practical support

A future-focused finance workstream aims to help the NHS make the best use of its resources for patients. Best possible value lead Caroline Clarke explains how

The notion of value in healthcare has been gaining real currency in recent years. As we seek to address the challenges of the *Five-year forward view*, a focus on value is a critical component of local (and national) conversations to ensure that we deliver the most benefit to our patients within the resources we have.

Everyone needs this focus, be they at board level, managing a service line or a team, and it was great to see the reports on value from the NHS Confederation and Academy of Medical Royal Colleges late last year. It feels like value is becoming more widely and explicitly acknowledged as being at the root of what we need to do to transform. This is a time of real opportunity.

In the finance world, as part of the future-focused finance (FFF) initiative – a five-year programme to build capability in the profession – we have a dedicated work stream on best possible value (BPV). In our BPV work we have defined value as the function of outcomes over resources:

$$\text{value} = \frac{\text{[clinical outcome + patient experience + safety]}}{\text{[revenue costs + capital costs]}}$$

Value can be increased by improving outcomes for a given resource level or by reducing the resource required to deliver a given outcome. I am sure this will be familiar to anyone who knows Harvard Business School professor Michael Porter's work on value-based healthcare.

Although we have described this as a formula, it's really a way of defining a problem, decision to be made or area to be improved, and ensuring that finance and clinical professionals concentrate on the same things. We must be careful not to fall into the trap of trying to weight elements of the equation, or define one magical value number.

We started with a survey to help us identify what would be most useful to people. This told us that in the NHS people often experience:

- A lack of clarity on respective roles and responsibilities in complex multi-stakeholder decision-making
- A narrow focus on the financial aspects of the options presented
- A lack of support, in terms of the right information and the right tools to make the right decisions.

Informed by this survey, over the past six months we have been working on a framework to give people practical tools to deliver decisions of best possible value. This will be made available to colleagues in the next few weeks.

We think the framework will help deliver on value by first getting the right people involved in the right way with decisions (clarity over who does what, when and why). Second, they will be approaching the decision with a different focus.

Essentially, we want our finance colleagues to begin to look beyond the traditional tests of 'Can we afford to do it?' or 'Do we want to do it?' and instead always start from 'Is this the best decision for patients – is it the best possible value?'.

Reflecting on the decisions we have to make at the Royal Free NHSFT, designing this framework has made me rethink the way we approach a number of decisions, including service transformation and how we prioritise our investment programme. The framework could help us be more transparent – perhaps avoiding the lengthy process for NHS transactions.

For example, it took my organisation two years, 53 board meetings and 19 levels of approval to acquire an NHS trust when we were the only bidder. If we had been clearer on who had decision rights and how decisions were going to get made at the start of the process, I'm sure we could have cut through some of the complexity.

Decision framework

We have been developing the decision framework focusing on the key decisions that organisations and health economies will have to make, identified through workshops with colleagues in the service. The framework will include a series of principles that will enable decision-makers to demonstrate that they have considered outcomes, patient safety and experience, as well as revenue and capital costs.

We concluded that most decisions fell into one or more of the following categories:

- Allocative decisions
- Changes in service delivery
- Investment (or disinvestment)
- Innovation.

In many cases, the resources to help make these decisions already

exist. Allocative decisions are those made about how resources are allocated to different populations and programmes. An example could be decisions by commissioners to fund a treatment. Here, the framework might prompt the use of programme budgeting data or the atlases of variation used by NHS Right Care.

Service delivery decisions include those where we are changing the model of care, such as moving services out of hospital and into the community. In this situation, an NHS organisation might look to other organisations that have already made a similar change to support its decision-making.

The *NHS Capital investment manual* is one tool that could be used to solve questions over investment and disinvestment. The final category – innovation – is one that finance professionals often find difficult as they can involve levels of risk uncommon in the health service. A decision to use telehealth/telecare could fall into this category.

We have a delivery group that is helping us test existing and new tools, and to define best practice. Do get in touch if you would like to be involved at futurefocusedfinance@nhs.net.

Pilot sites

The framework can be applied to long-term transformation programmes in a health economy, as well as more day-to-day operational decisions in organisations. We are testing it with a number of pilot sites, to be written up as case studies, so that the NHS can learn from others' experience.

Liverpool CCG and Derbyshire Healthcare Foundation Trust are our first pilots to go live, applying the framework to specific service delivery and investment decisions in their patches. We'll publish the outcomes on the FFF website in the coming months.

We still need more sites. Please contact Ruth Small at the email address above if you would like to be a pilot. (As well as Ruth, I'd like to thank Jennifer Howells from NHS England and Mark Redhead from Monitor, who are all helping shape and coordinate our work.) Our plan is that there will be a growing library of case studies, as a rich resource of experiences putting value into the NHS.

We want this work itself to be of value. So we will be shaping it in response to people's experiences of using it. We want to give practical assistance that will help effect change and promote the behaviours we need to get health economies on a robust, sustainable footing.

As an offer to the pilot sites, we are planning to work alongside them, bringing them together in a series of regional events to share learning and experiences of effective 'best possible value' decision-making. This will provide support by hearing from others as they are going through the decision-making process.

By sharing what has gone well and what could have been done better, people will be able to take away practical enablers that others have identified, to help everyone make progress on service change. We'll be writing up the learning from this as an FFF resource available to share with other NHS decision-makers.

This learning report will sit alongside the case studies as part of a wider training and support package to underpin implementation. This package is being designed now and we would welcome views on what would be most helpful. It is likely to comprise a series of webinars later in the year as well as e-learning offers and we are in discussion with the HFMA about what that could look like.

As part of the work programme, we want to celebrate what NHS colleagues have done to get value into our way of thinking and to deliver better results, so we are delighted to be able to support the HFMA's Best Possible Value Award. Look out for details later in the year.

Do also look on the website for more detail of the whole programme and how it all fits together. And I encourage staff to become value makers, when the application process opens again this month. This is a really great way of helping shape our work programme, meeting like-minded professionals in the NHS, and getting yourself skilled up to be part of the future.

The work from our programme will inform the work of the other FFF workstreams. I believe that value should be at the core of what we do, and should be a core competency to which we recruit individuals. That means in time we will see radically different job descriptions, roles and requirements reflecting this work. We'll see a common language of value that we can use with clinical colleagues, and we will be providing the learning and skill for this across the NHS.

I'd like to finish by urging you to be a part of what we are working to achieve. Please get involved, as a value-maker, a pilot site, a participant in the learning events, and by telling us what you think will be of most use to you in taking forward your work on best possible value.

Caroline Clarke is the senior responsible officer for the FFF 'Best possible value' action area and chief finance officer and deputy chief executive at the Royal Free London NHS Foundation Trust

"Value should be at the core of what we do, and should be a core competency to which we recruit. That means in time we will see radically different job descriptions, roles and requirements"

Caroline Clarke