Achieving ‘Value’-
The benefits of a Population Health Management approach in delivering improved health and care outcomes and financial sustainability

Population Health Management: responsibility for managing the overall health and well being of a defined population, and being accountable for the health and well being outcomes of that defined population.
“The goal is ambitious, the approach is simple”
Aim: Clinically led, innovative service re-design focused on an integrated model of care, planned and co-ordinated around the needs of patients and families.

Time after Time\(^1\) — Health Policy Implications of a Three-Generation Case Study

Three key messages

- Reorganize care around achieving value for patients — and that we have to do it in more thoughtful and strategic ways
- Plan and deliver on wider system than just traditional clinical care
- Breaking the pattern requires long term investment in prevention and early intervention.

1 Sayer and Lee, NEJM Oct 2014
The Challenges:

1. Population level:
   • Predictably poor health outcomes
   • Lack of focus on prevention
   • Lack of personal responsibility for health
   • Too little supported self-management

2. Systems level:
   • Reactive, poorly co-ordinated services little integration
   • Focused on organisations’ needs not patients’
   • Fragmented, duplicative and inefficient
   • Reliance on unplanned care
   • Payments and incentives that do not support integration

3. Individual:
   • Complex patients mirror complex system
   • Primary care needs support to manage
   • Health and social care not integrated
   • IT systems need developing
‘Time after Time’

PHM Approach

PHM in Action

Key messages
There are many influencing factors that impact on the health of the population.

Understanding Population Health – a Managed Approach

What are the Key Determinants of Health in Camden

- **Income**: Median Household Income in Camden is high at £32,625 (10% £31,552) (UK £27,580)
- **Housing**: 13% of the population in Camden have a second address elsewhere in the UK or abroad, the fourth highest incidence of the London Boroughs
- **Education**: Highest Proportion of young people who are confirmed as being in employment, education or training (EET) in Camden has the highest proportion of EET in London at 59.5% vs 41.3%.
- **Life Expectancy**: 50.5% of Camden adult residents have degree level education
- **Socioeconomic**: Life expectancy for men and women has improved at a faster rate over the past 10 years compared to London and England.

38.3% of population are in the highest socioeconomic class

Joint Strategic Needs Assessment:

- **Health Inequalities**
  - Life expectancy gap
  - 11.6 years in men
  - Cardiovascular Disease/Cancer
- **Young People**
  - 53% black or minority ethnic, and many vulnerable children
  - High levels of looked after and children with special educational needs
  - 20% children aged 10-11 obese
- **Mental Illness**
  - 2nd prevalence of severe mental illness in England
  - Alcohol misuse

Camden is the 6th most unequal borough, with a quarter of households with an annual income of £20,000 or less, and another quarter have an annual income of > £50,000

In August 2012, 38116 received housing benefits, 29% of all households in London, and 31% for Inner London. Camden has one of the highest social rented households in London.

Groups that underachieve in the Camden School System:
- Children Eligible for free school meals – esp. white British children
- Black African children esp. Congolese and Somali
- Children with special educational needs
  - Looked after children
  - 12.7% of adults have no qualifications at all

In 2006-10 there was a 1.6 year gap in life expectancy between male residents living in the 10% most and least deprived areas (3rd highest in London). The female gap is 6.2 years (6th highest in London)

Highest benefit claimant counts are in the most socioeconomically challenged areas.
Looking at issues through a Health Lens

Three areas of financial opportunity for Camden were identified in the latest Commissioning for value packs (Oct 2016)

- Mental Health
- Cancer
- Gastroenterology

Long Term Conditions and Mental Health packs show the CCG areas for improvement:

- Cancer screening (treatment outcomes perform in line with peers).
- High rates of gastroscopy and colonoscopy.
- IAPT waits and recovery rates
- High volumes of hospital admissions and bed days for mental health
- End of life of care
- Social factors

Camden CCG has the following areas within the Improvement and Assessment Framework where improvement is required.

**Clinical Priority Areas** that require improvement:

<table>
<thead>
<tr>
<th>Area</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>Cancers diagnosed at early stage</td>
</tr>
<tr>
<td></td>
<td>62 day treatment</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>Reliance on specialist inpatient care for people with a learning disability and/or autism</td>
</tr>
<tr>
<td>Maternity</td>
<td>Women’s experience of maternity services</td>
</tr>
<tr>
<td>Mental Health</td>
<td>IAPT recovery rate</td>
</tr>
</tbody>
</table>

**Areas from the four domains** that require improvement:

- Cancer diagnosis at early stage
- IAPT recovery rate
- Children and young people mental health services for transition
- Crisis Care Mental Health Liaison
- Women’s experience of maternity services
- Digital interaction between primary and secondary care

Second highest spend per weighted population in London, reflecting reliance on acute care.

Mental Health spend amongst highest in London, but variable outcomes.

In next 10 years Camden will see growth in LTCs, including dementia and mental health. (JSNA)

Sub-populations utilise services disproportionately to their share of the population.

Deprivation increases the likelihood of someone falling within the high utilisation segment.

Co-morbidities can influence likelihood of falling in high utilisation segment e.g. mental health, dementia.

People can move both ways between the segments to better health or more complex needs.

Multiple approaches are required to meet the needs of different sub populations e.g. ACS conditions

High volume activity but low complexity versus the high cost complex but low volume
Why Population Health Management?

- **A population health management** approach starts from the perspective of understanding people, their lives and the impact of the disease processes on them, rather than treating episodes of illness and then designing and delivering pathways of care that support them.

- Planning at an individual level is not practical but by **grouping patients with similar health needs** and to find ways to respond more effectively and efficiently to those needs can help deliver measurable improvements in patient outcomes and reduce costs to the system.

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**Strategic Aim**

**Population Health Management**

**Implementation and evaluation**

**Co-design and co-production**

**Patients—Their stories and the outcomes important to them**
Principles of Population Health Management

• **Identify and engage service users**
  Need to understand patient behaviour and health needs.

• **Navigate service users through the system**
  Provide patients with timely access to care, comprehensive services (no gaps) and coordination within the system.

• **Help service users achieve their goals**
  Individuals can often describe why they struggle with improving their health. This approach engages individuals in managing their health more effectively.

• **Provide transparent measures of cost and quality**
  Systems need information such as utilisation across services and total cost of care at both the aggregate population, segmentation and individual level.

• **Nurture sustainable care delivery models**
  New care delivery models need to contain or reduce costs throughout the entire system, not shift costs from one setting to another.
The Approach

- To use Population Health for system wide planning and outcome evaluation
- To segment populations and stratify risk
- To deliver personalised health and care to individuals
- Provides continuous health and well being

Visualisation of an inner London borough’s population

- Population health is not just a dashboard
- Data needs to be put to use
Cost of Emergency Admissions for ACS Services According to Complexity of Segment

<table>
<thead>
<tr>
<th>Main Segment</th>
<th>Population in this segment</th>
<th>Total Cost of Emergency ACS conditions</th>
<th>Admissions per patient</th>
<th>Cost ACS admissions per person in the segment</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC patients who need regular management and / or monitoring</td>
<td>4,609</td>
<td>£2,036,278</td>
<td>1.2</td>
<td>£442</td>
</tr>
<tr>
<td>Patients without LTC with limited potential to use secondary care</td>
<td>50,903</td>
<td>£35,862,151</td>
<td>1.8</td>
<td>£705</td>
</tr>
<tr>
<td>LTC patients with high potential to use secondary care – most complex</td>
<td>3,001</td>
<td>£17,395,263</td>
<td>2.7</td>
<td>£5,796</td>
</tr>
</tbody>
</table>

Patients that were admitted for ACS fall into 3 of the segments within the population health management tool;

- LTC patients who need regular management and / or monitoring
- Patients without LTC with limited potential to use secondary care
- LTC patients with high potential to use secondary care – most complex

Costs vary from £442 per admission to £5,796 for the most complex patients.

Of the most complex patients:
- 74% had at least one admissions for an ACS condition
- 44% had two or more admissions
### Impact of Co-existing disease on service utilization

<table>
<thead>
<tr>
<th>Disease</th>
<th>Overall average</th>
<th>No other condition</th>
<th>One other condition</th>
<th>Two or more conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patient average</td>
<td>1,204</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>5,013</td>
<td>3,628</td>
<td>4,548</td>
<td>7,165</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>5,768</td>
<td>2,283</td>
<td>3,198</td>
<td>6,914</td>
</tr>
<tr>
<td>Chronic kidney disease</td>
<td>5,796</td>
<td>2,421</td>
<td>7,603</td>
<td>7,114</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disorder</td>
<td>5,710</td>
<td>2,213</td>
<td>3,228</td>
<td>6,768</td>
</tr>
<tr>
<td>Diabetes</td>
<td>3,007</td>
<td>1,322</td>
<td>2,048</td>
<td>6,070</td>
</tr>
<tr>
<td>Heart failure</td>
<td>3,677</td>
<td>1,397</td>
<td>2,147</td>
<td>5,398</td>
</tr>
<tr>
<td>Mental health</td>
<td>3,266</td>
<td>1,298</td>
<td>2,358</td>
<td>3,816</td>
</tr>
<tr>
<td>Hypertension</td>
<td>3,137</td>
<td>1,245</td>
<td>2,179</td>
<td>5,061</td>
</tr>
</tbody>
</table>

**Average cost (£) per patient by number of comorbidities**

- One comorbidity increases average cost by
- Two or more comorbidities increase cost by

- Atrial fibrillation having two or more comorbidities was found to increase the cost of care threefold.

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**This view of the Camden population illustrates that 30% of individuals with dementia were in the most complex segment.**

- Never accessed secondary care: 138 (13.14%)
- Healthy individuals / limited need for healthcare: 249 (23.71%)
- Maternity / acute patients without LTGs with limited potential to use secondary care: 175 (16.67%)
- LTC but healthy: 172 (16.38%)
- LTC patients who need regular management and or monitoring: 316 (30.10%)

More complex need leading to increasing utilization of secondary care.
Impact of deprivation on health outcomes suggests we need to address wider determinants of health.

Proportionate amount of most affluent accessing urgent care.

Over representation of this section utilising secondary care by the poorest segment in the North.

Equal utilisation here but unequal utilisation as you get higher needs.

Older people: 7 in 100 older people fall in high needs segment in North locality.
Children: Age/Locality/Emergency Activity – Impact of wider determinants of health are manifested in over utilisation of secondary care from the most deprived locality

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Healthy Individuals / limited need for healthcare</th>
<th>Maternity / Acute patients without LTCs with limited potential to use secondary care</th>
</tr>
</thead>
</table>
| 0-4       | Healthy Individuals: 1,187 1,417 1,737 1,911 2,475 2,510 2,746 2,801 4,301<br>Locality: North, South, West<br>Utilisation: 6,555 (20.2%)<br>6,449 (19.9%)<br>4,890 (15.1%)<br>South<br>West<br>Maternity: 522 548 839 1,063 1,131 1,788 2,159 2,326 3,269 4,509<br>Utilisation: 3,236 (28.4%)<br>2,851 (25.0%)<br>2,278 (20.0%)<br>North<br>West<br>| Healthy Individuals: 1,187 1,417 1,737 1,911 2,475 2,510 2,746 2,801 4,301<br>Locality: North, South, West<br>Utilisation: 6,555 (20.2%)<br>6,449 (19.9%)<br>4,890 (15.1%)<br>South<br>West<br>Maternity: 522 548 839 1,063 1,131 1,788 2,159 2,326 3,269 4,509<br>Utilisation: 3,236 (28.4%)<br>2,851 (25.0%)<br>2,278 (20.0%)<br>North<br>West<br>
A data-driven process for timely identification of extreme patterns in a defined region of the healthcare system. Used to guide targeted intervention and follow-up to better address patient needs, improve care quality, and reduce cost.
What can we learn?

• People who have **never utilised** services-Primary prevention to stay well
• People **generally fit and well**-Access to high quality effective and efficient services to return them quickly to normal function
• People with **long term conditions** - Early identification, community-based help and support to stay well and prevent complications
• People with **complex co-morbidities** (children, mental health or the frail elderly) - Tailored individual care packages + MDT working to maintain quality of life

Improving outcomes varies between different segments

The benefits of working with each segment to understand the outcomes important to them

• It **drives integration** as most patient-defined outcomes cannot be achieved without services working together
• It is **meaningful** to patients and care providers and forms a powerful incentive to those delivering care
• It makes service users **partners and advocates** of new models of care

**Right Person** (Targeting)

**Right Way** (Integrated System)

**Right Time** (When and where most effective)
‘Time after Time’

PHM Approach

PHM in Action

Key messages
Achieving Value-PHM in Action

Four areas identified - Outcomes poor with High Costs

- Long term conditions
- Mental health
- Frail Elderly
- Children

Within each group a targeted set of outcomes were agreed with involvement of patients and carers

New models and ways of working were developed in partnership with providers
## Common Themes-Achieving value

<table>
<thead>
<tr>
<th>Common Themes</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizens Panel</td>
<td>- &gt;1000 people-identify need, define outcomes, design and support implementation and evaluation of services</td>
</tr>
</tbody>
</table>
| Integrating Care                                                                         | - Working across organisational boundaries (Gps supported by specialists in managing range LTC)  
- Health, LA, voluntary sector working together around childrens Transition services Mind the Gap |
| Increasing investment in community-based services                                         | - Rapid response community nurses reduced hospital admissions  
- Working with LA/schools re prevention and integration of care for children with disability |
| Strengthening Primary Care                                                                | - Clear agreed pathways accessible on GP website  
- Training and education, peer review                                                     |
| Adopting a Care Planning Approach                                                        | - MDTs of providers across health and social care and wider (eg schools, housing) |
| Information Shared                                                                       | - Integrated digital record (CIDR)  
- Population Health Management Tool-planning for delivery and evaluation |
Population Health Management in Practice-Frail Elderly

- To deliver high-value care, elderly patients and their caregivers were asked, “What is most important to you?”

- They defined “time spent at home,” and care was designed to achieve that patient-defined goal in.

- That outcome — spending time at home, instead of in the hospital — became the system measure of success.

- Focusing on a single, clearly understood goal — defined by patients and embraced by all involved in their care — created powerful clarity of purpose across a complex range of providers and organizations.

- The experience shows the potential for a patient-defined outcome to drive the collaboration needed to integrate care.
Population Health Management in Practice - Frail Elderly

**Benefit to the patient:**
*Increased time spent at home*

72% of patients spent the same amount or more time at home following MDT case management.

**Benefit to the CCG:**
*Secondary care savings*

An estimated £560k has been realised in secondary care savings since the MDT began.

- Emergency admissions average monthly saving 2014 is £25,770
- A&E average monthly saving 2014 is £1140

**Benefit to the Provider:**
*Fewer emergency bed days*

An 18% reduction in emergency bed days for these patients. This extra capacity can be used to treat elective patients who actually need to be in hospital.

**Improved Outcomes:**
- Patient
- CCG
- Provider
- System

Value and the MDT

*Population Health Management in Practice - Frail Elderly*
Key Strands to Deliver Improved Outcomes

Identification
- ...of people at high risk of illness or complications
  - Adequately resourced services responsible for identifying people at high risk
  - Training
  - Maximum use of IT capability

High quality services
- Good care in the right place at the right time
  - Clearly defined pathways
  - Sufficient capacity and skills
  - Quality of care information measures & feedback

Integrated Care
- Health and social care built around people’s needs
  - Creating an environment that promotes collaboration between existing services
  - Investing in services/roles that promote integrated care
  - Contractually incentivising an integrated care approach

Improved Outcomes
Prevention where possible - Early diagnosis - Consistent quality - Patient consultation - Review and reconfigure if necessary
Population Health Management in Practice-Diabetes (LTC)

The response to the local population health challenge in Diabetes was implementation of the Diabetes Integrated Practice Unit (IPU).

Monitoring measures the impact of agreed clinical outcomes. Data developed by clinicians shows for example prevalence increasing, reductions in amputations and the number of unplanned admissions decreasing and results in a nationally-rated outstanding outcomes.
Supporting and developing Primary Care’s Role in Population Health Management

Underpinning Primary Care Infrastructure
- Extended Access
- Improve Quality
- Reduce Variability

Training & Education
10 Events held with a total of 728 attendees (Jan-Dec 2016)

Specialist Services
Team around the practice offers flexible approach to mental health interventions which has assessed 2042 patients in General Practice over 2 years

Peer Review: GP Quality Dashboard
The dashboard presents clinical outcomes, referral rates, A&E attendances, QOF reporting and patient experience, and is presented at monthly locality meetings.

The element of peer review helps identify the variation between practices, and share the successes of good practice

CCAS: Referral Management Hub
81% of Camden GPs agree that CCAS provides a good service

100% are called within 120 hours of referrals being received

GP Website
Details of 34 clinical care pathways are hosted on the GP website recording over 190K website hits (Jan-Dec ‘16)
- 92% strongly agree or agree that the site is an essential tool in their practice

Pathways

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Acne June 2022, PEP-207,55-99</td>
</tr>
<tr>
<td>B</td>
<td>Atopic Eczema June 2023, PEP-328,021,526</td>
</tr>
<tr>
<td>C.D.</td>
<td>COPD and Suggested Management Pathway August 2022, PEP-308,046-99</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Care Pathways</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Systemic Lupus Erythematosus</td>
</tr>
<tr>
<td>B</td>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
</tr>
<tr>
<td>C</td>
<td>Acne June 2022, PEP-207,55-99</td>
</tr>
<tr>
<td>D</td>
<td>Atopic Eczema June 2023, PEP-328,021,526</td>
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<tr>
<td>E</td>
<td>COPD and Suggested Management Pathway August 2022, PEP-308,046-99</td>
</tr>
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</table>
System Value – ‘Thrive’ strategy for Childrens services

Breaking the pattern through long term investment in prevention and early intervention
Resilient Families Programme - planning and delivering on a wider system than clinical care
Aims:
• Improved outcomes for Children and Young People
• Building individual, family and community resilience
• Getting it right first time
• Better use of partnership resources

Outcomes:
1. Children and Young People safe and engaged
2. Thrive at school
3. Those with additional needs meet their full potential
4. Reduction in children living in poverty
5. Children and Young People protected from violence
6. Good physical and mental health

Examples of Impacts measured:
1. Reduce% young offenders receiving custodial sentences
2. Reduce % absences from school
3. Reduce repeat referrals to social care within 12 months
4. Reduce parental workless rates
5. Reduce Domestic Violence as presenting factor to MASH
6. Reduce % children overweight/obese

Example of Score-card

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<tr>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions for mental health conditions</td>
<td>228.3</td>
<td>391.6</td>
<td>226.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>94.2</td>
<td>87.4</td>
</tr>
<tr>
<td>Children aged 4-19 overweight or obese in Camden schools</td>
<td>22.2%</td>
<td>20.4%</td>
<td>20.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>21.9%</td>
<td>22.1%</td>
</tr>
<tr>
<td>Children aged 10-11 overweight or obese in Camden schools</td>
<td>34.4%</td>
<td>34.3%</td>
<td>37.7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>38.1%</td>
<td>34.2%</td>
</tr>
<tr>
<td>Hospital admissions due to alcohol specific conditions</td>
<td>35.5 (1012)</td>
<td>40.9 (2013)</td>
<td>37.7 (2014)</td>
<td>Reported annually</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>23.7</td>
<td>36.6</td>
</tr>
</tbody>
</table>

Reduce health inequalities & promote good physical and mental health
1. % of children overweight or obese
2. Hospital admission due to alcohol
3. Mental health hospital admissions
Examples of Value Chains for Mental health Initiatives

**Activity**

- Team Around the Practice - Mental Health Workers in GP Practices
- Mind The Gap - 16-24 years Transition to Adult Services - Hub and Spoke service including gangs and isolated young people

**Output**

- Implement service to manage those who ‘Fall through existing gaps in provision:
- Provides services, support and advice - health, MH, jobs, housing etc

**Outcomes**

- Improved patient anxiety and depression and function
- Improved GP confidence to manage
- Very high patient/carer satisfaction
- Successful transition went from 3% before service to 98% post implementation

**Impact**

- Reduced A+E attendances
- Independent evaluation suggests potential wider system savings £2-3.5 million over 7 years
Time after Time

PHM Approach

PHM in Action

Key messages
Impact of a Population Health Management Approach on Patient reported experience/outcomes

% of people who feel supported to manage their long term conditions

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<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Camden</td>
<td>70%</td>
<td>71%</td>
<td>61%</td>
<td>62%</td>
</tr>
<tr>
<td>England</td>
<td>83%</td>
<td>85%</td>
<td>87%</td>
<td>88%</td>
</tr>
<tr>
<td>London</td>
<td>60%</td>
<td>61%</td>
<td>62%</td>
<td>63%</td>
</tr>
</tbody>
</table>
Impact of a Population Health Management Approach on Achieving Financial Sustainability

Movement to top performing CCG based on Elective and Non-elective admissions per 1000 weighted population

Non-elective Inpatient Admissions per 1000 weighted population
#: CCG vs National Top Decile

-3.5% p.a.

<table>
<thead>
<tr>
<th>Year</th>
<th>CCG</th>
<th>National Top Decile</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-14</td>
<td>97.2</td>
<td>101.2</td>
</tr>
<tr>
<td>2014-15</td>
<td>94.2</td>
<td>101.4</td>
</tr>
<tr>
<td>2015-16</td>
<td>90.4</td>
<td>94.7</td>
</tr>
</tbody>
</table>

Elective Inpatient Admissions per 1000 weighted population
#: CCG vs National Top Decile

-6.4% p.a.

<table>
<thead>
<tr>
<th>Year</th>
<th>CCG</th>
<th>National Top Decile</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-14</td>
<td>21.3</td>
<td>21.4</td>
</tr>
<tr>
<td>2014-15</td>
<td>20.9</td>
<td>21.4</td>
</tr>
<tr>
<td>2015-16</td>
<td>18.6</td>
<td>18.7</td>
</tr>
</tbody>
</table>

SOURCE: HES
Achievement of System Value through implementation of Population Health Management Approach

Source: NHS Right Care, CCG Spend and Outcome tool
Barriers and Benefits to Achieving Value through a Population Health management Approach

Barriers exist at multiple levels

- Change management
- Contractual form
- Individuals/Organisations
- Data

 benefits

- Commissioners and providers gain better visibility into effective care delivery. They align incentives, harmonise performance metrics and prioritize resources to respond to the distinct health needs of different patient populations.
- System benefits from increased preventative care and early intervention
- Service Users receive better co-ordinated care and enjoy better health and wellbeing

Population Health is an enabler for Integrated Care Partnerships - it puts the accountability for the health of a person into the hands of an entity as opposed to asking individual providers to deal with episodes of ill health
Three connecting value based elements

• The value of the service in the sense of the outcomes achieved for the money spent.

• The importance of organisations and individuals working together in valued partnerships.

• The importance of shared values of culture and behaviour.
Future Considerations

How far should accountability **focus on outcomes**, such as population health and wellbeing, compared to activity, standards of care, and processes? Is its focus short term or long term?

How much of the accountability should be **set nationally** and how much left to local discretion?

How far should accountability be **organization-based** and how far should it be **place-based**?

How much focus should be on **accountability** to the hierarchies, and how much to patients and the local community?

Taking a **whole system value approach** it is not always easy to measure impact of specific changes especially understanding and measuring the contribution of partnership working and shared values **BUT** the combined impact of pursuing a value-based approach:

- Increases patient and professional satisfaction within new services
- Improved outcomes
- Modified demand for acute hospital care

Source: Health Foundation, 2016
“Before I sit down, may I just say this. We hear so much of what is wrong and we hardly ever hear of what is right. It is inevitable because only misfortune is news, and we hear all the time about this little defect and that little defect and that piece of maladministration, but you know better than I do that the National Health Service as a whole is responsible for the relief of an enormous amount of human suffering and very many young people are getting benefit from it. We are being watched by practically the whole of the world to see whether this National health Service is going to be a success. We know it is going to be a success”

Aneurin Bevan 5 May 1950