work taking place to promote value, in the UK and internationally. It summarises the key themes to provide members of the Institute with a quick understanding of what we mean by value and how HFMA will be contributing to its development.

The main themes we cover are:

- What do we mean by value in the health setting?
- What academic work is there on value, nationally and internationally?
- What work is being delivered within the NHS on value at a national and local level?

The sources used to inform the review include national agencies and regulators, think tanks, other Institutes and Associations, academia and individual organisations. The sources are contemporary where possible but recognise there is a significant body of academic work on value in healthcare that has been produced over the last few decades. The sources are wide-ranging but publicly available – we did not search using subscription-based tools, journals or websites.

This document is separated into summaries of the key themes and suggestions for further reading.

We use the definition that value is the ratio of outcomes to costs, as explained in more detail in the next section. The variables quality and cost are however, not well-defined. The Institute is currently using a definition of quality that includes four variables - clinical outcomes, safety, delivery of standards (for example, waiting times and infection rates) and patient experience / satisfaction. There are other definitions.

Different trusts and sectors are at different stages in improving the granularity of costing. To measure costs accurately at patient level requires good quality information about the inputs (such as staff time, theatre time and so on). HFMA is the thought leader in NHS costing and has produced the national clinical costing standards for acute and mental health services.

However, while costing at patient level in individual organisations by condition is becoming more sophisticated, the gold standard is to measure costs over the whole cycle of patient care.

## What do we mean by value in the health setting?

In the UK achieving value is a high priority for managers and politicians. A combination of safety concerns, demand for health services and financial constraints has led to the current focus on value.

Value for money has generally been understood, in the UK public sector, as the three Es: economy, efficiency and effectiveness. Economy is measured as minimising inputs spent unnecessarily, efficiency is measured as achieving the same output for reduced inputs and effectiveness as delivering a better service for the same inputs.

While considerable attention has been given to measuring expenditure and understanding costs, health outputs are less well understood. The health service has been quantified by the number of beds, outpatient attendances, hospital patient spells and GP appointments but only recently have the outcomes for patients been addressed.

One approach has been to assess the value of healthcare interventions by determining the quality life adjusted years (QALY) that patients would receive in relation to the money to be spent. This approach has been applied, notably by NICE (National Institute for Health and Clinical Excellence) but generally for drugs and medical devices rather than applied to spending by entire organisations or areas.

The Health Foundation think-tank produced a summary of the evidence (Ref. 1) around value for money in the NHS in 2006. One of its conclusions was that productivity (a proxy for value), estimated by dividing the output measure by a measure of NHS inputs, had no definitive methodology. The focus at the time was to attempt to derive a single measure of value for money to quantify the processes in place, rather than to change the processes themselves. The report explored how the additional funding made available to the NHS had been spent and what the outputs were (as opposed to health outcomes, which were not available at the time).

### Kaplan and Porter

Value in healthcare as we understand it today has largely been down to the work of Professor Robert Kaplan and Professor Michael Porter of Harvard Business School in the USA.

'The proper goal for any health care delivery system is to improve the value delivered to patients. Value in health care is measured in terms of the patient outcomes achieved per dollar expended. It is not the number of different services provided or the volume of services delivered that matters but the value. More care and more expensive care is not necessarily better care.'

*Kaplan and Porter Ref 2*

Porter and Teisberg (Ref. 3), define value as the health outcomes achieved that matter to patients relative to the cost of achieving those outcomes, often known as the value equation.

***Figure 1: The Value Equation***

$$\text{Value} = \frac{\text{Health outcomes}}{\text{Costs of delivering the outcomes}}$$

**Outcomes** are the full set of patient health outcomes over the cycle of care

**Costs** are the total costs of resources used to care for a patient's condition over the care cycle

For the numerator of the value equation Porter (Ref. 4) identified three categories of outcomes.

***Figure 2: Porter's Outcome Measures Hierarchy***

| | |
|---|---|
| Tier 1 Patient health status achieved or retained | • Survival<br>• Degree of health or recovery achieved or retained |
| Tier 2 Process of recovery | • Time required to achieve recovery (e.g. time to diagnosis, time to treatment plan, duration of treatment)<br>• Disutility of the care process (e.g. missed diagnosis, failed treatment, anxiety, discomfort, errors) |
| Tier 3 Sustainability of health | • Recurrences of original disease or associated longer-term complications<br>• New health problems created as a consequence of treatment itself |

Professor Kaplan delivered a masterclass at the HFMA Healthcare Costing for Value Institute's April 2015 conference. A write up of his lecture can be found in the HFMA Costing for Value Resource Library. He explained value is multi-faceted and it is important to differentiate between process measures – the number of readmissions for example – and real measures of good outcomes such as a cancer being in remission. Kaplan and Porter note (Ref. 2) outcomes and cost must be measured at patient level and 'must encompass the entire cycle of care for the patient's particular medical condition'.

Much of the work of identifying outcomes by medical condition is now being undertaken centrally. For example, non-profit body the International Consortium for Health Outcomes Measurement (Ref. 5) has already published outcomes for 12 conditions in 2013 and 2014 and the programme is set to expand, according to Kaplan. www.ichom.org

Kaplan has developed the costing denominator of the value equation, in particular proposing time-driven activity-based costing as the most appropriate method. Costs, like outcomes, need to be considered along the whole care cycle. Kaplan's approach to time-driven activity based costing uses process maps that identify the personnel and equipment involved in each step and the time taken.

As reported in Healthcare Finance magazine (Ref. 6), 'the next step involves identifying the total costs associated with having these different personnel available to treat patients and their total capacity – how much time these personnel actually have available for treating and caring for patients. This enables cost/minute rates to be calculated and assigned to each of the process steps for the relevant personnel. A total cost for each process is calculated and then the costs of all the process steps in a care pathway can be added up.'

Costing normally focuses on day-to-day revenue spending but it is important not to forget to include capital spending in some form when calculating total costs over the whole cycle of care. This is an area that is not currently well understood when taking decisions on large capital projects.

The final step, according to Professor Kaplan, is to devise a payment system that drives organisations to focus on value. Rather than fee-for-service, global provider budgets or global capitation budgets a bundled payment approach is needed, with a single payment given for treating a condition over the full cycle of care, with some element of pay for performance.

Taking both elements of the value equation suggests value will be increased by either focusing on improving outcomes while holding any increase in costs at a lower level than the improvement in outcomes or reducing costs while maintaining or improving quality and outcomes.

## Decisions of Value report – Academy of Medical Royal Colleges and NHS Confederation

The Academy of Medical Royal Colleges and NHS Confederation produced a report on 'Decisions of Value' (Ref. 7). One finding was that although it is widely accepted that poor quality increases costs it is less clear that improvement in outcomes reduces costs. This is an area for further research.

A further conclusion of the Decisions of Value report was that reducing error to eliminate poor care can work in times of austerity but innovation to improve quality requires additional funding. The authors note that, 'although there is a growing literature which tackles the question of how and to what extent cost and quality imperatives can be pursued simultaneously, the relationship between quality and finance remains disputed. This is partly a result of multiple usages of both terms and partly reflects the various factors that influence both domains.'

## Sir Muir Gray

Sir Muir Gray, speaking at the HFMA Commissioning Finance Forum 'Commissioning for Value' (Ref. 8), set out the NHS view of value. His work covered value for taxpayers, understood in terms of allocation of public spending budgets between programmes, between systems and within systems, as well as the technical efficiency of spending by provider organisations. Value is maximised by ensuring the right patients receive the right proportion of available resources. The government view of value also includes consideration of carbon as a cost to be considered.

## Social Value

Consideration of 'social value' (Ref. 9) potentially widens the scope of what constitutes value in health care. While the NHS remains publicly funded it is worth considering the effect of the good health of the population on other aspects of public expenditure, such as the benefits system, by making the link between a healthy population and the ability of people to work. Conversely, public spending on improving education, tackling unemployment, providing adequate housing and reducing crime can have a positive impact on population health. Consequently this can reduce the costs to the health service and affect how health care funding is allocated.

## Service Transformation

The value agenda has grown rapidly in importance over the last few years due to constraints to public spending on the NHS. The main government agencies and regulators have offered guidance about how the NHS can improve value in practice, most commonly referred to as 'transformation' of services.

Provider regulator Monitor (Ref. 10) identified savings of between £6.5 billion and £12.1 billion by 2020/21 from potential productivity gains by improving the quality, safety and efficiency of care delivered through existing services. A further £2.4 billion to £4 billion is expected to come through delivering the right care in the right settings and up to £1.9 billion from developing new ways of delivering care.

NHS England in its landmark *Five-Year Forward View* report (Ref. 11) also set out a view of how improving value could reduce costs, closing the gap between projected spend and government funding. To close the gap the report suggested the NHS would need infrastructure and operating investment to enable efficiency gains in excess of the historical trend of achievement in the NHS. The report set out how to achieve the efficiency savings and improvements to care quality through improving public health, giving patients greater control of their care, breaking down barriers between the current providers of care to redesign care pathways.

Ultimately, however, value in healthcare can never be measured accurately where patient reported metrics are used. No two patients will report the same level of satisfaction from exactly the same procedure because value to a patient is a personal, subjective thing. 'Value in health care, however, depends on who is looking, where they look, and what they expect to see' (Ref. 12).

References and further reading


1. *Value for money in the English NHS: Summary of the Evidence*, Stephen Martin and Peter C Smith, University of York, Sheila Leatherman, University of North Carolina, 2006, The Health Foundation
2. *The Big Idea: How to Solve the Cost Crisis in Health Care*, Robert S. Kaplan Michael E. Porter, September 2011, Harvard Business Review
3. *Redefining Health Care: Creating Value-Based Competition on Results*, Michael Porter and Elizabeth Teisberg, 2006, Harvard Business School Press
4. *The Strategy That Will Fix Health Care*, Michael E. Porter and Thomas H. Lee, October 2013, Harvard Business Review
5. http://www.ichom.org/medical-conditions International Consortium for Health Outcomes Measurement *(accessed 6 May 2015)*
6. *Practical value*, Steve Brown, May 2015, Healthcare Finance Magazine
7. *Factors influencing decisions of value in health care: a review of the literature*, Iestyn Williams and Hilary Brown, July 2014, University of Birmingham Health Services Management Centre
8. *Presentation by Muir Gray*, 29 April 2015, HFMA Commissioning Finance Forum 'Commissioning for Value'
9. *Introduction to social value*, Vic McLaren, July 2011, National Association for Voluntary and Community Action
10. *Closing the NHS funding gap: how to get better value health care for patients*, Monitor, October 2013, Monitor
11. *Five-Year Forward View*, NHS England, 2014, NHS England
12. *The Whole Ball Game — Overcoming the Blind Spots in Health Care Reform,* Lisa Rosenbaum, M.D., March 2013, New England Journal of Medicine


Additional resources

Better Value Healthcare website: http://www.bvhc.co.uk/

Avoiding low value care. Carrie Colla, Scott Halpern, and Bruce Landon discuss decision making regarding low-value care in a video roundtable moderated by Atul Gawande.

https://www.youtube.com/watch?v=JtNu3RXr-9s, April 2014, New England Journal of Medicine Video

# What academic work is there on value, nationally and internationally?

In the previous section we introduced the definition of value proposed by Porter and Teisberg as well as Kaplan's work on costing.

This section summarises some of the key points from academic and think-tank papers on value, outcomes, costing and payment reform. The body of literature produced on value over the last decade or so is vast and this review is intended as an introduction to selected work only.

## Kaplan and Porter

Kaplan and Porter, in *The Big Idea: How to Solve the Cost Crisis in Health Care* (Ref. 2) identify opportunities to improve value as:

- Eliminate unnecessary process variations and processes that don't add value
- Improve resource capacity utilisation
- Deliver the right processes at the right locations
- Match clinical skills to the process
- Speed up cycle time
- Optimise over the full cycle of care

But they note that costing must be accurate to calculate the effect of improvements to processes. When attempting to improve value through reducing costs, the work must be redirected where the quality of care can be maintained or improved. They write 'a cruel fact of life is that total costs will not actually fall unless providers issue fewer and smaller paychecks, consume less (and less expensive) space, buy fewer supplies, and retire or dispose of excess equipment.'

Kaplan and Porter argue that the introduction of more effective payment systems has been delayed because of difficulties in measuring costs and comparing them with outcomes. In their work they suggest outcomes and cost must be measured at patient level and 'must encompass the entire cycle of care for the patient's particular medical condition, which often involves a team with multiple specialties performing multiple interventions from diagnosis to treatment to ongoing management'.

Kaplan and Porter suggest that better outcomes often have lower total care cycle costs, where spending is increased on early detection and diagnosis, hence increasing value overall. They suggest that providers use the time-driven activity-based costing (TDABC) system to determine costs at each process step along entire patient pathways for each medical condition. This method requires providers to estimate the cost at each step of 'each of the resources used in the process and the quantity of time the patient spends with each resource'.

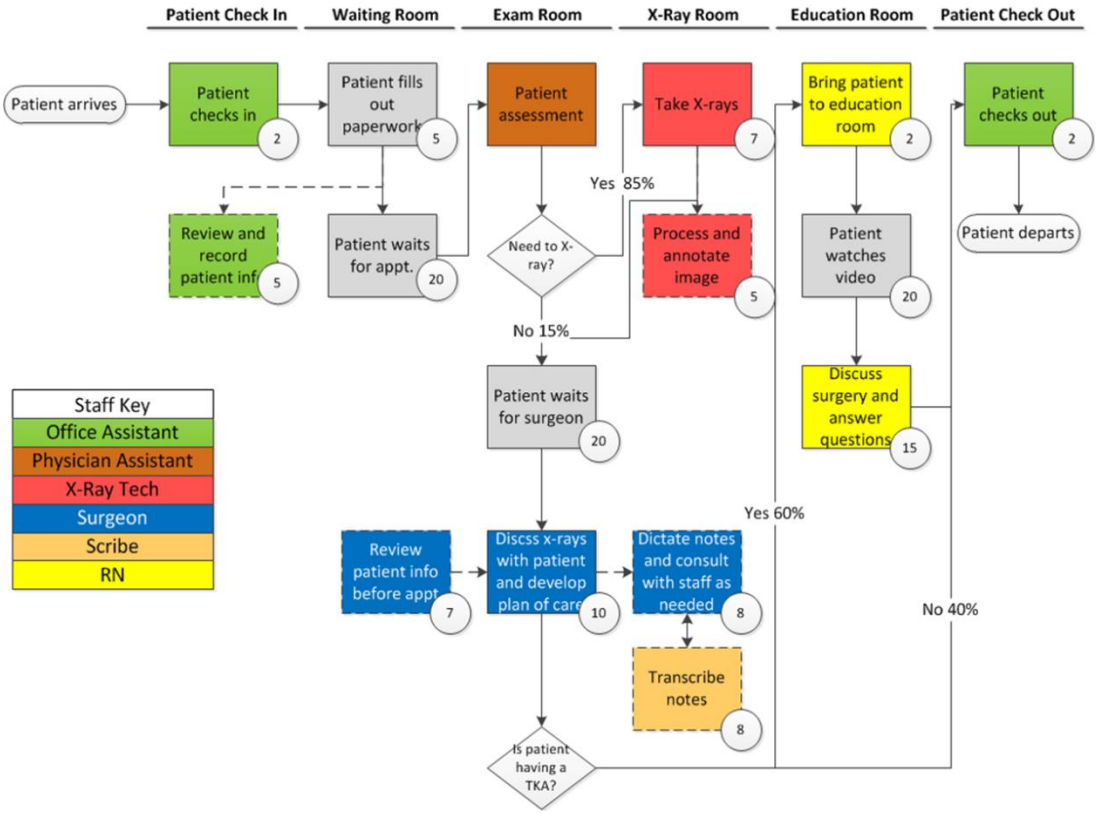
The important difference between Porter and Kaplan's model and the current method of costing in the NHS is that providers generally cost individual department or services, rather than medical conditions. This, they suggest, would 'encourage the shifting of costs from one type of service or provider to another, or to the payor or consumer' and does little to improve value.

To adopt the whole of cycle care approach can be achieved by process mapping. Kaplan says (Ref. 13) this should ideally from the primary care stage, when a patient first enters the system. He identifies three building blocks for a value-based healthcare system

- Measure and improve costs by medical condition
- Measure and communicate outcomes by medical condition
- Develop bundled payments to compensate providers for treating medical conditions.

Kaplan has focused on costing, which forms the denominator of the value equation, in particular proposing TDABC as the most appropriate method. Kaplan's approach to TDABC uses process maps to identify the personnel and equipment involved in each step and the time taken, as shown in Diagram 1.

**Diagram 1: Process map, colour coded to show for each step both the staff involved and the time taken**




Source: (Ref. 13)

The approach also provides the opportunity to identify potential cost improvements around the use of staff. For instance, high-cost surgeons may be doing work that could be done by cheaper staff who still have the right level of training to maintain quality.

## Porter and Lee

The alternative to focusing on cost reduction is to improve outcomes while maintaining expenditure. In a 2013 article *The strategy that will fix health care* (Ref. 4) Porter and Lee argue, 'we must move away from a supply-driven health care system organised around what physicians do and toward a patient-centred system organised around what patients need. We must shift the focus from the volume and profitability of services provided — physician visits, hospitalisations, procedures, and tests — to the patient outcomes achieved. And we must replace today's fragmented system, in which every local provider offers a full range of services, with a system in which services for particular medical conditions are concentrated in health-delivery organisations and in the right locations to deliver high-value care.'

They note that 'value is determined by how medicine is practised'. They argue that as the cost of providing healthcare increases and there continues to be variation in the price charged for the same treatment by different providers they will have no choice but to improve value and also be able to demonstrate that value. Put simply, 'if providers can improve patient outcomes, they can sustain or grow their market share. If they can improve the efficiency of providing excellent care, they will enter any contracting discussion from a position of strength.'

They outline a six component model to illustrate the concept, as shown in Diagram 2:

**Diagram 2: The Value Agenda**


Source: Ref. 4

The concept of the integrated practice unit (IPU) is described in more detail in the article but in essence an IPU is 'organised around a medical condition or a set of closely related conditions (or around defined patient segments for primary care). Care is delivered by a dedicated, multidisciplinary team of clinicians who devote a significant portion of their time to the medical condition. The team takes responsibility for the full cycle of care for the condition, encompassing outpatient, inpatient, and rehabilitative care, and supporting services (such as nutrition, social work, and behavioural health). Patient education, engagement, and follow-up are integrated into care.'

## Institute for Healthcare Improvement

Also in the USA, the Institute for Healthcare Improvement outlines its own approach to quality improvement as the systematic identification and elimination of waste, while maintaining or improving quality. IHI's strategy for reducing waste and enhancing value in health care is based on the following assumptions:

- Better care does not always mean higher-cost care.
- Providers will face steadily increasing pressure to take cost out of the system (in other words, reduce waste) while maintaining or increasing the quality of care.
- Health care organisations can remain financially viable and maintain an acceptable margin when revenues fall only if systems are fundamentally redesigned.

The IHI paper *Increasing Efficiency and Enhancing Value in Health Care* (Ref. 14), offers three approaches to improving value, with practical examples, around reducing waste, ensuring the right care is provided at the right time and that patients receive care that they perceive as high value.

## Mental health

NHS practitioners that have improved their costing have already noticed the ability this gives them to make changes to clinical practice too. The 2013 HFMA report on the role of the finance team in transformation (Ref. 16) found that work on mental health costing clusters led to challenge and change to clinical practice due to costing work identifying unwarranted variation. Also in mental health, one HFMA Mental Health Faculty member said of their costing work, 'the journey is as much about clinical understanding – clearly identifying what we deliver, and whether it has value for service users, as it is about the amount of money paid. Progress has been made…discussing the linkages between patient activity, interventions, outcomes, income and costs. This is a strong basis for improving the delivery of services in the future.'

## Payment systems

### Kaplan and Porter

The third point in building a value based healthcare system, according to Kaplan and Porter (Ref. 4), after improving costing and outcomes measurement is to develop bundled payments to compensate providers for treating medical conditions.
The bundled payment would cover 'a full care cycle for acute medical conditions, the overall care for chronic conditions for a defined period (usually a year), or primary and preventive care for a defined patient population (healthy children, for instance).'

### English payment system

In the English NHS the national payment system is the responsibility of NHS England and Monitor. They state, 'we want the design of the payment system to promote value for patients, where promote value means continually improve the quality of care using scarce resources sustainably' (Ref. 15).

In their paper the reforms they propose include:

- Standardising activity definitions
- Mandating patient-level cost data (PLICS)
- Developing quality metrics

**The Nuffield Trust**

In researching payment system reform The Nuffield Trust (Ref. 17) found that in Europe payments for hospital care are mainly diagnosis-related group (DRG) based and that system is expanding. The system has been in use in the English NHS for some years, introduced under the name payment by results, which is now being reformed and expanded further still. The Nuffield Trust notes that DRG-based payments are intended to cover a number of treatments/ services and that 'a general trend has been to increase the number and complexity of DRGs, leading to worries that, as the number of DRGs increases, the number of cases in some DRGs may be low – which may lead to difficulty setting stable prices from year to year.'

In the English NHS and other countries they argue DRG-based payment has increased activity and the total cost of care which has led to some countries introducing episode-based payments. The report states that, 'episode-based payment generally means the payment is made to two or more providers: for example, a hospital and its affiliated primary care doctors. Episode-based payment is intended to reward a pathway of care for an individual across providers – promoting more efficient use of expensive services (for example, hospital care, acute services), coordinated care and better quality outcomes by reducing complications and readmissions.'

The report cites one evaluation in the Netherlands. While it found that 'episode-based payment for standard care for patients with a number of common chronic health problems helped to improve both the coordination of care among health care providers and adherence to care protocols', it also found that, 'large price variations were also found that were not fully explained by differences in the amount of care provided and at a significant administrative cost (de Bakker and others, 2012)'.

One goal of payment system reform is to improve value across whole health systems rather than individual organisations. This involves some level of cooperation between clinicians in different organisations, from joint working in multi-disciplinary teams to managed care pathways where payment would cover one patient's care across several providers, including some element of pay for performance or specified outcomes.

The Nuffield Trust paper notes that the latter version is called value-based contracting and examples can be found in the Netherlands. Value-based contracting is considered to be challenging and this type of payment system requires vastly improved data on activity, cost and outcomes especially 'for some of the ambulatory and primary care based interventions, which are key components of the effective management of patients with chronic disease.'

## Preparing for a value-based healthcare system

In the USA, that country's HFMA established its Value Project, which is intended to help its members move from a volume-based to a value-based healthcare payment system.

In its report Value in Health Care (Ref. 18), HFMA USA highlights four capabilities that organisations should develop:

- 'People and culture: The ability to instil a culture of collaboration, creativity, and accountability
- Business intelligence: The ability to collect, analyse, and connect accurate quality and financial data to support organizational decision making
- Performance improvement: The ability to use data to reduce variability in clinical processes and improve the delivery, cost-effectiveness, and outcomes of care
- Contract and risk management: The ability to develop and manage effective care networks and predict and manage different forms of patient-related risk'

Thomas Lee, in *Putting the Value Framework to Work* (Ref. 19), writes about what has actually happened and what organisations are actually doing to move to value based healthcare. He notes that 'when measurement is oriented toward what happened to patients instead of what services were performed, interesting challenges and opportunities arise.' Lee says that 'to improve outcomes and efficiency for patients with specific conditions, providers must organize interdisciplinary teams around those conditions'. This is because making progress with value means capturing data from many parts of the system and taking collective accountability for performance. Lee says of provider business units, this 'pushes them toward functioning as one organization focused on delivering excellent outcomes as efficiently as possible'.

In the UK, the Academy of Medical Royal Colleges and NHS Confederation produced a report on Decisions of Value (Ref. 20). They found that 'Decisions of Value, in other words, those that balance quality, financial and operational considerations, rely on having the right relationships, behaviour and environments in place'. In particular the report notes six key factors:

- Stronger clinical and financial rapport
- Greater patient involvement
- Deeper values-based behaviour
- More information-driven decision-making
- Increasingly supportive environments
- Larger networks of peer support'

While the theory of value is becoming well established, the move towards its implementation, especially in an era of financial constraint will lead to many challenges in practice.

References and further reading


13. *Use Better Measurement of Costs and Outcomes to Align the Healthcare System around Value: Master Class for Healthcare Costing for Value Institute Conference April 2015*, Bob Kaplan, April 2015, HFMA Kaplan Video-Conference Recording
14. *Increasing Efficiency and Enhancing Value in Health Care: Ways to Achieve Savings in Operating Costs per Year*, Martin LA, Neumann CW, Mountford J, Bisognano M, Nolan TW, 2009, Institute for Healthcare Improvement
15. *How can the NHS Payment System do more for patients?,* Monitor and NHS England, 2014, Monitor and NHS England
16. *Transforming healthcare: the role for the finance team*, Richard Edwards, 2013, HFMA.
17. *Reforming payment for health care in Europe to achieve better value*, Anita Charlesworth, Alisha Davies and Jennifer Dixon, August 2012, Nuffield Trust
18. *Value in Health Care: Current State and Future Directions*, June 2011, HFMA USA http://www.hfma.org/valueproject/
19. *Putting the Value Framework to Work*, Thomas H. Lee, M.D., December 2010, New England Journal of Medicine
20. *Decisions of value*, Academy of Medical Royal Colleges and NHS Confederation, October 2014, Academy of Medical Royal Colleges and NHS Confederation


Additional resources


*What Is Value in Health Care?* Michael E. Porter, December 2010, New England Journal of Medicine
*Value-based healthcare delivery*, Professor Michael E. Porter, May 2014, Harvard Business School Institute for Strategy & Competitiveness Redefining Health Care website http://www.hbs.edu/rhc/index.html
*Measuring value for money in healthcare: concepts and tools*, Peter C Smith, Centre for Health Economics University of York, 2009, The Health Foundation

# What work is being delivered within the NHS on value at a national and local level?

## NHS Right Care

At national level, in England, there are several bodies working to help improve value in the NHS. NHS England and Public Health England are working with NHS Rightcare (Ref. 21) on a range of programmes outlining practical approaches to improving value and making use of data to direct resources to where they are most needed. Its website notes that 'the primary objective for Right Care is to maximise value:

- the value that the patient derives from their own care and treatment
- the value the whole population derives from the investment in their healthcare'.

The NHS RightCare approach is described in greater detail in an HFMA publication (Ref. 22). The underlying principles of the Right Care approach are:

- Know where to look for opportunities to improve
- Use research and evidence to determine what needs to change to deliver that improvement
- Understand how to deliver the changes by adopting and following a systematic business process that drives delivery.

**Commissioning for Value**

In conjunction with NHS England and Public Health England, NHS RightCare has developed the Commissioning for Value collaboration (Ref. 23). The programme helps CCGs identify priority programmes that offer the best opportunity to improve healthcare for their local populations. Each CCG has been provided with a bespoke Commissioning for Value data pack. This is to assist CCGs with step 1 of the RightCare approach outlined above – knowing where to look.

**Socio-technical allocation of resources (STAR)**

NHS RightCare has also developed the STAR (Socio-technical allocation of resources) approach to increasing value. This technique is used to evaluate value for individual health interventions, using routinely collected data on the number of patients benefiting from a service, demographic data about the patients and value judgements to assess the average benefit per patient treated. The outputs are visual indicators of population health gain, value for money triangles and efficiency frontiers, which help to prioritise different interventions according to their value. Further information can be found in the publication *STAR – Socio-technical allocation of resources: engaging stakeholders in decisions* (Ref. 24).

**Outcomes-based commissioning**

NHS RightCare has also produced resources on outcomes-based commissioning (Ref. 25). Outcomes-based commissioning differs from traditional commissioning in that PCTs and CCGs have previously allocated resources to programmes such as acute care or mental health, specifying inputs rather than outputs. Outcomes- based commissioning is a progression towards specifying outcomes measures under a contract, sometimes referred to as a Capitated and Outcome-Based Incentivised Contract (COBIC). The NHS has started to introduce pay for performance schemes to incentivise providers to focus on certain aspects of care that commissioners are trying to improve. One such scheme is CQUIN – Commissioning for Quality and Innovation – which allows commissioners to withhold a percentage of the contract value unless outcomes measures are met. Further information about COBIC can be found at http://www.nhsiq.nhs.uk/media/2590529/cobic_explained.pdf

## Monitor: 'Closing the Gap'

In provider organisations, at the national level promoting value is being influenced to some extent by Monitor's *Closing the Gap* report (Ref. 10), which outlined areas where Monitor believes savings will be found over the next five years.

## Five-Year Forward View: new care models

NHS England, as part of its *Five-Year Forward View* (Ref. 11) has set up a network of 'vanguard' sites, published at http://www.england.nhs.uk/ourwork/futurenhs/5yfv-ch3/new-care-models/ . In the first wave, announced in March 2015, 29 sites will take the lead in developing new models of care. The new models cover three broad aims – to integrate primary and acute care systems by joining up GP, hospital, community and mental health services; setting up multispecialty community providers by moving specialist care out of hospitals into the community and enhancing health in care homes by offering older people better, joined up health, care and rehabilitation services.

## Dalton review

Alongside this, the Department of Health asked Sir David Dalton to review organisational forms for providers that could help new models of care to develop (Ref. 26). The report identifies five themes:

- One size does not fit all
- Quicker transformational and transactional change is required
- Ambitious organisations with a proven track record should be encouraged to expand their reach and have greater impact
- Overall sustainability for the provider sector is a priority
- A dedicated implementation programme is needed to make change happen

The review recommends that a system be set up to help spread good practice in successful organisations to others.

## Scotland

In Scotland, the Scottish Government has embraced the quality improvement methods of the IHI, described in the previous section. This work links finance staff with clinical staff to ensure that high quality care is the main goal, with financial savings a secondary benefit that accrue due to the fact that high-quality care costs less than poor quality care. More details about the Scottish Patient Safety Programme can be found on the website http://www.scottishpatientsafetyprogramme.scot.nhs.uk/

## System leadership

Several examples of national programmes designed to help commissioners make best use of their resources are currently in existence but the challenge is for leadership to emerge in local health systems. It is not clear that leadership is sufficiently strong at the moment to drive the required change, as HFMA found in a recent report on system leadership (Ref. 27).

## The Nuffield Trust

The Nuffield Trust, in a 2011 report (Ref. 28) found that 'NHS priority setting has to move beyond new and marginal expenditure. PCT clusters and clinical commissioners will face the challenge of having to review their total expenditure with a view to making significant efficiency savings.'

When considering the practical aspects of using data driven approaches to prioritising budgeting they note, 'in particular, there remain questions over how technical approaches to decision making can be incorporated into broader strategies of governance, implementation and legitimisation.'

In part, the problem of making system-wide decisions is because value for providers is not the same for commissioners in all cases. As separate organisations, each will tend to protect their own bottom line. There is no guarantee that quality initiatives that are likely to result in savings will be prioritised when the savings are difficult to attribute to one organisation, potentially resulting in winners and losers. Individual organisations and their boards may be reticent of taking certain courses of action where they do not receive the benefit of cash savings directly. Linked to this focus on organisations is the problem that although providers may be the best value they can be, the care they provide could still be delivered in a different setting for greater value. The oversight for taking value decisions must be at the right level – be that organisational, local or regional.

## Other national examples

There are also notable examples of other national organisations working to promote value, including the following web-based resources:

KPMG What works – value-based organisations website
http://www.kpmg.com/Global/en/IssuesAndInsights/ArticlesPublications/value-based-organizations/Pages/default.aspx

Future Focused Finance – best possible value workstream
http://www.futurefocusedfinance.nhs.uk/blogs?type=22

UCL partners clinical quality and value theme
http://www.uclpartners.com/our-work/cross-cutting-themes/clinical-quality-and-value/

## Examples at local level

At local level there are some examples of how the NHS is responding to the pressures of financial constraints and improving quality.

- The Salford Royal NHS Foundation Trust improved its quality and financial performance by implementing the quality approach outlined by the IHI and known locally as the Advancing Quality initiative (Ref. 29).

- In the HFMA's report on the role of the finance in transformation projects (Ref. 16) we include case studies on Southern Health NHS FT's experience of integrating mental health and physical healthcare and on the Scottish Government's approach to quality.

- The NHS RightCare website provides a number of case studies, or casebooks, outlining the experiences of CCGs that have implemented the commissioning for value approach http://www.rightcare.nhs.uk/index.php/resourcecentre/commissioning-for-value-best-practice-casebooks/ .

- At the HFMA's Value in Healthcare conference in September 2013, Birmingham NHS FT demonstrated how it uses technology to measure quality indicators and report on them in better and more useful ways that allows it to improve value. The slides (Ref. 30) show the FT's quality dashboard which can provide real time data.

- At the area level the 'devo Manc' proposals are an emerging example of how local government and the NHS are planning to integrate budgets and care strategies to improve value in the Greater Manchester area. Analysis of the proposals is provided by the King's Fund http://www.kingsfund.org.uk/blog/2015/03/devo-manc-health-social-care-wellbeing-greater-manchester

- Alan Brace, Deputy Chief Executive, Director of Finance and Procurement, Aneurin Bevan Health Board and HFMA Finance Director of the year 2014 is involved with the Welsh Government work on value. Aneurin Bevan is one of four pilot sites in Wales for applying 'prudent healthcare'. The work on value-based care came about as a result of earlier work on reducing waste, harm and clinical variation and through the need for change (Ref. 31). The initiative is consistent with the Welsh government prudent healthcare programme (http://www.prudenthealthcare.org.uk/). It calls for the NHS to work on value-based principles, placing greater value on patient outcomes rather than volume of activity to create a patient-centred system.

References and further reading


21. *NHS RightCare website* http://www.rightcare.nhs.uk/ (accessed 6 May 2015)
22. *Achieving Value in Health Systems*, Matthew Cripps, 2013, HFMA
23. *NHS England Commissioning for Value* website http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/
24. *STAR – Socio-technical allocation of resources: engaging stakeholders in decisions*, Dr Mara Airoldi (London School of Economics), March 2014, NHS RightCare
25. *Outcomes-based commissioning: A Reading List produced by NHS Right Care*, Nicola Pearce-Smith, Sir Muir Gray, December 2014
26. *Examining new options and opportunities for providers of NHS care (The Dalton Review)*, Sir David Dalton, 2014, Department of Health
27. *System leadership in the NHS*, Richard Edwards, 2014, HFMA
28. *Setting priorities in health: a study of English primary care trusts,* Suzanne Robinson, Helen Dickinson, Iestyn Williams, Tim Freeman, Benedict Rumbold and Katie Spence, September 2011, Health Services Management Centre, University of Birmingham and the Nuffield Trust
29. *The Advancing Quality Initiative in the North West,* Presentation by Tony Whitfield, HFMA annual conference December 2010
30. System Changes Required to Build Quality Amidst Financial Strain, Presentation by Dame Julie Moore, HFMA Value in Health Care Delivery conference September 2013
31. *Leading from the front*, Seamus Ward, February 2015, Healthcare Finance Magazine


Additional resources


*Looking for value in hard times*, The Health Foundation, 2012, The Health Foundation
*A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost* Stiefel M, Nolan K., 2012, Institute for Healthcare Improvement.
*How Not to Cut Health Care Costs*, Robert S. Kaplan and Derek A. Haas, November 2014, Harvard Business Review