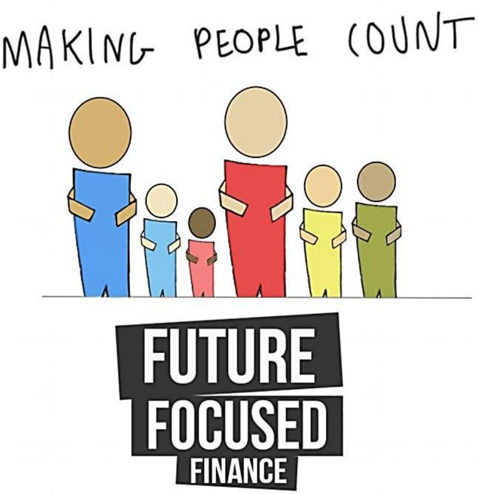

Making Best Possible Value Decisions

Jennifer Howells, NHS England
Peter Ridley, Royal Surrey County Hospital NHS foundation trust

7 July 2015

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The importance of value

The five year forward view is a means to achieve value in a sustainable NHS – using our resources wisely to maximise patient benefit in terms of both quality and access

Today's event reflects an increasing and welcome sector focus on value. We are here today to help build momentum around the sector vision and narrative that will help people put value into the way they work, assisted by our resources!

We will outline the work we are doing with the NHS finance community and a growing number of professional colleagues across clinical and managerial functions to put value at the heart of decision making.

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Future Focused Finance:

A five year programme of capability building

Six inter-related work streams

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Our mission is to deliver a Best Possible Value health service

Situation

- Demand for health services is growing faster than funding
- There is consensus that the health service must deliver better value

Challenges

- Devolved authority, cross-accountability, and conflicting incentives produce deadlocks, inefficient processes and sub-optimal results

Resolution

- A new approach that moves beyond organisation structures is needed to deliver the best possible value for patient and public

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Our aspiration for the Finance function is to be leaders in delivering value

FINANCE TODAY		FINANCE TOMORROW
Focused on cost	→	Focused on value
Work with financial metrics	→	Combine the best in financial informatics and health economics
Analyse challenges	→	Solve biggest challenges
Input into decisions	→	Leadership role as drivers of robust decision-making based on value

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How will the future be different?

At an individual decision level outcomes can be significantly improved if focused on value

<u>Decision example</u>: Decide stroke care pathway and service configuration within a hospital

NOT FOCUSED ON VALUE

- Focused on service delivery
- Different people in charge of different parts of pathway
- Considered as an isolated unit not part of a system
- Consultants not empowered to make decisions
- Lack of tools / financial framework

✗ **Stroke unit clogged**
✗ **Failed interventions**
✗ **Sub-optimal recovery** for healthy patients due to delays

FOCUSED ON VALUE

- Focused on clinical outcomes, particularly failed interventions for most unwell
- Holistic pathway view: 16% of patients use 50% resource
- Best practice, data and patient / family input considered
- Consultants empowered and given the financial framework

✓ **Improved clinical outcomes for healthy patients**
✓ **Improved experience for most unwell**
✓ **Resource reduction:** 50% of beds and 24 staff

Source: Delivery Group member interview – based on a decision made within a London hospital

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Value equation and a menu of outcomes and metrics provide a “common currency” for decision-makers

=

Outcome

Clinical effectiveness	Patient experience	Safety
e.g. population health, survival rate, extent of functional recovery	e.g. comfort, treatment by staff, waiting time, ease of access	e.g. diagnostic error, post-op complications, infections

---

Resources

Revenue costs	Capital costs
e.g. income, time, salaries, system maintenance, facilities	e.g. Investment in infrastructure / equipment

Source: based on Michael Porter (HBR, NEJM), HFMA “Value in Health Care”, Delivery Group interviews

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Overview of Best Possible Value connections with other Future Focused Finance work-streams

ELEMENTS OF BEST POSSIBLE VALUE		OTHER FFF WORK STREAMS
Value outcomes and measures	BPV defines metrics for measuring value; processes & systems required to put information in hands of those who need it	**Efficient Processes and Systems**
Decision roles and Behaviours	Promoting value requires close finance & clinical partnering	**Close Partnering**
Decision-making tools and methodology	Tools and methodologies require skills and capability building across finance and clinical professionals in order to implement	**Skills and Strengths**
Finance as leaders in delivering value	Finance's role as leader in delivering best possible value requires support and development throughout career	**Great Place to Work**
Knowledge management	Development of decision handbooks and achieving benefit of collective experience requires infrastructure to spread information and give access to all	**Foundations for Sustained Improvement**

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To deliver value we must have effective decision-making

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Why focus on decisions? Organisations have become more and more complex; a new approach is needed to ensure they're effective

"The matrix is becoming a cube"

COMMAND AND CONTROL

EMPOWERED BUSINESS UNITS

MATRIX

CUBE?

A focus on decisions can cut through this complexity

Source: Adapted from 'The Future of Work', Thomas Malone

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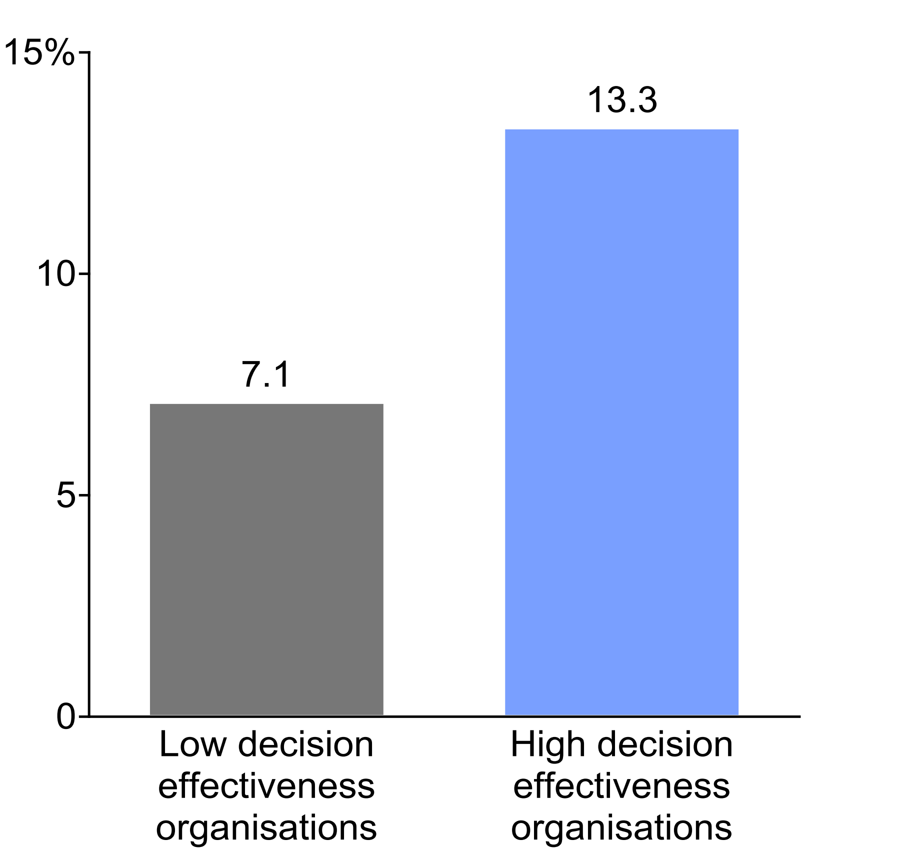
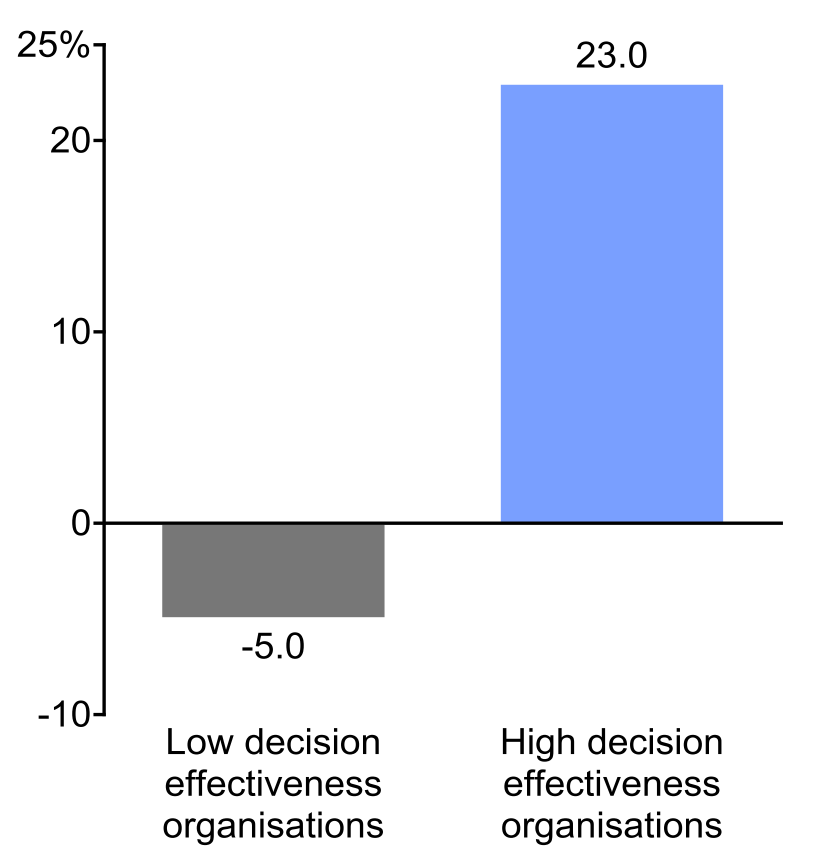
Why focus on decisions? Research shows a focus on decisions supports outperformance on financial and people dimensions





Note: High decision effectiveness range = top quintile of "decision multiplier" scores; Low/Mid = all other
Source: Worldscope; Bain decision and organisation effectiveness survey

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What makes a decision effective?

Decision effectiveness = quality, speed, yield, effort

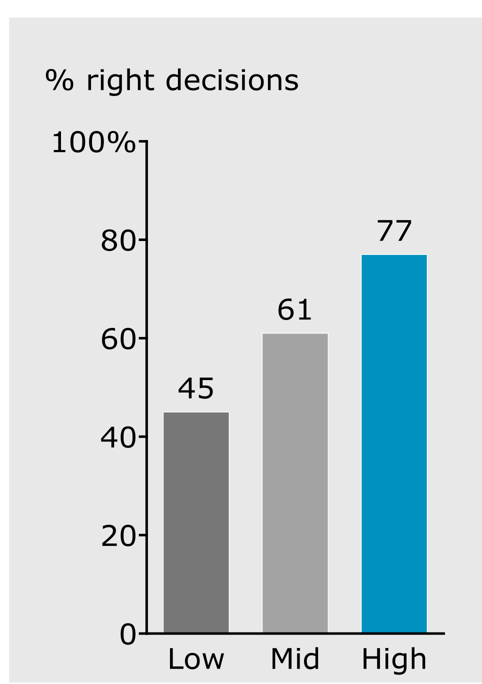
Quality x **Speed** x **Yield** - **Effort**

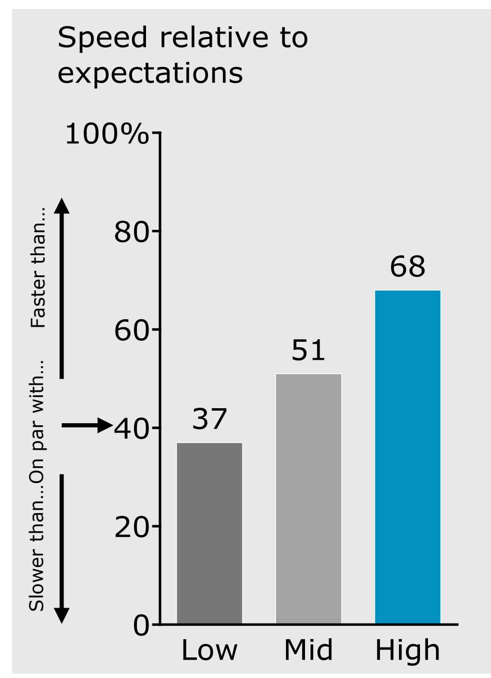
"How often do you choose the right course of action?"

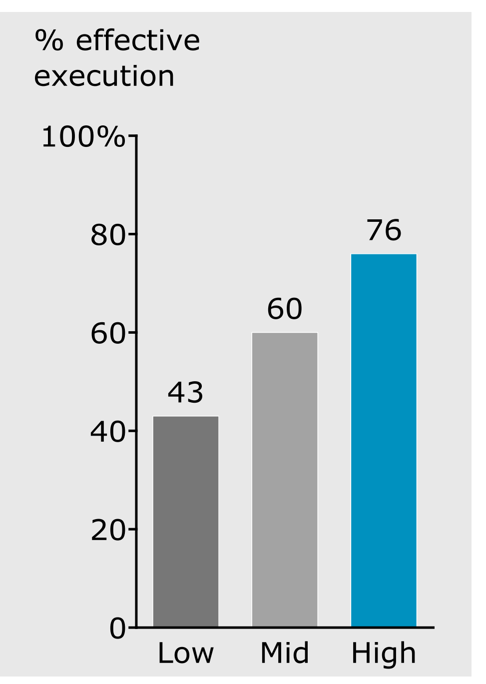
"How quickly do you make decisions vs. stakeholder expectations?"

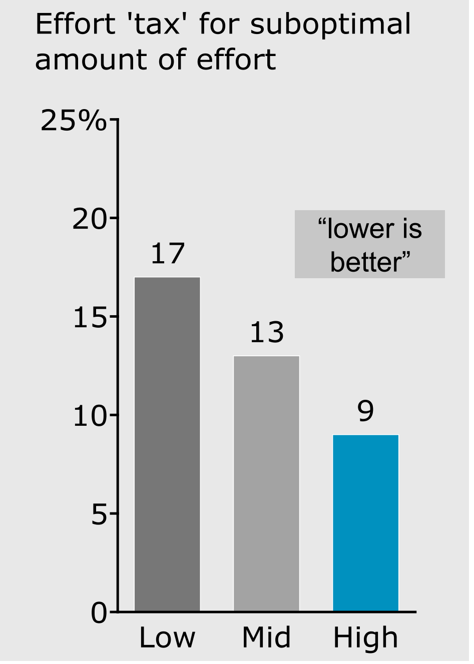
"How often do you execute decisions as intended?"

"Do you put the right amount of effort into making & executing decisions?"









Decision Effectiveness Benchmarks

High decision effectiveness range = top quintile of decision effectiveness scores; Low = bottom quintile; Mid = all other
Source: Bain decision and org effectiveness survey Jan 2013 (n=1001)

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How well do we make decisions today? NHS performs below average on each category, particularly on speed

Quality x **Speed** x **Yield** - **Effort**

"How often do you choose the right course of action?"

"How quickly do you make decisions vs. stakeholder expectations?"

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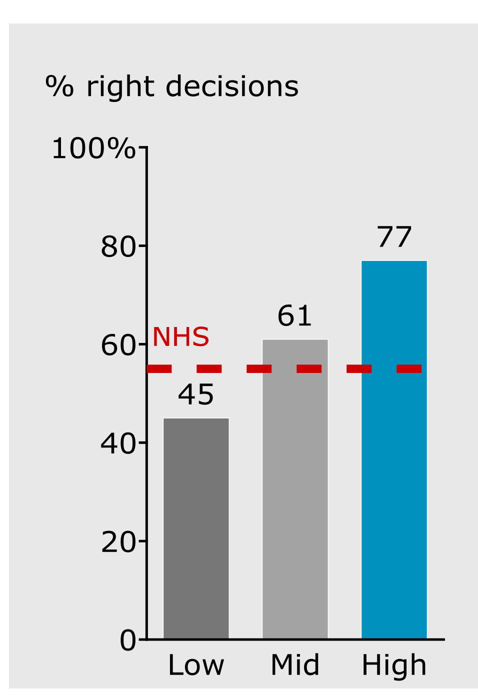

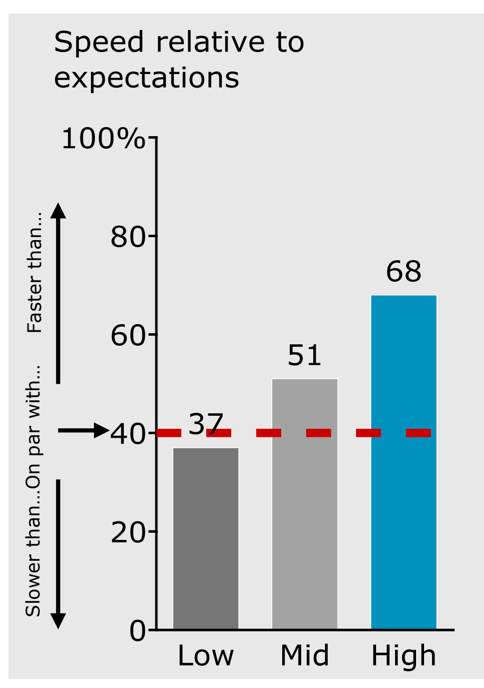

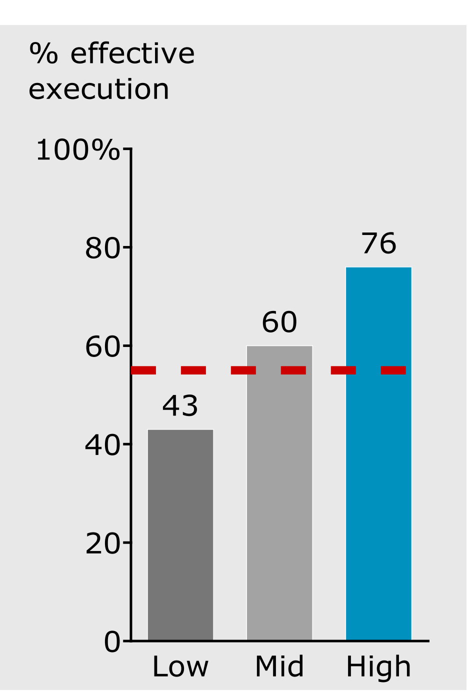

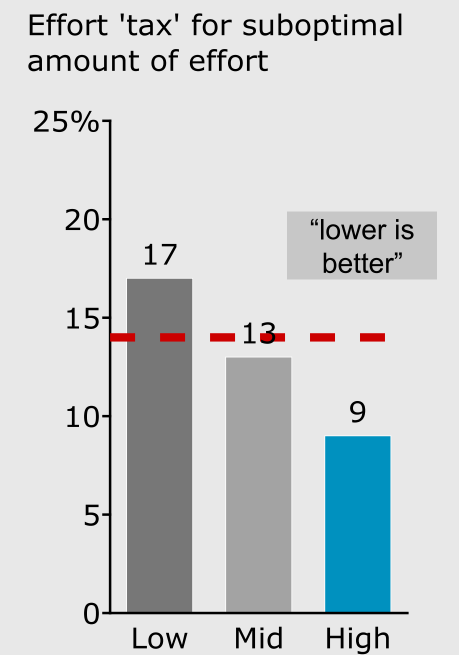

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State of “value” today in the NHS

STRENGTHS TO BUILD ON

- The NHS is one of the best value health care systems in the world
  - Ranks highly on effective, safe, coordinated and patient-centred care at a cost per patient that is far lower than in other developed countries
- Quality Adjusted Life Years is used as a measure of value in certain circumstances
- Tools and guides are available for particular types of decisions
  - e.g. RightCare approach, STAR tool, Commissioning for Value packs, Capital Investment Manual
- Data and metrics are captured that are relevant for the value calculation

AREAS OF DEVELOPMENT

- Variation in outcomes across organisations within the NHS
- No single definition of value
- No “common currency” of outcomes and metrics that is understood by Finance and Clinicians
- Use of existing tools is patchy and driven by individual initiative
- Data is insufficiently granular, coverage and access is inconsistent

Source: The Commonwealth Fund; Delivery Group member interviews

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A Decision-Effectiveness Framework

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A "what-who-how-when" toolkit

1 What

- Define the decision we are actually trying to make
- Frame the decision in an appropriate way
- Split into sub-decisions if necessary

2 Who

- Clarify upfront who will play what role in each decision (e.g. decision-maker, recommender)

3 How

- Install structured decision approach
- Design and specify:
  - Interactions
  - Critical meetings/ committees
  - Closure and commitment
  - Feedback loops

4 When

- Clarify timeline for decision and execution, and key milestones
- Consider creating a decision calendar for on-going, interconnected decisions

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The “what, who, how and when” for a specific decision

1

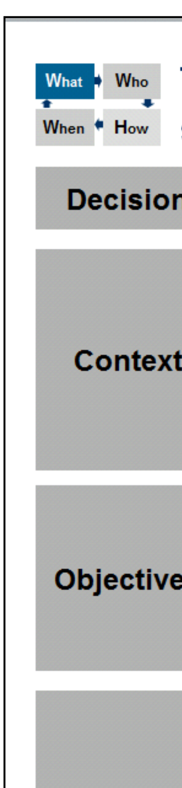
What

Clarify exactly **what decision** is under consideration:

- Make sure everyone is **on the same page** regarding how to define the decision being made
- **Frame the decision correctly** so participants can make appropriate tradeoffs
- **Unbundle** the decision into its sub-decisions before working through next steps

What | Who | When | How

The decision charter should be framed to emphasise system-wide value, including objectives and constraints



Decision	Decide how to invest/disinvest in infrastructure to provide safe and sustainable maternity care
Context	• Two trusts in a rural area serve an increasingly aging population, such that demand for maternity services has dropped considerably. Currently these services are offered in 5 different locations across the area, but 3 of these would be sufficient to meet demand. The two service commissioning CCGs have decided that investment/disinvestment in infrastructure needs to be made to provide safe and sustainable maternity care. • The two CGGs now need to decide how to invest/disinvest to maximise value and the two trusts need to decide how to respond to and implement the commissioning changes.
Objectives	• Value must be considered in terms of outcomes, patient experience, safety and cost and should strive to reach “best in class” • Offer services in good standard facilities • Avoid critical shortage of patients and staff
Constraints	• Must be acceptable to all key stakeholders including patients/public, clinical staff, financial staff • Public input must be taken into option appraisal and choice of preferred option • Must align with commissioning strategy and allocation decisions • Must consider all viable options and must not destabilise providers beyond their ability to cope

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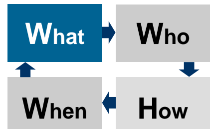

Example value criteria and metrics for this decision should be adapted to match your decision context

COMPONENTS OF VALUE		CRITERIA	METRICS (EXAMPLES)
Outcomes	Clinical Effectiveness	• Quality of pre, during and post child delivery care • Outcome of interventions • Recovery	• Volume of at risk births (e.g. premature, low weight, medical condition) • Perinatal mortality and still birth rate • Volume of births by birth type (e.g. natural, c-section, episiotomy, induced) • Medical complication rate (e.g. postpartum haemorrhage) • % of complications successfully treated • Days to discharge post-c-section / premature birth
	Patient experience	• Accessibility to care facility • Accessibility to people within care facility • Comfort of environment • Quality of interactions • Patient choice	• Average and maximum travel time to maternity ward within catchment area • Ratio of midwives and obstetricians to patients • Availability of alternative birthing facilities e.g. home birth support • % of patients able to choose where to have their baby • % of patients provided with advice on post-birth baby care
	Safety	• Avoidance of harm to patient • Safe environment that supports delivery of care • Adequate resourcing	• Rate of avoidable mortality • Rate of avoidable harm done to patient e.g. infection rate • % adherence to best practice estate maintenance protocols • % of time staffed according to best practice minimum staffing levels • Staff experience (measured as number of patients per staff per year)
Resources	Revenue costs	• Clinician salary • Admin staff salary • System running costs	• "Stranded costs" i.e. costs of unmet overhead as result of disinvestment • Staff relocation and training costs • Co-dependency expansion costs (e.g. gynaecology consultant salaries) • Operating cost per birth
	Capital costs	• Investment in facilities / equipment • …	• Upfront investment for facility expansion • Co-dependency expansion costs (e.g. additional facilities)

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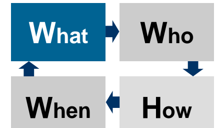

This example investment/disinvestment decision has seven key sub-decisions

Decision: Decide how to invest/disinvest in infrastructure to provide safe and sustainable maternity care

Set Up	Execution

Phases: Establish Charter; Case for change; What To Change (CCG); What To Change (trust); How to Change; Closure

◆ = Key sub-decision

1. CCGs decide commissioning configuration (e.g. lead commissioner)
2. CCGs decide value criteria
3. CCGs decide case for change
4. CCGs decide service specifications to commission
5. Trusts decide service reconfiguration to meet spec
6. Trusts decide implementation and mobilisation plan
7. Decide CCG and provider contract(s)

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The “what, who, how and when” for a specific decision

2

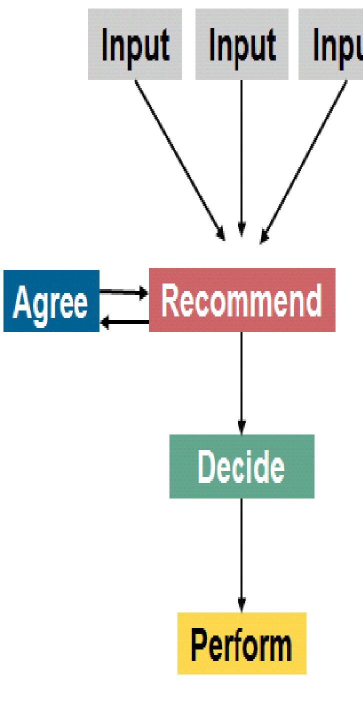
Who

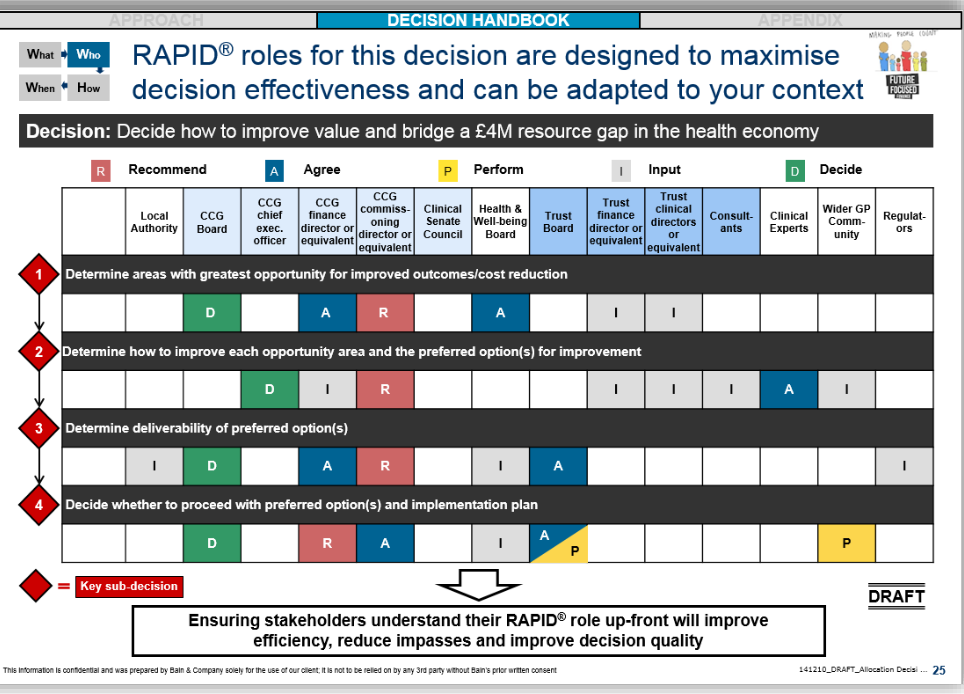
Clarify upfront who will play what role in each decision - who has the “D”?

WHAT THE ROLES ARE

Recommend	**Recommend** a decision or action
Agree	Formally **agree** a recommendation • Must be consulted • Must work with R to resolve issues
Perform	**Perform** a decision once made
Input	Provide **input** to a recommendation • Must be consulted, may or may not be reflected in final view
Decide	Make a final **decision** and commit the organisation to action

HOW THE ROLES INTERACT





RAPID® roles for this decision are designed to maximise decision effectiveness and can be adapted to your context

Decision: Decide how to improve value and bridge a £4M resource gap in the health economy

R Recommend A Agree P Perform I Input D Decide

	Local Authority	CCG Board	CCG chief exec. officer	CCG finance director or equivalent	CCG commiss-oning director or equivalent	Clinical Senate Council	Health & Well-being Board	Trust Board	Trust finance director or equivalent	Trust clinical directors or equivalent	Consult-ants	Clinical Experts	Wider GP Comm-unity	Regulat-ors
1 Determine areas with greatest opportunity for improved outcomes/cost reduction														
		D		A	R		A		I	I				
2 Determine how to improve each opportunity area and the preferred option(s) for improvement														
			D	I	R				I	I	I	A	I	
3 Determine deliverability of preferred option(s)														
	I	D		A	R		I	A						I
4 Decide whether to proceed with preferred option(s) and implementation plan														
		D		R	A		I	A / P					P	

◆ = Key sub-decision

DRAFT

Ensuring stakeholders understand their RAPID® role up-front will improve efficiency, reduce impasses and improve decision quality

The “what, who, how and when” for a specific decision

3

How

Install structured approach

Design and specify:

- Interactions, meetings/ committees
- Closure, commitments, feedback loops

The 6 “C”s

APPROACH | DECISION HANDBOOK | APPENDIX

What | Who | When | How

Decision component snapshot for sub-decision one

DRAFT

Sub-Decision: Determine areas with greatest opportunity for improved outcomes/cost reduction

RAPID Roles	D CCG board	R CCG commissioning head	A CCG finance head	A Health & Wellbeing Board	I Trust finance head	I Trust clinical directors or equivalent

Criteria	Critical Steps	Choices Considered	Committees
• Focus on areas where underperforming relative to demographic peer group clinically or financially • Focus on populations that consume most resources • Seek to incorporate cost, quality, safety and experience considerations to deliver best possible value • Alignment with CCG long-term strategic priorities, JSNA and other key stakeholder priorities • Asset / facility utilisation	• Map resource use by population group • Refresh/review risk stratification • Assess baseline costs • Analyse peer group, patient and provider benchmark data • Review Joint Strategic Needs Assessment, and long-term strategic priorities of CCG, stakeholders and Health & Wellbeing Board • Gather patient input	• programme/pathway budget allocations • Provider/care setting allocations • Contracting frameworks (e.g. payments linked to outcomes, lead provider arrangements, capitation) • Investment in self-managed care (e.g. web-accessible integrated digital care records) • Decommissioning services	• **Clinical Reference Group or equivalent:** commissioning board sub-committee of clinicians - commissioning head gets Input as needed • **Transformation Stakeholder Working Group or equiv.:** Joint provider / commissioner group - Input mechanism for Trust finance and clinical heads • **Health & Wellbeing Board:** includes local authority, public health, Healthwatch, head of adult and children's social services reps - Commissioning head seeks Agreement. Recommendation must reflect views, even if dissenting

DECISION

Communication	Closure
• Send “influencing paper” with high-level case for change opportunities and forward view to commissioning, provider, patient and public stakeholders Click these icons throughout the Handbook for additional resources	• Commissioning director or equivalent initiates **programme/pathway review** and **stakeholder engagement** through the Clinical Reference Group • CSU or internal business intelligence staff allocated for further analysis

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The "How": Combination of the right people and information in the right sequence to make decisions

Pre-decision

Criteria	• We establish **clear criteria** for how we will evaluate options / make decision
Critical steps	• We are clear which **facts and evidence** need to underpin decisions; working from **one version of the truth** for decision inputs • Necessary pre-decision steps
Choices	• We ensure we consider the **full range of alternatives** • We **evaluate** alternatives vs. agreed criteria using rigorous data and analysis
Committees	• We make **effective use of committees and meetings** throughout the decision process

DECISION

Post-decision

Communication	• We clearly **communicate decisions once made** to all relevant stakeholders
Closure	• Once a decision is made, we **move swiftly to launch execution** - Resources allocated (people and money) - Execution plan in place (actions, accountabilities, milestones) - Feedback loops in place to drive fast corrective action or replicate successes

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The “what, who, how and when” for a specific decision

4 When

- Clarify timeline for decision and execution, and key milestones
- Consider creating a decision calendar for on-going, interconnected decisions

APPROACH | DECISION HANDBOOK | APPENDIX

What → Who → How → When

DRAFT

Decision timeline

Decision: Decide how to improve value and bridge a £4M resource gap in the health economy

Stage	Key sub-decision	Decision Calendar	Mo 1	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6	Mo 7	Mo 8	Mo 9	Mo 10
Where To Look	1	Determine areas with greatest opportunity for improved outcomes/cost reduction										
		Announce commissioning Intentions / notice of desired changes					X					
What To Change	2	Determine how to improve each opportunity area and the preferred option(s) for improvement										
		Identify smaller items within the overall plan										
		Identify larger scale transformative changes										
	3	Determine deliverability of preferred option(s)										
How To Change	4	Decide whether to proceed with preferred option(s) and implementation plan										
Closure		Announce implementation plan								X		
		Sign new or amend existing contracts										X

Iterative process, misaligned incentives and behaviours can extend this process

◆ = Key sub-decision

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Applying the framework in the NHS

Liverpool CCG

The Decision Effectiveness Framework has helped to:

- gain clarity on the decisions being made and who is making the decisions
- make better decisions in times of uncertainty
- put value at the centre of the business case for the investment decision
- put a clear framework around delivering the intended outcome
- identify what the value metrics should be to inform the decision and what the role of different parties in the decision are
- clearly map out the path for taking the decision forward.

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Applying the framework in the NHS

Mid-Cheshire NHS Foundation Trust

As a result of using the framework, colleagues at Mid-Cheshire observed that:

- The end-to-end “What-Who-How-When” toolkit was felt to be highly practical and intuitive
- The decision was clearly framed by use of the toolkit, and clear path ahead exists
- It is hoped to use the pilot outputs as a clear blueprint for other investment decisions
- They achieved strong alignment on definition of value and how to measure this
- They had great attendance and energy from all participants

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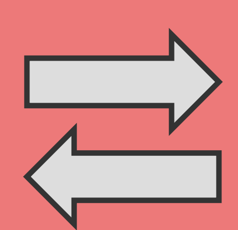
The framework will be part of a series of resources, but to succeed we need a strong system narrative too!

The decision effectiveness framework will be released alongside toolkits, case studies, videos and other materials.

RESOURCES

We are also planning practical learning events where NHS colleagues can work through decisions of value.



Our resources support a shift in mind-set and capability, which will be further enabled through supportive system signals and incentives.

ENABLING SYSTEM MESSAGES

Our ask to you today is to make today's event the start of putting value at the heart of the system narrative

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Questions?

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