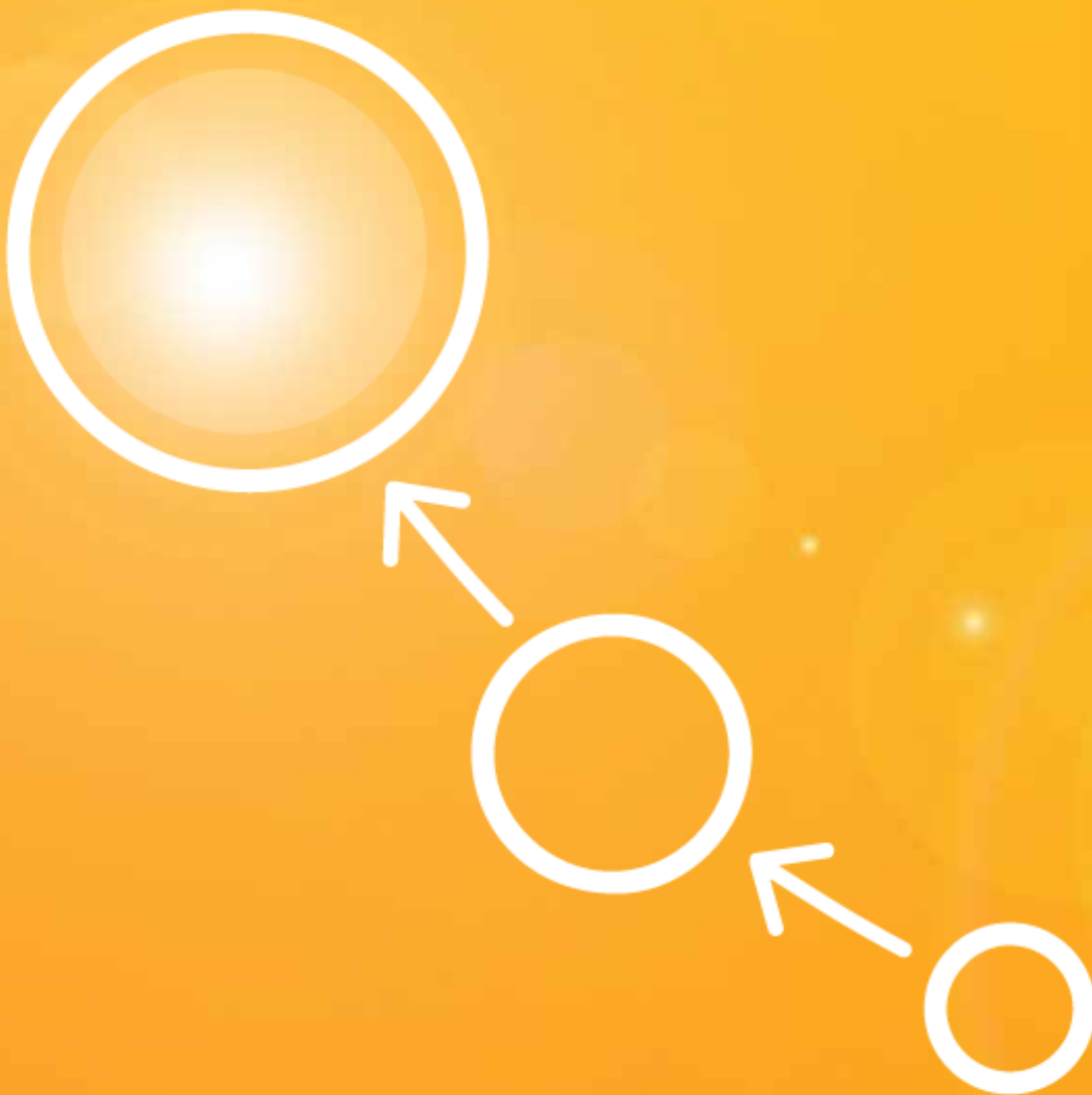




Healthcare  
**Costing**  
for **Value**  
Institute

# What finance data is required to drive value at a population level?

HFMA briefing  
June 2019





**‘For me, obtaining best value comes down to the intelligent use of data to make good decisions – whether you are a commissioner deciding what investments will have the greatest impact on your population’s health, a provider seeking to optimise a care pathway or a clinician wanting to obtain excellent outcomes for patients. In our resource-constrained world, optimal or best-value decisions will be made by combining our excellent costing information with the wealth of outcome and performance data we have at our disposal in an intelligent way.’**

**Bill Gregory, HFMA president, HFMA annual conference, December 2018**

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# Introduction

As we move to a more collaborative, integrated approach to designing, planning and delivering health services, the question of how we allocate finite resources in a way to maximise outcomes becomes increasingly important. Echoing the HFMA president's 2019 theme – 'value the opportunity' – delivering value is essential as the NHS transforms into a service fit for the future.

Our research included interviews with NHS finance staff, clinicians and transformation leads, as well as a literature review of relevant material. A key question for local health and social care systems is how they should allocate resources across their patch to maximise the outcomes for their local population. This paper focuses on what NHS finance data is required to understand how resources are currently distributed across different parts of the system. Other data sets, including outcomes and social care, will be explored in a future briefing.

By setting out what is meant by value at a population level, exploring the finance data required and sharing how some health and social care systems are developing their data flows to drive value, this briefing aims to support system leaders as they look to improve the health of their local populations in a financially sustainable way.

# Value for local populations

There is an increasing emphasis on improving population health in a financially sustainable way, with greater integration and collaborative thinking cemented in national plans across the United Kingdom<sup>1, 2, 3, 4</sup>.

England's *NHS long-term plan* states: 'Local NHS organisations will increasingly focus on population health – moving to integrated care systems everywhere'. NHS England notes: 'In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.'<sup>5</sup>

'Population health', 'population health management', 'population segmentation', and 'allocative value' are all terms used when discussing health improvement. However, the meaning of each is not always clear. The first part of this briefing looks at what we mean by these terms, before focusing on the finance data required to support value.

## Population health

Population health has strong overlaps with the public health agenda, which has been around for a long time. The King's Fund notes: 'Referring to "population health" rather than the more traditional phrase "public health" helps avoid any perception that this is only the responsibility of public health professionals. Population health is about creating a collective sense of responsibility across many organisations and individuals, in addition to public health specialists.'<sup>7</sup>

**NHS England describes population health as 'an approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population. It includes action to reduce the occurrence of ill health, including addressing wider determinants of health, and requires working with communities and partner agencies'<sup>6</sup>**

Population health is a key component of the 'Triple Aim'. The Institute for Healthcare Improvement Triple Aim<sup>8</sup> is a framework that describes an approach to optimising health system performance. It believes new ways of working must be developed to simultaneously pursue three goals:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of healthcare.

In Wales, the plan for 'a 'wellness' system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health'<sup>2</sup> is based on the Quadruple Aim. Building on the Triple Aim, it also explicitly acknowledges the critical role of the workforce in healthcare transformation by adding 'improving the experience of providing care'.<sup>9</sup>

## Population health management

NHS England states: 'Population health management improves population health by data driven planning and delivery of proactive care to achieve maximum impact. It includes segmentation, stratification and impactability modelling to identify local 'at risk' cohorts – and, in turn, designing and targeting interventions to prevent ill health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.'<sup>6</sup>

A recent report, *The transition to integrated care: population health management in England*, describes population health management as 'the concept of gathering data and insights about population health and wellbeing across multiple care and service settings, with a view to identifying the main healthcare needs of the community and adapting services accordingly.'<sup>10</sup>

<sup>1</sup> NHS, *The NHS long-term plan*, January 2019

<sup>2</sup> Welsh Government, *A healthier Wales: our plan for health and social care*, October 2018

<sup>3</sup> Department of Health, *Quality 2020 - a ten year strategy to protect and improve quality in health and social care in Northern Ireland*, November 2017

<sup>4</sup> NHS Health Scotland, *A fairer healthier Scotland - a strategic framework for action 2017-2022*, May 2017

<sup>5</sup> NHS England, *Integrated care systems*, website extract, June 2019

<sup>6</sup> NHS England, *Population health management flatpack*, April 2019

<sup>7</sup> The Kings Fund, *What does improving population health really mean?*, March 2019

<sup>8</sup> Institute for Healthcare Improvement, *The IHI Triple Aim*, website extract, June 2019

<sup>9</sup> BMJ Journals, *The Quadruple Aim: care, health, cost and meaning in work*, September 2015

<sup>10</sup> Deloitte, *The transition to integrated care: population health management in England*, March 2019

**‘[Population segmentation] can be used in understanding people’s wants and needs holistically rather than according to the healthcare setting – acute, mental, community or social care. Traditionally, the health and social care sector has been organised around groups of professionals with similar skills rather than groups of people with similar needs. It has mostly been a one size fits all approach, not exactly focused on outcomes that matter to people.’**  
**Thomas Kibasi and Sorcha McKenna, McKinsey<sup>11</sup>**

### Population segmentation

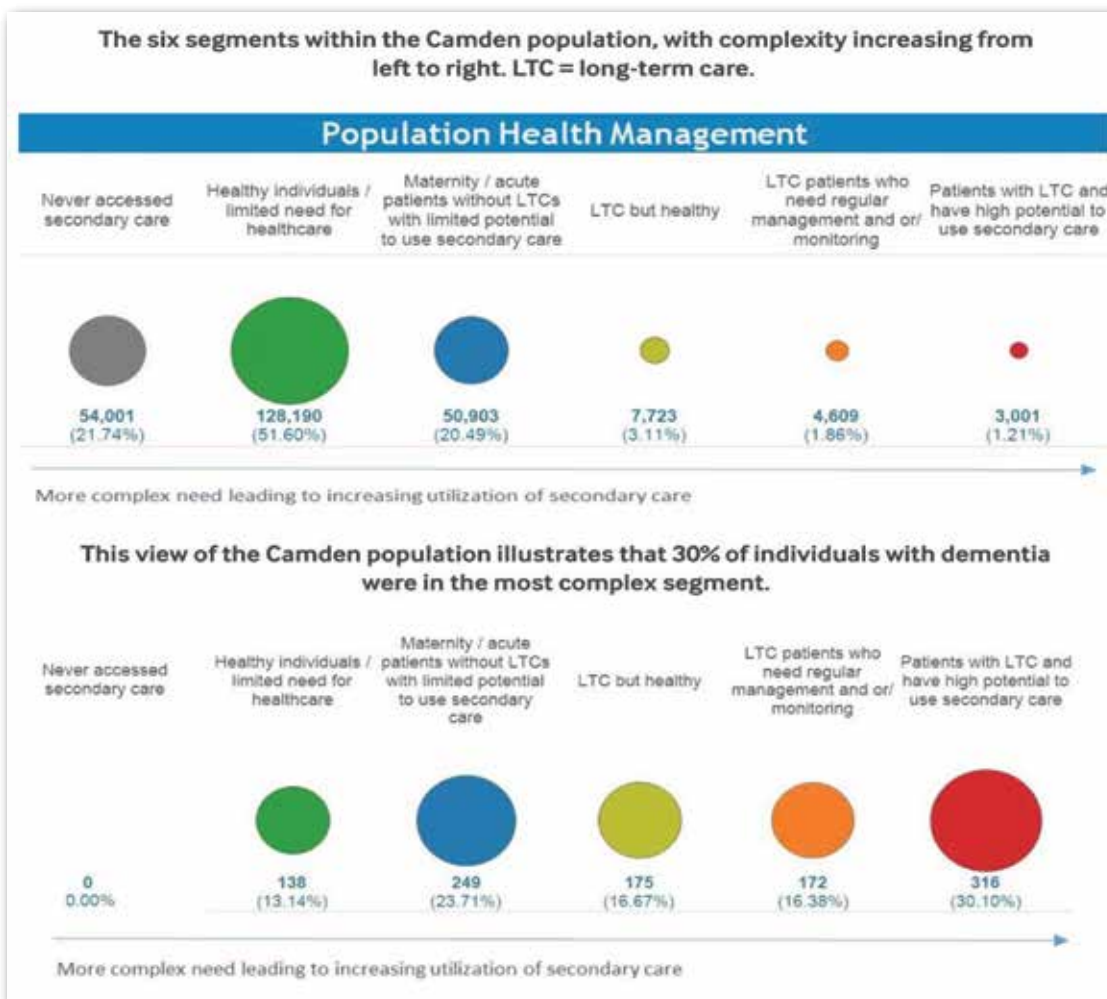
Population segmentation is the grouping of local populations into distinct categories who share similar characteristics or needs. For example, groupings based on demographics, diagnosis or the use of healthcare services reflecting the kind of care needed or how often it is needed.

By understanding the needs of the population, meaningful insights can be drawn by measuring outcomes that match those needs. Population segmentation can be used to plan and deliver services, informing the choice of schemes and services to be offered, as well as providing a more preventative and proactive approach. On a practical level, it can help focus on what is most relevant to the local population and help with prioritisation decisions.

The use of the Camden population management tool<sup>12</sup> at Camden Clinical Commissioning Group (CCG) in north London has enabled commissioners to segment the population (**Exhibit 1**), with the use of healthcare as a proxy for health need. This can provide an indication of where pathway improvements could improve health outcomes or reduce the costs of care for a particular segment of the population.

Segmentation information from the tool has been used to design an integrated diabetes service across acute, community and primary care services in Camden.

**Exhibit 1: Segmentation of the Camden CCG population by service utilisation**



Source: Camden population management tool<sup>12</sup>

<sup>11</sup> HSJ, *Segment the population to enable better integrated care*, December 2014

<sup>12</sup> Healthcare Costing for Value Institute, *A population approach to value-based healthcare*, May 2018

## Allocative value

The ambition to improve population health needs to be achieved in a financially sustainable way. This is where 'value' comes in. How can we maximise the use of resources available to improve the health of defined populations?

The notion of value in healthcare has largely been based on the work of Professor Robert Kaplan and Professor Michael Porter of Harvard Business School in the US. They define value as the 'health outcomes achieved that matter to patients relative to the cost of achieving those outcomes'. This is often referred to as the value equation (**Exhibit 2**). Professor Sir Muir Gray defines this as 'technical value' – that is, optimising the use of resources to achieve the best possible outcomes for people being treated within a given pathway or process.

Achieving technical value is important for both individual organisations and systems, but a preceding question for systems is 'how should we allocate healthcare resources across the system to maximise outcomes for our local population?'. Professor Sir Muir Gray describes this as 'population value' (**Exhibit 3**). It is also often described as allocative value or allocative efficiency – in this paper, we use the term allocative value.

Funding allocations to clinical commissioning groups (CCGs) in England are designed to take account of the needs of the local population. For example, the 2019/20-2023/24 CCG allocation includes key changes to the allocation formula, reflecting community dataset pilots, mental health data and a 12-month population average.<sup>15</sup>

Allocative value is determined by how well resources are distributed by the local health system to different subgroups in the population to meet the health needs of the local population (**Exhibit 4**).

It is key that systems consider allocative value as well as technical value. A hospital might optimise its treatment pathway such that admitted patients receive the best possible care in that setting. But this is only part of the patient's pathway; real value might be delivered if the patient had not been admitted in the first place. If someone had been identified earlier as needing support and then that support had been provided in a community setting, it may well have delivered better outcomes for patients/service users by avoiding a hospital admission and – at a system-level – reduced overall costs of treatment.

## Exhibit 2: 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

*Source: An introduction and background to value in healthcare<sup>13</sup>*

## Exhibit 3: Triple value

Professor Sir Muir Gray describes three dimensions of value:

**Personal value** Improving the outcomes that matter to an individual for a given amount of resources used not only by the health system but also by the individual and their family, recognising that the experience of care is a critical element

**Technical value** Optimising the use of resources to achieve the best possible outcomes for people being treated within a given pathway or process

**Population value** Investing resources more wisely within a health system to optimise the outcomes for the population for which the health system is responsible

*Source: Joint working vital for sustainability<sup>14</sup>*

## Exhibit 4: Allocative value

How well are resources distributed to different subgroups in the population:

- Between programmes of care – for example, between cancer and respiratory programmes?
- Between systems in each programme – for example, between asthma and chronic obstructive pulmonary disease (COPD) in the respiratory programme?
- Within each system – for example, between prevention, drug therapy, rehabilitation and long-term care for people with COPD?

<sup>13</sup> Healthcare Costing for Value Institute, *An introduction and background to value in healthcare*, June 2015

<sup>14</sup> HFMA, Blog by Professor Sir Muir Gray CBE: *Joint working vital for sustainability*, January 2019

<sup>15</sup> NHS England, *Notes on Clinical Commissioning Group (CCG) Allocations 2019/20-2023/24*, January 2019

# Finance data required to measure allocative value

Having described what we mean by population health, population health management, population segmentation and allocative value, we move on to consider what finance data is needed to support the measurement of allocative value, and what the gaps are. NHS England suggests a fully mature population health system has the right infrastructure, intelligence and interventions in place. An integrated data architecture with a single version of the truth is an important part of the infrastructure.

## Measuring allocative value

Measuring allocative value requires a wide range of data across the whole health and care system:

- Finance data, and its associated activity data, is needed to understand how resources are currently distributed across different parts of the system.
- Data on the health needs of the population and outcome data is needed to measure how effectively resources are distributed across different parts of the system.

Robust data on the allocation of resources allows systems to benchmark themselves with others and identify areas for improvement (**Exhibit 5**).

Decision-makers need information that helps them fully understand the value gained from each pound spent. Different levels of data are needed at different times to measure and explore allocative value.

High-level data, which also enables comparisons with others, is a good starting point to identify areas for further review.

More detailed data can be analysed and reviewed – with a clinical lens – to make decisions about the potential impact on both the cost and outcomes resulting from proposed changes to services.

## Exhibit 5: Understanding variation in the allocation of resources across a healthcare system

As an example, a local health system compares its spend and outcomes for its programmes of care with its peers. They find they are broadly in line except in two programmes:

- They spend £3m more on asthma than their demographic peers for worse outcomes
- They spend £2m less on mental health and have less access to services and more high-intensity users of non-mental health acute care as a result

*Can they improve their outcomes for asthma at a reduced cost, allowing them to spend more on mental health?*

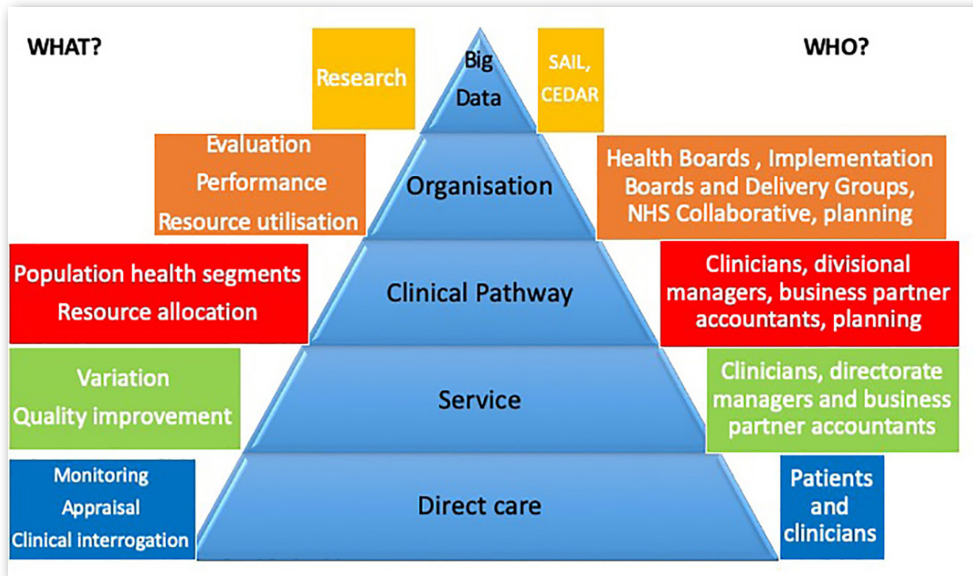
Another health system compares one programme of care with its peers, and finds significant variation:

- They allocate 12% of stroke spend to secondary prevention. Their peers allocate 15% and their population has fewer strokes, admissions and readmissions, fewer excess lengths of stay and longer healthy life expectancy

*How can they change their allocation of resources to improve outcomes for stroke?*

*Source: based on an example by Professor Matthew Cripps, director of sustainable healthcare, NHS England and NHS Improvement*

**Exhibit 6: Data requirements in Wales**



Source: Dr Sally Lewis, national clinical lead for value-based and prudent healthcare, NHS Wales<sup>16</sup>

The data pyramid in **Exhibit 6** provides an example of how NHS Wales identifies the different data requirements. It covers the programme level, sub-population level, performance and quality level. The pyramid is designed to help users map out the data required, identify where gaps exist and start to determine how they can fill those gaps.

As previously stated, this paper focuses on finance data, with outcomes data to be explored in more detail at a later date.

**What finance data is needed to measure allocative value?**

To measure allocative value, finance and its associated activity data is needed to understand how resources are distributed across different parts of the health system and across subgroups (**Exhibit 4**).

**Exhibit 7** sets out the requirements we believe finance data must meet to support healthcare systems to measure allocative value.

**Exhibit 7: Finance data requirements to measure allocative value**

Finance and activity data needs to be:

**System-wide** Measuring whole patient pathways across primary and secondary care, and linking between different organisations – primary care, community services, hospitals, ambulance and mental health

**Granular and flexible** Granular enough to be cut in different ways – for example, to match how a particular health and care system has decided to segment its population – and flexible enough to allow high-level diagnosis as well as deep-dive analysis

**Based on cost** Measuring the cost to the local system rather than being a mix of price and costs

**Timely and accurate** Up-to-date and robust enough to represent the current allocation of resources

**Accessible** Available to all organisations within a healthcare system, and to other healthcare systems to allow benchmarking

<sup>16</sup> SAIL is a secure anonymised information linkage database and Cedar is an NHS academic evaluation centre, which is part of Cardiff and Vale University Local Health Board (UHB) and Cardiff University



## What finance data is available?

The English NHS has two national financial data sets which are collated by clinical categories: programme budgeting; and reference costs and patient-level costing.

### Programme budgeting

Programme budgeting is a financial framework based on categories from the World Health Organisation's *International classification of diseases (ICD10)*<sup>17</sup>. It is the only source of financial data in England that provides information on how resources are distributed across a system or a programme of care.

Programme budgeting data is collected annually from CCGs and covers all CCG expenditure. The main purpose of the data is to provide benchmarking information enabling NHS organisations to make evidence-based investment and prioritisation decisions. CCGs are provided with guidance and mapping documents on how to allocate expenditure to programme categories and care settings.

### Reference costs and patient-level costing

All provider trusts are required to submit cost data as part of the National Cost Collections. The traditional reference cost collection is gradually being replaced by patient-level costing (commonly known as PLICS). PLICS brings together healthcare activity information with financial information at a provider level, providing detailed information about how resources are used at patient-level – for example, staff, drugs and diagnostic tests.

NHS England and NHS Improvement's *Approved costing guidance*<sup>18</sup> sets out the costing approach that NHS trusts must follow, with a set of healthcare costing standards. PLICS is currently mandated for designated acute providers and is being rolled out across ambulance trusts and mental health trusts in 2019/20, with community services following shortly afterwards.

The national PLICS portal is available to acute trusts who have successfully submitted PLICS data in 2017 and 2018. It allows providers to compare costs with their peers, and identify opportunities in a number of dimensions – for example, point of delivery, treatment function code, healthcare resource group (HRG), primary diagnosis and procedure.

The data from programme budgeting and reference costs is used as the financial element for one or more of the following national value and efficiency initiatives: NHS RightCare; the Model Hospital; and Getting it right first time (GIRFT).

Scotland, Wales and Northern Ireland take different approaches.

**Exhibit 8** overleaf sets out what national finance data sets are used by the following value and efficiency initiatives.

### NHS RightCare

The NHS RightCare programme<sup>19</sup> supports improvements in population health by providing local health economies with comparative data on spend and outcomes by programmes of care. The *NHS atlases of variation*<sup>20</sup> demonstrate that there is significant unwarranted variation in access to health services, quality, cost and outcomes across England. Bespoke data packs for each CCG and sustainability and transformation partnership (STP) highlight the top priorities and best opportunities to increase value by addressing unwarranted variation. The data packs are made publicly available on NHS RightCare's website.

There are a number of examples where the NHS RightCare approach has been successfully used to identify opportunities for improvement. For example, in Lancashire and South Cumbria, NHS RightCare highlighted musculoskeletal (MSK) disorders as an outlier. As a result, clinicians and managers together have agreed changes that will be evaluated after six months against set objectives.

NHS Scotland introduced its own atlas of variation in 2018. NHS Forth Valley used the atlas to identify a higher than average rate of knee replacements and a lower than average age of surgery than the rest of Scotland, leading to a project plan for improvement, designed collaboratively by healthcare and local authority partners.

### The Model Hospital

The Model Hospital<sup>21</sup> provides a comparative view of NHS operational productivity at a provider level. It is broken down into six sections offering different perspectives from which to review hospital activity: board-level oversight; clinical service lines; corporate service lines; people; care settings; and clinical support services. Using a weighted activity unit (WAU), it helps NHS trusts compare their productivity on a like-for-like basis. Versions of the Model Hospital have recently been launched for mental health, community and ambulance services. The Model Hospital is only accessible by trusts.

### GIRFT

GIRFT is designed to improve the quality of care within the NHS by reducing unwarranted variations at a provider level. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.<sup>22</sup> There are currently over 40 clinical workstreams under way, predominantly in the acute surgical and medical specialties. Trusts are provided with their own bespoke data packs.

<sup>17</sup> NHS England, *Programme budgeting*, website

<sup>18</sup> NHS England and NHS Improvement, *Approved costing guidance*, ongoing

<sup>19</sup> NHS England, *NHS RightCare pathways*, website

<sup>20</sup> NHS England, *Atlases*, website

<sup>21</sup> NHS Improvement, *The Model Hospital*, website

<sup>22</sup> *Getting it right first time*, website

**Exhibit 8: Finance data sets used by national value and efficiency programmes**

Data collection	National programmes using the data	Intelligence available in national programmes
Programme budgeting	NHS RightCare	<p><b>CCG and STP data packs</b> A suite of resources tailored to local health systems to support local discussions and inform further in-depth analysis</p> <p><b>Long-term condition scenarios</b> Comparing the impact of sub-optimal scenarios against an ideal pathway for a range of separate long-term conditions</p> <p><b>Atlases of variation</b> Identifying variations in care by relating investment, activity and outcome to the whole population in need rather than those who happen to make contact with a particular service</p> <p><b>Casebooks</b> Sharing commissioning innovations that highlight the philosophy and tools behind the NHS RightCare programme</p> <p><b>NHS RightCare pathways</b> Providing a set of resources to support local health economies to concentrate their improvement efforts</p>
Reference costs <sup>23</sup>	The Model Hospital	<ul style="list-style-type: none"> <li>• Information on how a provider trust is performing in comparison to their self-selected peers</li> <li>• Relevant information at board, specialty, functional and workforce levels</li> <li>• Themed compartments, presenting key performance metrics within these areas</li> <li>• User-selectable peers for each compartment.</li> </ul>
	GIRFT	<p>Recommendations are highlighted through national specialty reports as well as trust level implementations plans. Trusts are provided with bespoke data packs.</p> <p>National reports currently available:</p> <ul style="list-style-type: none"> <li>• Spinal services</li> <li>• Oral and maxillofacial surgery</li> <li>• Urology</li> <li>• Cranial neurosurgery</li> <li>• Cardiothoracic surgery</li> <li>• Vascular surgery</li> <li>• General surgery</li> <li>• Adult elective orthopaedic services</li> </ul>

<sup>23</sup> The intention is that in future, reference costs will be replaced by PLICS in the Model Hospital and GIRFT data sets

### What are the gaps in finance data to support the measurement of allocative value?

The *NHS long-term plan*, and the vision for the NHS across the United Kingdom, set a clear aspiration for the use of data to support population health management.

Earlier in this briefing, we explored what finance data is needed to measure allocative value, setting out the key criteria. **Exhibit 9** compares the two national finance data sets in England – programme budgeting and reference costs/ PLICS against the requirements set out in **Exhibit 7**.

**Exhibit 9** shows that the current national finance data sets do not fully meet the needs of healthcare systems in order to measure how resources are allocated across services.

**‘We will deploy population health management solutions to support ICSs to understand the areas of greatest health need and match NHS services to meet them. Over the coming years these solutions will become increasingly sophisticated in identifying those groups of people who are at risk of adverse health outcomes and predict which individuals are most likely to benefit from different health and care interventions, as well as shining a light on health inequalities. We will be able to routinely identify missed elements of pathways of care for individuals and ensure that those gaps are filled. This will also support greater transparency of health and social care data on population health outcomes and organisational performance.’**  
*NHS long-term plan, January 2019<sup>1</sup>*

### Exhibit 9: How well do the current national finance data sets support the measurement of allocative value?

	Programme budgeting	Reference costs/ PLICS
System-wide		<ul style="list-style-type: none"> <li>• Data not linked across organisations</li> <li>• No primary care data</li> </ul>
Granular and flexible	<ul style="list-style-type: none"> <li>• Can't cut data in different ways</li> </ul>	<ul style="list-style-type: none"> <li>• Not all sectors have PLICS yet</li> </ul>
Based on cost	<ul style="list-style-type: none"> <li>• Based on CCG spend</li> </ul>	
Timely and accurate	<ul style="list-style-type: none"> <li>• Most recent data available is 2014/15</li> <li>• Concerns over accuracy</li> </ul>	<ul style="list-style-type: none"> <li>• New PLICS data sets need time to become stable and robust</li> </ul>
Accessible		<ul style="list-style-type: none"> <li>• PLICS data only available to trusts who submit PLICS</li> </ul>

*Green indicates that the data set meets the criteria; amber indicates that it meets the criteria in part; red denotes where the data set does not meet the criteria.*

### Programme budgeting

Programme budgeting offers a system-wide view, but is not granular enough to be cut in different ways – for example, to match how a particular health and care system has decided to segment its population, or flexible enough to allow high-level diagnosis as well as deep-dive analysis.

Based on CCG spend, it does not provide healthcare systems with the true system cost of resources.

Although CCGs continue to submit programme budgeting data on an annual basis, the most recent programme budgeting data available in the NHS RightCare focus packs is 2014/15. NHS England recognises that there are concerns regarding the accuracy of programme budgeting data – for example, in London 33% of CCG spend is recorded as ‘other’.

### Reference costs/PLICS

While reference costs/PLICS capture cost data for acute, community, mental health and ambulance services, they do not capture the costs of primary care, and currently do not link the costs of care across different organisations. The sectors are at different stages in the implementation of PLICS. Acute services now have access to granular data at patient level, but the majority of mental health and community services have yet to implement PLICS.

The relatively recent introduction of the new PLICS costing standards means that it will take some time before the data sets become stable and robust. Reference costs are publicly accessible, but PLICS data is only available to those trusts that have submitted PLICS data.

### Fragmented data landscape

Those healthcare systems that are starting to explore value at a population level are faced with the challenge of a fragmented finance data landscape. There is a wide range of finance and activity data held in different formats and places. Significant amounts of time are spent by all staff in inputting data into templates and systems, not always knowing what it is used for. This is acknowledged in the *NHS long-term plan* (see extract below).

Although there are a number of resources available to NHS organisations, particularly to act as a diagnostic tool pointing users in the right direction for further discussion, currently data to support system-wide allocation decisions is made up of a jigsaw of different pieces in different places.

In addition, there is the added complexity of funding flows across boundaries to consider. Achieving one single, accessible and simple version of the truth – which could be cut and sliced depending on the level or view of information needed to inform allocative value decisions – is the challenge.

There are examples of healthcare systems that are beginning to fill these gaps. Surrey and Dorset are developing system-wide information on their populations through integrated working from their informatics teams. Rather than the common focus on the counting and coding challenges of recent years, data analysts in both commissioning and provider organisations are now working together to provide clinical teams and decision-makers with access to a suite of system-wide performance dashboards and population health management tools.

Outside the NHS, in Jersey the system is now able to plot costs across primary, secondary and tertiary care to identify the top 20 most costly patients (from a cohort of 100,000) over a given timeframe and assess the whole spectrum of interventions provided for them.

Similarly, in Derby, work is under way to use granular detail to combine both health and social care data to produce a resource consumption map at the patient level. The map will enable the system to identify groups of patients using the most resource, and in what setting, before assessing whether those patients’ needs can be met in a better way.

**‘The NHS is made up of hundreds of separate but linked organisations, and the burden of managing complex interactions and data flows between trusts, systems and individuals too often falls on patients and clinicians.’**

*NHS long-term plan, January 2019<sup>1</sup>*

## Broader challenges

Our research confirms that adopting an allocative value approach within health systems is at a very early stage. In many areas, it is something that is just starting to be talked about.

As well as the specific challenges about the availability of appropriate finance data for the measurement of allocative value, our interviews with NHS finance staff, clinicians and transformation leads highlighted a number of broader challenges:

### Common understanding

In many cases, there is not yet an agreed understanding of what driving value at a population level means and what it aims to achieve. It is important for finance, clinical and operational staff to have the conversation, nationally and locally, to develop this common understanding. The first section of this briefing aims to help the NHS develop this.

### Cultural change

Significant cultural change is needed to move from a competitive organisational focus to a collaborative and population-wide approach. The English NHS architecture currently drives competition and the *NHS long-term plan*<sup>1</sup> sets out an expectation that this will change. Changing mindsets will take time, leadership and engagement. Many of those interviewed are seeing a step change in contracting discussions, with a move from focusing on the value within an organisation to system value. The recent HFMA system finance and governance series looks in more detail at examples and top tips for system working – looking at aligning resource across a system<sup>24</sup>, system decision-making<sup>25</sup> and system risk management<sup>26</sup>.

### Data sharing

Sharing finance data across multiple organisations is extremely challenging. As one interviewee said: 'The data is all there but getting it is a problem.' Those healthcare systems who have managed to put in place a data-sharing agreement have found that it is a very lengthy process. Even once the agreement is in place, there can continue to be obstacles with inconsistent approaches to information governance within organisations. The Healthcare Costing for Value Institute's *Report on the value challenge pilot*<sup>27</sup> looks in more detail at the challenges of sharing data across organisations.

### Patient focused

Value-based solutions require a multidisciplinary approach, centred around the patient, or those at risk of becoming patients. Collaborative working between clinicians and finance professionals is key.

### Accountability conflicts

Allocative value requires shared ownership of goals and risks across a number of public sector organisations with different accountability mechanisms. Planning and transforming services for tomorrow on a collaborative system basis, while also being regulated on meeting current organisational targets focusing on what is happening today, is a challenge. This can act as a barrier in moving money around the system, particularly for transformational change when double-running costs may be needed or there are perceived 'losing' organisations requiring difficult risk-share arrangements.

### Reallocating funding

With competing demands on resources and multiple stakeholders, acting upon evidence to reallocate funding is difficult. The *Best possible value decision framework* supports the NHS to put value-based decision-making into practice.<sup>28, 29</sup>

### Capacity and skills

A lack of workforce time, capacity and skills mean that allocative value may fall down the agenda or not be supported by up-to-date data and tools.

<sup>24</sup> HFMA, *How do you align resource plans across the system?*, October 2018

<sup>25</sup> HFMA, *How do you support effective system decision-making?*, November 2018

<sup>26</sup> HFMA, *How do you ensure robust system risk management arrangements?*, December 2018

<sup>27</sup> Healthcare Costing for Value Institute, *Report on the value challenge pilot*, May 2017

<sup>28</sup> Future-Focused Finance, *Best possible value decision framework*, ongoing

<sup>29</sup> HFMA, Blog by Paul Miller: *The importance of being earnest about value*, April 2019

# Conclusion

This briefing has explored what is meant by value at a population level and has considered what finance data is required to understand how resources are currently distributed across different parts of local health systems.

Adopting a value-based approach to improving population health will support the delivery of the long-term aspirations for health and social care, transforming the way NHS services are delivered in a sustainable way. Although progress is being made in pockets across the United Kingdom, further work is required for this to become common-place. There is a need for open and honest discussions within systems about how best they can manage population health and develop a shared understanding of population segmentation and allocative value.

Measuring allocative value requires a wide range of data. First, finance data is needed to understand how resources are currently distributed to subgroups of the population. National direction and local input is needed to ensure data is flexible enough to be cut in different ways for informed decision-making.

Second, data on the health needs of the population and outcomes are needed to measure how well resources are distributed. This paper has focused on finance data and we will return to the other data requirements in future research.

While some local systems are developing their own methods for gathering finance data across the system, our research demonstrates the need for a common national finance data set, which meets the criteria set out in **Exhibit 7**.

NHS England and NHS Improvement is committed to developing a national finance data set to support local health systems with allocative value. The HFMA and its Healthcare Costing for Value Institute support this ambition. Before developing or refining a national finance data set, it will be important to ask local stakeholders what finance data they need to support them to measure allocative value.

A prerequisite to all of this is the continued shift in behaviours and cultures required to allow the resulting information to be used wisely. In addition, leaders in health and social care need to ensure that in the pursuit of maximising value at a population level, sight is not lost of the experiences of individual patients. What is evident from our research is that collaboration, rather than competition, generates an opportunity to explore fundamental, outcomes-based changes in the way resources are allocated driving maximum value for our local populations. As one interviewee commented: 'It poses the question, are we doing better things rather than doing the things we already do better?'

# Acknowledgements

The HFMA is grateful to those who assisted with this research:

- Andrew Pepper, South Yorkshire and Bassetlaw ICS
- Andy Ray, Mid and South Essex Joint Commissioning Team
- Bill Gregory, Lancashire Care NHS Foundation Trust
- Claire Green, Wales Finance Delivery Unit
- Craig Wakeham, Dorset CCG
- David Phillips, Dorset CCG
- Duncan Orme, Nottingham University Hospitals NHS Trust
- Healthcare Costing for Value Institute Council and Costing Group
- Helen Atkinson, Surrey County Council
- HFMA Policy and Research Committee
- HFMA System Finance Special Interest Group
- Hywel Jones, Wales Finance Delivery Unit
- James Woodland, Dorset CCG
- Jeremy Cook, South Yorkshire and Bassetlaw ICS
- Jess Crocker, NHS England and NHS Improvement
- Karen Kirkham, Dorset CCG
- Karen McDowell, NHS Guildford and Waverley CCG
- Karl Simpkins, Cornwall & Isles of Scilly STP
- Keith Wood, NHS England
- Kerry Broadhead, Abertawe Bro Morgannwg University Health Board
- Lee Outhwaite, Chesterfield Royal Hospital NHS Foundation Trust
- Matthew Cripps, NHS England and NHS Improvement
- Matt Gaunt, Chorley and South Ribble CCG and Greater Preston CCG
- Paul Sheldon, South Warwickshire CCG
- Pete Papworth, The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust
- Phil Bradley, Northampton General Hospital NHS Trust
- Sally Lewis, NHS Wales
- Sangeeta Saran, East Berkshire CCG
- Scott Urquhart, NHS Forth Valley
- Steve Wilson, Greater Manchester Health and Social Care Partnership
- Susan Bishop, NHS Forth Valley
- Tasso Gazis, Nottingham University Hospitals NHS Trust
- Tessa Martyn, States of Jersey



## About the Healthcare Costing for Value Institute

HFMA's Institute champions the importance of value-based healthcare for supporting the delivery of high-quality financially sustainable healthcare.

Through its member network, it supports the NHS to improve costing and make the most of patient-level cost data to drive improvements in patient care and deliver efficiencies. By bringing together senior finance and clinicians to explore what value means, the Institute helps the NHS to turn the theory of value into practice and make value-based healthcare a reality.

[www.hfma.org.uk/our-networks/healthcare-costing-for-value-institute](http://www.hfma.org.uk/our-networks/healthcare-costing-for-value-institute)

## About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For nearly 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

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HEA.FIN.067 03/17

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