



South East
Clinical Senate

South East

Clinical **senate**

EMPHASISING QUALITY, DELIVERING VALUE

A briefing for clinicians in Kent Surrey and Sussex on achieving
the best patient outcomes within available resources

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Foreword

The concept of 'value' in health care is taking centre stage as one of the keys to sustainable health services in 21st century. Thanks to the pioneering work of Michael Porter and Robert Kaplan in the USA, and the vision, inspiration and influence of Professor Sir Muir Gray in the UK, there is increasing recognition that what health services now need to focus on is delivering value for patients and the population, defined as the achievement of the best patient-defined outcomes for the expended resources.

We are only at the early stages of developing methodologies to assess value, which requires a re-definition of meaningful outcomes from health care interventions (prevention, diagnostics and treatments), enablement of more active participation of patients in deciding on their best treatment through shared decision making, and having a better health economic understanding of the full pathway costs of the different treatment options available.

The South East Clinical Senate recognised that there is a low level of awareness of this value paradigm amongst health care professionals, and undertook to produce this briefing document to enhance understanding of the benefits of the value-based approach to healthcare, and make recommendations as to how clinicians in the region can take this forward in partnership with their patients and population, and managerial colleagues. It is hoped that this briefing document will help clinicians in taking forward the understanding and promotion of value in to their own practice and areas of influence.

I would like to thank members of the clinical senate's working group for their co-authorship of this report, and for the clinical senate's council for their additional review and contributions.



Dr Lawrence Goldberg,
South East Clinical Senate Chair

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1 Summary

The inexorable rise in demand for healthcare and growing pressures and constraints on the workforce and finance threaten the sustainability of the NHS. For clinicians across all disciplines, this means that we need to focus our combined resources on the care that delivers the greatest value.

Value in healthcare is defined as the achievement of the best outcomes for individual patients and for the public within available resources. It also means doing less of things that add little or no value to patients. To achieve best value will require the development and use of standardised outcome measures that are more relevant to patients (such as the impact on their functional status and wellbeing), and their more active involvement through the process

of shared decision making with well-informed patients. It also involves recognising unwarranted local variation in the delivery of high value care and addressing it.

There is increasing international recognition of the importance of addressing value in health care, and it is vital that clinicians are fully involved and helping to lead this drive, whether within their working environment or at a more strategic level. Recognising this, the South East Clinical Senate has produced this briefing for clinicians and others working in healthcare in the region, to enhance understanding of the concepts, and recommend ways for clinicians and clinical commissioners to take this forward.

2 Context

Demand for healthcare in the south east (as across the country and internationally), is increasing inexorably, due to a growing and ageing population (see fig 1), an associated increase in the prevalence of many chronic diseases (both physical and mental health conditions), co-morbidity, and related acute conditions, and a high level of public expectation of which treatments should be available on the NHS.

Age group	2017	2026	% increase
0-19	1,097	1,185	8.1%
20-39	1,115	1,125	0.8%
40-59	1,287	1,286	-0.1%
60-79	943	1,124	19.2%
80+	274	361	32.0%
Total	4,717	5,083	7.7%

Figure 1. Population projections 2017-2026, Kent, Surrey and Sussex (figures in ,000s)

In addition, an increasing array of new technologies and medicines to diagnose and treat patients adds to the cost of healthcare which needs to be delivered within a finite NHS budget (at whatever level that budget is set). At present, financial projections for the three Sustainable Transformation Partnerships (STPs) in Kent Surrey and Sussex (KSS) are a £1.2 billion increase in spend beyond planned funding by 2021 unless significant changes to the way care is organised and delivered are made¹.

In this context, individual clinicians have an explicit responsibility to ensure the wisest use of the available resources at their disposal to deliver the best outcomes, not only for their patients, but also for their local population, as described for all staff in the NHS in the NHS Constitution, and for all doctors by the General Medical Council (see box 1).

One established way to demonstrate whether good outcomes and clinical care are being delivered is by comparison across equivalent patient populations or peer organisations, such as through national clinical registries, and the national Atlas of Variation and RightCare programme. Such information is vital for understanding where the quality improvement focus should be. However what it does not address is the question of which treatments and interventions deliver the most net benefit for our patients and populations compared with the cost of doing so, i.e. which treatments and interventions are of most 'value'?

This briefing document addresses what healthcare value for patients and the public is, and how we need to re-think how we deliver care in a way that maximises value for the greatest good.

Box 1. Expectations for clinicians to use resources for maximum patient and public benefit ^{2,3}

1. The General Medical Council requires of doctors that:

Whatever your role or level in your organisation... you should be willing to demonstrate leadership in managing and using resources effectively. This means you should be prepared to contribute to discussions and decisions about a) allocating resources and setting priorities in any organisation in which you work, and b) the commissioning of services for the wider population of patients. You should have enough understanding of how finances are allocated and managed in the services in which you work to help with your role in committing resources for the benefit of patients.

2. The NHS Constitution states that:

The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.

¹Data provided by NHS England (South) on 10.4.17 for Kent and Medway, Sussex and East Surrey and Surrey Heartlands STPs combined.

²GMC Leadership and management for all doctors. 2012. Paras 79-80.

http://www.gmc-uk.org/static/documents/content/Leadership_and_management_for_all_doctors_-_English_1015.pdf

³NHS Constitution (principle 6). 2011.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf

3 What is 'value' in health care?

Value is not a financial term. It is a term that integrates high quality, safe and cost effective care that improves patient or population outcomes. It can be represented as follows:

$$\text{VALUE (of an intervention)} = \frac{\text{OUTCOME (health and social)}}{\text{RESOURCES REQUIRED (to deliver the outcome)}}$$

'Outcome' means the net long term outcomes that matter for and are experienced by the patient, taking account of the potential benefits, risks and adverse events associated with intervention, and the effect on their functional status. This applies to both investigation or treatment of an active condition, or to prevention measures.

'Resources' refers to the totality of resources required across the pathway of care (community, hospital and social care), to deliver the intervention (i.e. not just the provider tariff). It also should take account of the impact of unnecessary, duplicative and fragmented care ('waste'), the costs of adverse events, the clinical time expended, and environmental impact and opportunity costs.

Delivering value to the individual patient or to the population

This approach to determining value can equally apply to populations as well as to individual patients, though the estimated value may differ. For an individual patient, there may be a net overall benefit to them from a high cost treatment, but at a population level, there could be a greater net benefit from investing the available and limited resources in other ways, including prevention, and therefore restricting access to certain treatments, even if evidence based. This is an unavoidable and inherent tension for clinicians and managers working within the

NHS, but needs to be explicitly recognised for all those commissioning and delivering clinical services.

The relationship between increasing the resources applied to a health care intervention and the value obtained is summarised in figure 2 on the following page. When selecting patients for specific interventions, the criteria used should be referenced against the 'point of optimality', beyond which value decreases.

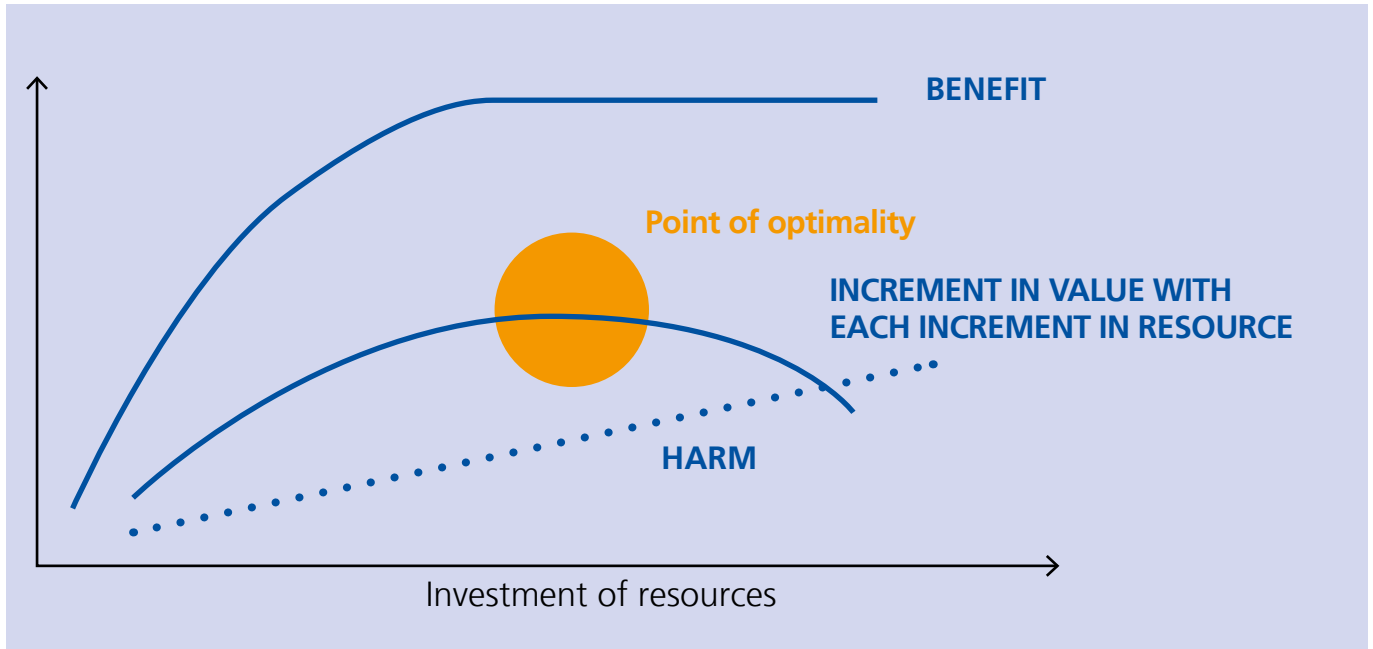


Figure 2. The relationship of increasing resources on benefits, harm and value⁴

Using this approach, health care professionals and clinical commissioners have a way of evaluating the clinical impact and cost effectiveness of the different types of care they could offer, and of determining what treatments should be prioritised, if of higher value, or restricted or withdrawn if of lower (or no) value, in the context of finite resources.

4 Variation and value

Variation in outcomes

Whilst there is a wealth of evidence-based published clinical guidelines for the delivery of high quality care, there is marked variability amongst providers in both primary care and secondary care in performance against these standards, and in clinical outcomes for different conditions and patient groups. Such variation may be 'warranted' (due to identifiable factors such as demographics and case mix), but often the variation appears unexplained or 'unwarranted', Unwarranted

variation may be due to a wide range of factors, including the local availability of services, funding decisions, local specialist interest and a range of clinician biases and sociological factors⁵. What is therefore important, if there is local unwarranted variation, is for clinicians (both from primary and secondary care, together with public health), to work jointly within their health systems (such as at STP level) to understand and reduce such variation.

⁴Concept developed by Avedis Donabadian. Described in 'A culture of stewardship: The responsibility of NHS leaders to deliver better value healthcare.' Muir Gray. NHS Confederation and Academy of Medical Royal Colleges, Sept 2015.

http://www.nhsconfed.org/~media/Confederation/Files/Publications/Documents/NHS%20DoV%20Briefing%20Document_WEB.pdf

⁵Drivers of poor medical care. Saini V et al. Lancet 2017. [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(16\)30947-3/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30947-3/abstract)

The RightCare 'Commissioning for Value' programme has analysed comparative data between all CCGs (and amalgamated at STP level), using appropriate peer groups, across a wide range of health metrics⁶. This is a key source for outcomes data and clearly demonstrates widespread

variation in the type and volume of treatments undertaken. This data is now being used by all CCGs in England to identify aspects of care for clinicians and managers to review in their own area, and work together to improve care where required.

Re-defining important outcomes for patients and the population

When determining the value of the healthcare we provide, we should be focussed on things that make a difference to patients' lives. Outcome measures are therefore best described and defined together with patients (co-produced), rather than using those that are process based or that use surrogate measures such as clinical indicators.

The development of condition specific patient outcome measures requires clinical leadership, undertaken in partnership with patients, and supported by an evidence base. There is an increasing recognition of the need for such outcomes definitions and data. The Kings Fund reviewed the benefits of putting patient reported

outcome measures (PROMs) at the heart of NHS decision making⁷. An example from the orthopaedic sphere shows the benefits of using PROMs to monitor the impact of treatments on patients' self-reported functional status⁸.

ICHOM (the International Collaboration for Health Outcomes Measurement) is providing international leadership on this work⁹, and NICE, the royal medical colleges and specialist societies are increasingly focussed on developing such metrics. A succinct and powerful case for the development and international standardisation of outcome measures relevant to patients has recently been made by Porter and colleagues¹⁰.

From outcomes to value

Whilst such data is important and useful for comparing what and how well we are doing with others, it does not however address the question of which treatments and interventions deliver the most net benefit for our patients and populations compared with the cost of doing so, i.e. which treatments and interventions are of most value?

Some treatments are effective and produce good patient outcomes, but they are very expensive, and there may

be alternative treatments available. In other cases, the diagnostics and treatments offered to patients could be seen as excessive, unjustified, and potentially harmful. There is a growing literature on the mis-directed care associated with excessive diagnostics or treatments of limited clinical effectiveness (see box 2).

⁶NHS RightCare Commissioning for Value. Home page: <https://www.england.nhs.uk/rightcare/intel/cfv/> and follow links for STP data packs, and for CCG data packs.

⁷Devlin N and Appleby J. Getting the most out of PROMs. Kings Fund 2010.

<https://www.kingsfund.org.uk/sites/files/kf/Getting-the-most-out-of-PROMs-Nancy-Devlin-John-Appleby-Kings-Fund-March-2010.pdf>

⁸Baumhauer J and Bozic K. value-based healthcare: patient-reported outcomes in clinical decision making. Clin Orthop Relat Res 2016. <https://link.springer.com/article/10.1007%2Fs11999-016-4813-4>

⁹ICHOM home page <http://www.ichom.org/why-we-do-it/> (and see video 'The power of outcome measurements in healthcare' on the webpage, and ICHOM standard sets at <http://www.ichom.org/medical-conditions/>)

¹⁰Standardizing Patient Outcomes Measurement. Porter M et al. NEJM 2014. <http://www.nejm.org/doi/pdf/10.1056/NEJMp1511701>

Box 2. Initiatives reviewing healthcare that is mis-directed or limited clinical effectiveness and value.

- **The Choosing Wisely programme**, supported in the UK by the Academy of Royal Medical Colleges¹¹, and which currently includes a list of 52 recommendations from 11 medical colleges¹².
- **The Lancet and Lown Institute 'Right Care' Initiative**¹³ (this is distinct from the NHS RightCare programme).
- **Getting It Right First Time**¹⁴, this programme commenced with adult elective orthopaedics and is being spread to another 28 specialties.
- **NICE's 'Do Not Do' recommendations**¹⁵, identifying and addressing clinical activity that is of low value will reduce inappropriate care for patients, and release resources for more clinically effective care.

Account must be taken of the resources required to deliver those outcomes, and whether those resources would achieve better overall outcomes if used differently. A health economic approach is therefore necessary if the values of different interventions are to be compared. This requires meaningful data on both patient outcomes and the costs of interventions¹⁶.

¹¹Choosing Wisely programme. Home page <http://www.choosingwisely.co.uk>

¹²Choosing Wisely speciality recommendations. <http://www.choosingwisely.co.uk/i-am-a-clinician/recommendations/#1476656741023-851ffdd6-39ae>

¹³Lown Institute and Lancet Right Care series. <http://www.thelancet.com/series/right-care>

¹⁴Getting It Right First Time. A national review of adult elective orthopaedics services in England. Briggs T, 2015. <https://www.boa.ac.uk/wp-content/uploads/2015/03/GIRFT-Executive-Summary-Mar15.pdf>

¹⁵NICE Do Not Do list recommendations, by topic. <https://www.nice.org.uk/donotdo/conditions-and-diseases>

¹⁶Laying the Foundation for Health System Transformation. World Economic Forum Value in Health Care project. http://www3.weforum.org/docs/WEF_Insight_Report_Value_Healthcare_Laying_Foundation.pdf

¹⁷Mulley A et al. Patients' preferences matter: stop the silent misdiagnosis. Kings Fund 2012.

<https://www.kingsfund.org.uk/publications/patients-preferences-matter>

5 The importance of shared decision making in achieving patient-defined value

Understanding patients' preferences

Evidence shows that what patients want often differs from what doctors (or even family members) think they want, and when patients are well informed and are asked to consider the outcomes that matter to them, they make different choices about their treatment. How they decide also depends on how the information is presented (see

box 3). The risk of misdiagnosing patient preference relates to both clinician and patient knowledge (see figure 3). Addressing such so-called 'preference misdiagnosis' can result in choosing less complex treatments, better outcomes (as described by patients), and less expenditure on procedures that patients may not want.¹⁷

Box 3. Examples of misdiagnosis of patient preferences (source Mulley et al, Kings Fund 2012)

1. For patients with breast cancer¹⁸:

- » Doctors believe that 71% of patients rate keeping their breast as a top priority, vs 7% of patients.
- » Doctors believe that 96% of patients considering chemotherapy rate living as long as possible as a top priority, vs 59% of patients.

2. For women with menorrhagia (Kennedy et al, 2002, UK)¹⁹:

- » There was a 20% relative decline in surgery rates if informed with a decision aid and interview to clarify their treatment preferences.

3. For patients referred for PCI for stable coronary artery disease (Rothberg et al, 2010, USA)²⁰:

- » Patients were 4 times more likely to believe that PCI would prevent a myocardial infarction than their cardiologists

4. For patients with mild hypertension²¹:

- » The proportion of people who would accept treatment varied between 44% and 92%, depending on how the benefits were presented.

¹⁷Mulley A et al. Patients' preferences matter: stop the silent misdiagnosis. Kings Fund 2012. <https://www.kingsfund.org.uk/publications/patients-preferences-matter>

¹⁸Lee CN et al. 2010. Development of instruments to measure the quality of breast cancer treatment decisions'. Health Expectations, 13(3): 258–72.

¹⁹Kennedy A et al. Effects of decision aids for menorrhagia on treatment choices, health outcomes, and costs: a randomized controlled trial. JAMA 2002. <http://jamanetwork.com/journals/jama/fullarticle/195580>

²⁰Rothberg M et al. Patients' and cardiologists' perceptions of the benefits of percutaneous coronary intervention for stable coronary disease. Ann Intern Med 2010. <http://annals.org/aim/article/746015/patients-cardiologists-perceptions-benefits-percutaneous-coronary-intervention-stable-coronary-disease>

²¹Misellbrook D and Armstrong D. Patients' responses to risk information about the benefits of treating hypertension. B J Gen Practice 2001. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1313976/pdf/11458479.pdf>

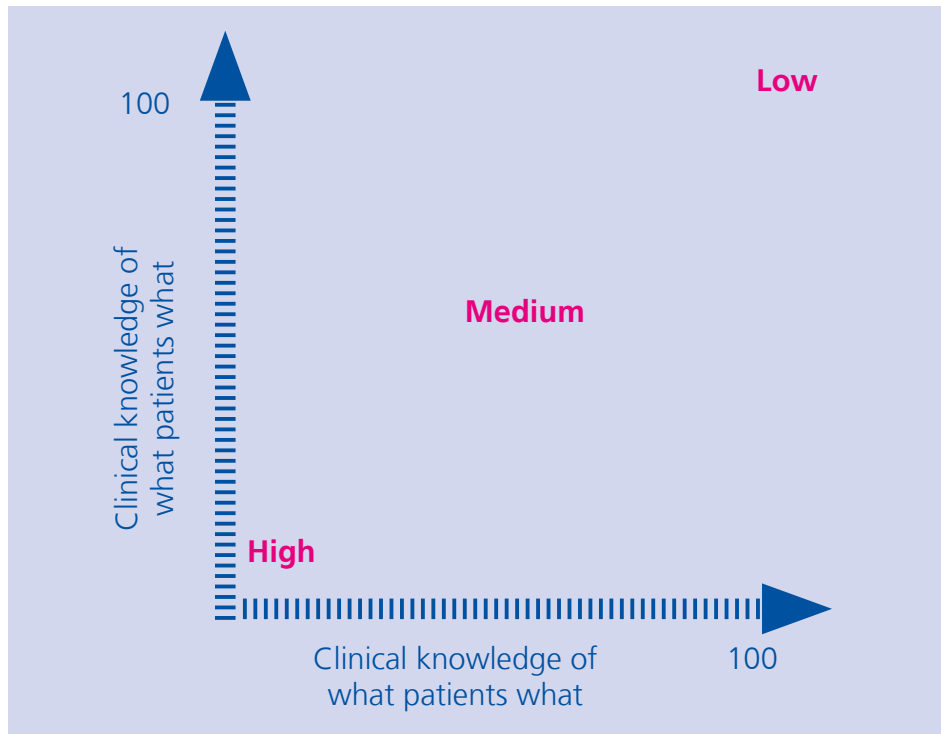


Figure 3. The risk of misdiagnosing patient preference relates to both clinician and patient knowledge²²

What is shared decision making?

Making the right decisions for patients requires a process that has been termed shared decision making (SDM). It is a collaborative process in which the patient and their clinician together decide on treatment and care, that takes into account the best evidence available, and critically, the patient's values and preferences²³. Together they share:

- The clinician's expertise, such as treatment, care or support options, evidence, risks and benefits.
- What the patient knows best: their preferences, personal circumstances, goals, values and beliefs.

The role of the clinician in SDM might better be seen as the facilitator, or guide, for the patient's decision making, rather than being the primary decision maker themselves. SDM applies across professions, and across community

and hospital based care, and is as relevant in the private healthcare sector as in the NHS.

Key to SDM is the provision of evidence based information on the benefits and risks for the potential range of treatments available, presented in an unbiased way that is easily understandable to the lay person. This will require a detailed review in many areas of care of what information should be provided, and how. These discussions should take place where possible in primary care to avoid unnecessary referrals and treatments that may not be in the patient's best interests, but also to ensure patients are better informed before seeing a specialist should they need to (depending on the complexity of the treatment or clinical condition). NICE have produced a series of decision support tools for patients for a range of conditions²⁴.

²²Mulley A et al. Patients' preferences matter: stop the silent misdiagnosis. Kings Fund 2012. <https://www.kingsfund.org.uk/publications/patients-preferences-matter>

²³Shared decision making. NHS England. <https://www.england.nhs.uk/ourwork/pe/sdm/>

²⁴NICE Patient Decision Aids (PDAs)

SDM may involve longer (or several) consultations, but as the decisions made should result in better value care (i.e. improved outcomes at less cost), consultation resources should be targeted accordingly. The need for additional time spent with the patient can be mitigated by the provision of decision aids and information to read in advance of consultations, by directing patients (and carers) to online resources, and by using a range of non-medical staff to initiate or progress the discussions. Continuity of care is of particular importance in fostering the clinician-patient relationship that enhances trust and the incremental discussions involved in shared decision making.

However, not all patients necessarily wish to be such active partners in decisions about their care, or take responsibility for it, so clinicians should be sensitive to the motivations and expectations of individual patients, and accept that some wish to take a more passive role and have decisions made for them. Involving carers and family in decision making in such situations can though, with a patient's agreement, help to ensure the best decisions are being made.

Advance care planning is an important element of shared decision making, which enables patients to describe the way they would like to be cared for in the future should they lose the capacity to make such decisions. This should be widely promoted for patients at such risk.

Factors that can distort appropriate decision making

There are many factors that influence the decision making process between clinician and patient, which are extensively discussed by Saini et al in the Lancet Right Care series²⁵. External factors include political priorities,

funding allocation formulae, misallocation of resources, payment by results tariffs, and commercial interests (drug and device industry priorities and sponsored research). Some of these are shown in box 4 on the following page.

Changing practice

The degree to which individual clinicians practice SDM is highly variable²⁶, and for it to become routine practice will require a culture change across the health care professions and within organisations. SDM is a consultation skill that most clinicians have not been formally taught or trained in. Although a range of materials is generally available about how SDM can be done (such as the training module on Health Education England's e-Learning for Healthcare site²⁷), making SDM mainstream will require a system response, and not be

left purely to individual clinicians. It will take time, energy, tools, focus, training and monitoring, which organisations will need to address. A recent review by KPMG suggests nine themes that health systems could use to self-assess, as one way forward²⁸, and Mulley²⁹ describe more generally the ways that change and innovation in current practice can be implemented. AQuA (the Advancing Quality Alliance) together with NHS RightCare have developed an important set of tools and learning for the widespread take up of SDM³⁰.

²⁵Lancet <http://thelancet.com/series/right-care>

²⁶NHS England Shared Decision Making Programme Decision point maps <https://www.england.nhs.uk/wp-content/uploads/2013/08/smd-maps.pdf>

²⁷Shared decision making online learning resource. Health Education England. <http://www.e-lfh.org.uk/programmes/shared-decision-making/how-to-access/>

²⁸Creating new value with patients, caregivers and communities. KPMG 2016. <https://assets.kpmg.com/content/dam/kpmg/pdf/2016/04/creating-new-value-with-patients.pdf>

²⁹Mulley A et al. Pages 31-45). Patients' preferences matter: stop the silent misdiagnosis. Kings Fund 2012. <https://www.kingsfund.org.uk/publications/patients-preferences-matter>

³⁰Your Health, Your Decision. Evaluation & Output Report of the AQuA Workstream within the National Shared Decision Making Programme. <https://www.aquanw.nhs.uk/resources/shared-decision-making/Your-Health-Your-Decision-Evaluation-Report.pdf>

Box 4. Beliefs and behaviours of patients and clinicians that contribute to poor decision making

Patients

- Medicine is based strictly on science.
- Testing, especially high-tech testing is accurate (poor understanding of error rates and other limits in tests and treatments).
- Unquestioning trust in the doctor's expertise.
- Fear of offending clinician by asking questions.
- My neighbour, niece, co-worker had this done, and they had a good outcome.
- Demand induced by providers and other commercial actors in the health-care industry.
- More care is better care, especially in a system without continuity of care, whereby the measure of caring is by doing rather than by being present.
- Misplaced assumptions and mistrust about financial motives of providers.
- Anxiety about uncertainty and adverse outcomes.

Clinicians

- Evidence contradicts training or practice experience.
- Clinician innumeracy.
- Over-reliance on pathophysiological and anatomical reasoning and faith in surrogate outcomes.
- A so-called better to know bias that might not be warranted.
- Improper weighing of relative risk versus absolute risk.
- Regret of omission overriding regret of commission.
- Therapeutic or technological enthusiasm.
- Recent adverse outcome, rear-view mirror bias (a manifestation of the affect heuristic).
- Defensive medicine-avoiding litigation.

6 Aligning the allocation of resources with value

To use available NHS resources to best effect, it is essential to minimise unnecessary costs and waste. The recent Carter review: 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' has identified significant variation in back office, procurement, medicines and staffing costs across hospitals for instance, and has also led to the major expansion in the Get It Right First Time (GIRFT) programme³¹.

However, there is significant additional potential for better targeting resources by focusing on delivering high value pathways and treatments, and reducing or stopping the provision of those with low or no value. To understand this better requires a consideration of the total all-in costs of patient care (not just the payment by results tariff or other fees for service), and requires a pathway-based approach, patient level costing, and consideration of

programme based budgeting. This is well summarised in a recent 'think piece' from Professors Muir Gray and Matthew Cripps³², following on from the key report from Robert Kaplan 'Costing and the pursuit of value in healthcare', which shows some of the costing techniques that can be used³³.

A good example of improving outcomes with a reduction in cost is that for liaison psychiatry, as demonstrated with the RAID (Review: Agree: Implement: Demonstrate) model. Taking a whole system approach to the analysis, there was a benefit: cost ratio of more than 4:1³⁴.

Clinicians will need to participate in the health economic assessment of current pathways and treatments, and in the potential impact of new ones, to ensure such cost benefit analyses and evaluation of value have the required clinical perspective.

³¹Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. Lord Carter. NHS Feb 2016. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

³²Chief Finance and Value Officers and Directors of Finance and Value – We Need You Now. Gray M and Cripps M. Healthcare Costing for Value Institute. Sept 2016.

<https://www.hfma.org.uk/docs/default-source/our-networks/healthcare-costing-for-value-institute/institute-publications/directors-of-finance-and-value-hfma-september-final>

³³Costing and the pursuit of value in healthcare. Kaplan R. Healthcare Costing for Value Institute. June 2015

<https://www.hfma.org.uk/docs/default-source/our-networks/healthcare-costing-for-value-institute/institute-publications/costing-and-the-pursuit-of-value-in-healthcare>

³⁴Economic evaluation of a liaison psychiatry service. Parsonage M and Fossey M. Centre for Mental Health 2011.

<https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=d6fa08e0-3c6a-46d4-8c07-93f1d44955e8>

7

Conclusion, and recommendations for embedding value based healthcare in local health systems

Changing our focus on to delivering value is a paradigm shift, that requires a change in the way clinicians and patients think about and make health-related decisions. The changes in culture, mindset and practice will require support, training, new outcome measures, better health economics, and the promotion of shared decision making.

The following are a range of recommendations to help to develop and embed value based healthcare in local health systems.

- Clinicians, patients and commissioners should work together to determine the relative value of treatments and interventions, by agreeing relevant outcome measures (particularly those for patient reported outcomes), and by calculating the comparative costs along the whole patient pathway. This approach should be undertaken for both individual patient treatments, and for population-based disease prevention strategies.
- Clinicians working across clinical pathways should be provided with information on the variation in outcomes in their area of practice using the relevant RightCare, Getting It Right First Time and other published comparative data and findings. Public health colleagues should be fully involved with the provision or relevant population data.
- Health systems (such as STPs or more local partnerships) should undertake a clinically led programme of work to identify the causes of any significant variation in patient outcomes (warranted and unwarranted), then focus on those that, if addressed, could have the biggest impact on improving value (i.e. the biggest gain in outcomes from the resources required).
- The relative value of the various screening and disease prevention strategies should be included for review when determining where resources are best directly to improve patient outcomes.
- Clinicians require training in shared decision making and the appropriate communication skills. Organisations should make this part of mandatory training, to help embed a culture and the competencies that support SDM. Medical schools for undergraduates, and royal medical colleges for trainees, should include the concept of value, and the benefits of shared decision making, in their curricula.
- Health care professionals should ensure that they and their patients have access to relevant, accurate, comprehensible and balanced information on the potential outcomes (benefits and harms) of their treatment choices. This should include local audit data and published results of complication rates. This gives patients their deserved autonomy in make decisions about their own healthcare that are consistent with their aspirations and beliefs.
- The public needs to be informed about the importance of providing value in healthcare, and their own role in supporting this through shared decision making. This should be promoted at local, regional and national levels. The NHS should develop a clear and consistent message.
- Commissioners and clinicians should aim to enhance patients' confidence and ability to make more active decisions about their own health care. The 10 key actions described in the Realising the Value report³⁵ are recommended, and an assessment of the 'patient activation measure' (PAM) tool is underway³⁶, which if successful should be widely adopted.

³⁵Realising the Value. Health Foundation and Nesta. Nov 2016. <http://www.health.org.uk/sites/health/files/RtVRealisingTheValue10KeyActions.pdf>

³⁶Patient activation. NHS England website. <https://www.england.nhs.uk/ourwork/patient-participation/self-care/patient-activation/>

- Commissioners should recognise the additional consultation time required (whether in primary or secondary care) for shared decision making, balanced by its potential cost effectiveness arising from reduced demand for specialist referrals and certain treatments when patients are fully informed of and understand the benefits and risks of alternative approaches. Non-medical staff, such as nurses or health navigators, could assist in helping patients make choices about their care.
- Performance measures should start to focus on the proportion of patients participating in shared decision making for specific primary preventative strategies (such as the management of hypertension and hypercholesterolaemia), rather than just the achievement of designated treatment targets³⁷.
- Advance care planning is an important element of shared decision making, which enables patients to describe the way they would like to be cared for in the future should they lose the capacity to make such decisions. This should be widely promoted for patients at such risk³⁸.
- Clinicians and clinical commissioners should work with patients to co-produce meaningful and relevant outcome measures.
- The Scottish NHS Chief Medical Officer's reports Realistic Medicine³⁹, and Realising Realistic Medicine⁴⁰, are key resources that describe how a whole country's health system is being mobilised to address unwarranted variation, shared decision making and value in healthcare⁴¹.

³⁷Evidence based medicine: a movement in crisis? Greenhalgh T et al. BMJ 2014. <http://www.bmj.com/content/348/bmj.g3725>

³⁸Improving advance care planning in Kent, Surrey and Sussex. South East Clinical Senate 2014. <http://www.secsenate.nhs.uk/clinical-senate-advice/published-advice-and-recommendations/advance-care-planning/>

³⁹Realistic Medicine. NHS Scotland 2015. <http://www.gov.scot/Resource/0049/00492520.pdf>

⁴⁰Realising Realistic Medicine. NHS Scotland 2016. <http://www.gov.scot/Resource/0051/00514513.pdf>

⁴¹NHS Scotland CMO blog introducing Realistic Medicine. <https://blogs.gov.scot/cmo/2017/02/27/realising-realistic-medicine/>

Appendix: Clinical senate working group and council membership

1. Membership of the South East Clinical Senate working group on value based healthcare in the South East.

Name	Roles
Alison Barnett	Deputy Centre Director, Public Health England South East.
Amit Bhargava	Clinical Chief Officer, NHS, Crawley CCG, and representing Sussex CCGs. Clinical Commissioner Sussex CCGs Collaborative
May Bullen	PPE
Peter Carpenter	KSS AHSN
Claire Fuller	Clinical Chair, Surrey Downs CCG, representing Surrey CCGs. Clinical Commissioner Surrey CCGs Collaborative
Lawrence Goldberg (Chair)	South East Clinical Senate Chair, and Chair of working group. Consultant Nephrologist, Brighton and Sussex University Hospitals NHS Trust
Larisa Han	General Practitioner, Merrow Park Surgery, Guildford
Marianne Illsley	Consultant Clinical Oncologist, and Deputy Medical Director, Royal Surrey County Hospital Foundation Trust.
Caroline Jessel	Lead for Clinical Transformation and Outcomes Medical Directorate, NHS England South East, and Lead for Sustainability and Health, NHS England South Region
Rachael Liebmann	Deputy Medical Director, and Consultant Pathologist Queen Victoria Hospital Foundation Trust
Hugh McIntyre	Consultant Physician. East Sussex Healthcare NHS Trust.
Bruce Pollington	NHS RightCare Delivery Partner
Ali Parsons	SECS Associate Director
Steve Sparks	NHS RightCare Delivery Partner

2. South East Clinical Senate Council membership.

Name	Roles
Amanda Allen	Therapy Manager, Maidstone and Tunbridge Wells NHS Trust
Sally Allum	Director of Nursing & Quality, NHS England South (South East)
Mandy Assin	Consultant Psychiatrist, Sussex Partnership NHS Foundation Trust
Alison Barnett	Deputy Centre Director, Public Health England, South East
Amit Bhargava	Clinical Chief Officer, Crawley CCG Representing Sussex CCGs
Michael Bosch	General Practitioner, Horley, Surrey
May Bullen	Independent Patient and Public Engagement
Maxine Bullen	Independent Patient and Public Engagement
Heather Caudle	Chief Nurse, Ashford & St. Peter's Hospitals NHS Foundation Trust
Priscilla Chandro	Patient and Public Engagement Representative
Peter Clarkson	Consultant Cardiologist
Charlotte Canniff	Clinical Chair North West Surrey CCG
David Davis	NHS111 Workforce National Clinical Lead, NHS England
Graeme Dewhurst	Postgraduate Dean Health Education England, Kent, Surrey & Sussex
Andrew Foulkes	General Practitioner, Avisford Medical Group, Arundel
Tony Frew	Consultant Respiratory Physician and Professor, Brighton and Sussex Medical School, Brighton and Sussex University Hospitals NHS Trust
Lawrence Goldberg	Clinical Senate Chair Consultant Nephrologist, Brighton and Sussex University Hospitals NHS Trust
Peter Green	Chief Clinical Officer, General Practitioner, NHS Medway CCG. General Practitioner. Representing Kent and Medway CCGs
Larisa Han	General Practitioner, Merrow Park Surgery, Guildford
Timothy Ho	Medical Director, and Consultant Respiratory Physician, Frimley Health NHS Foundation Trust
Des Holden	Medical Director, Surrey and Sussex Healthcare NHS Trust
Jackie Huddleston	Associate Director, SE Clinical Senate & Clinical Networks NHS England South (South East)
Marianne Illsley	Consultant Clinical Oncologist, and Deputy Medical Director, Royal Surrey County Hospital Foundation Trust
Rachael Liebmann	Registrar and Consulting Lead, Royal College of Pathologists. Deputy Medical Director, Queen Victoria Hospital, East Grinstead. Consultant Pathologist

Rachel Mackay	Head of Medicines Management NHS Guildford and Waverley Clinical Commissioning Group
Liz Moulard	Chief Nurse and Director of Clinical Standards Director of Infection Prevention and Control (DIPC) Caldicott Guardian. First Community Health and Care
Hugh McIntyre	Consultant Physician, East Sussex Healthcare NHS Trust
James Nicholl	Consultant Orthopaedic Surgeon, Maidstone and Tunbridge Wells NHS Trust
Ali Parsons	Associate Director South East Clinical Networks & Clinical Senate, NHS England South (South East)
Waqar Rashid	Consultant Neurologist, Brighton and Sussex University Hospitals NHS Trust
Jonathan Richenberg	Consultant Radiologist, Brighton and Sussex University Hospitals NHS Trust
Mansoor Sange	Consultant Anaesthetist and Intensivist, Dartford and Gravesham NHS Trust
Aneetha Skinner	Clinical Director of Adult Specialist Rehabilitation Services, Sussex Community NHS Foundation Trust
James Thallon	Medical Director, NHS England South (South East)