
New approaches to value in health and care

Report

November 2016

About this report

This report was written as part of the Realising the Value programme. It was written by Don Redding, National Voices.

The report makes a series of calls to action to ensure that the approach to understanding, capturing, measuring and assessing value in health and care takes full account of value, as it is experienced and created by people and communities.

It is written for decision- and policy-makers, as well as practitioners and professionals seeking to add value to people's lives and mobilise the value that people and communities themselves can create for health and wellbeing.

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We hope you find it useful.

Acknowledgements

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Summary and calls to action

Why do we need new approaches to value in health and care?

The NHS has set new directions for itself. Its ‘new care models’, with new purposes (population health), new ways of working with communities and new cultures of care (engagement and empowerment) need new frameworks and measures for the value they are seeking to achieve.

This means starting now to develop better measures that will be capable, in three to five years’ time, of capturing whether integrated local systems are maximising the value created by people and communities, and securing the outcomes that matter most to them.

When people are actively involved in their own health and wellbeing, or support others to stay well, it creates value for them and the health and care system in a number of ways.

On an individual level: People make decisions every day that can impact on their longer-term health and wellbeing – for example in relation to exercise, managing stress, taking part in social activities or developing skills to successfully look after a health condition. The Wanless Review suggested that ‘for every £100 spent on encouraging self-care, around £150 worth of benefits can be delivered in return’.¹

Caring for others: Over six million people are involved in informal caring, a quarter of them full time, with the total value estimated at £132bn a year – greater than the NHS budget.² They are the biggest ‘workforce’ and deliver the bulk of care.

Volunteering: Around a quarter of all adults are involved in regular volunteering,³ with the Office for National Statistics (ONS) estimating formal volunteering to be worth almost £24bn per year.⁴

Only a portion of this activity is directly related to health or care, but much of it supports individual and community wellbeing.

The majority of this value, however, goes unrecognised by formal systems. The Realising the Value programme therefore set out to explore what ‘value’ means for people and communities, and how this can be understood most appropriately by the NHS.

This paper builds on a discussion paper published in 2015 and subsequent engagement undertaken as part of the Realising the Value programme. It makes a series of calls to action to ensure that the approach to understanding, capturing, measuring and assessing value in health and care takes full account of value, as it is experienced and created by people and communities. The calls to action include:

- building a consensus on replacing the National Outcomes Frameworks with a simplified cross-system framework
- basing core national outcomes on the health and wellbeing outcomes that are most important to people and communities
- prioritising support for commissioners to build skills, knowledge and confidence to commission for the outcomes that people and communities value
- ensuring widespread use of the Public Services (Social Value) Act 2012⁵ in health commissioning.

These calls to action will enable a shift to a future articulation of value that is aligned across health and social care and community organisations.

The report also proposes a set of **value statements** and accompanying pledges. These could be adopted immediately by local areas or New Care Model programme vanguard sites, seeking to add value to people's lives and mobilise the value that people and communities themselves can create for health and wellbeing.

We value the creation of health and wellbeing

We value people feeling supported, in control, socially connected and independent

We value the outcomes that are most important to people and their communities

We value people's contributions (their strengths, time, effort, and skills)

We value sustainable outcomes over time, achieved through working together, as services and in partnership with people

We value equity, and the gains to be made by targeting and tailoring our approaches to people with greater need for our partnership.

1. Introduction

Why a review of ‘value’ was required

The NHS Five Year Forward View proposed that the NHS would need new relationships with people and communities that mobilise their energies in order to create better health and wellbeing.⁶

The NHS is now piloting ‘new models of care’, oriented towards population health and wellbeing, based on engaging with ‘activated’ individuals and communities.* The ambition is that these will spread to half the population of England by 2021.⁷

At the same time, all local areas are expected to make progress in delivering ‘integrated’ care, bringing services together around the needs of people.

This raises fundamental questions about the nature of the value to individuals and society the NHS and other services should seek to achieve. These questions include:

- What is the value contributed by individuals actively engaged in managing their health, and by communities that participate in supporting and promoting health and wellbeing?
- What additional value can the NHS secure by involving people and communities in new cultures of care?
- Are these types of value understood? How can they be ‘captured’ in value frameworks and measurement?

In order to explore these questions, the Realising the Value programme set out to develop ‘a new articulation of value’ that is appropriate for the future direction of the NHS.

Thinking about co-production

An individual who actively takes care of his or her own health is ‘producing’ health. Where they interact with the formal health service, making decisions together with professionals, they are ‘co-producing health’.⁸

Likewise, community activity that supports people’s wellbeing helps to produce health; and where the formal and informal sectors cooperate in this, they are ‘co-producing health’.⁹

For example, a person with a long-term condition or at risk of mental illness who looks after their diet, takes regular exercise, monitors symptoms, and seeks support and advice to build their knowledge, creates value in a number of dimensions.

For the individual, the most important of these are their personal health and wellbeing, and quality of life. But by keeping well, they may also be staying in work (creating positive economic value, and also avoiding welfare costs); continuing to care for others; and making the most appropriate use of health and care resources (including avoiding unnecessary urgent and emergency care).

The majority of this value goes unrecognised by formal systems. The NHS mainly counts what it spends on people who present with illness. It judges outcomes mainly at the level of the results of specific treatments in single episodes of illness and/or in single service settings.

* ‘Patient activation’ describes the knowledge, skills and confidence a person has in managing their own health and care. For further information see: www.england.nhs.uk/ourwork/patient-participation/self-care/patient-activation/pa-faqs/

In adult social care things have developed differently. Co-production is better understood and more commonly used as a principle for commissioning and service delivery.¹⁰

As the ‘personalisation’ agenda has evolved over at least the last decade, the emphasis has moved away from counting the statutory sector’s activity and inputs, and onto securing quality of life outcomes such as independence and control.¹¹

As health care, social care and other services join together in integrated local systems with a common purpose around population wellbeing, a common cross-system understanding and measurement of the dimensions of value will increasingly be required. System leaders across health and social care have recognised this in their ‘shared commitment’ to engaging and empowering communities.*

How the Realising the Value programme has reviewed concepts of value in health and care

There is a substantial literature and evidence base that examines the effectiveness of interventions to engage people in their health and health care.¹² There is more limited, but promising evidence on the value of community-based interventions.¹³

The Realising the Value programme has carried out a comprehensive evidence review¹² and selected a small number of approaches to study further, using the knowledge and data from local partner sites that are successfully delivering them.

We have used the best available evidence to produce economic modelling tools for commissioners seeking to establish these approaches, to enable commissioners to consider establishing them.¹⁴ We have also looked at the most effective ways to support local populations to make and sustain changes in their health-related behaviours.¹⁵ We have used the insights from this set of evidence and tools to develop a conversation about overall concepts of value.

We published a discussion paper in September 2015¹⁶ that reviewed various systems of value and their relevance to the NHS Five Year Forward View. You can find a summary of that discussion in Annex 1. The discussion paper set out initial proposals for changing value and outcomes frameworks, and we have received continuing feedback on these, ranging from formal submissions to social media reactions.¹⁷ We have discussed and debated these concepts with many types of stakeholders – not least with our five local partner sites who are directly involved in co-producing value with people and communities.†

In this paper, we summarise the ideas that have gained shape over the course of the programme. We make a series of calls to action to ensure that, when the statutory care systems capture and measure value, they take full account of value as it is experienced and created by the people and communities they work with.

* See forthcoming publication on engaging and empowering communities from the Think local act personal (TLAP) partnership: www.thinklocalactpersonal.org.uk

† For details of the Realising the Value programme partner sites and the work that they do, please see *Making the change: Behavioural factors in person- and community-centred approaches for health and wellbeing*.

2. People, communities and value

How do people create value in health and wellbeing?

This section briefly outlines the types of value that people and communities can generate. Some of these are not yet captured, measured or mobilised by the formal health system.

As individuals, people make frequent decisions about their health and how to manage it. These decisions are not made in a vacuum, but are instead made in the context of managing their lives and the impact that health conditions have on them.

These decisions may relate to one or more factor, including:

- exercise
- diet
- managing stress, anxiety and the risk of depression
- taking part in social, cultural and physical activities
- learning about their health conditions and developing skills and strategies to manage them successfully
- adhering to medication, treatment and preventive regimes
- deciding how to use health and care services appropriately.

The original Wanless report suggested that ‘for every £100 spent on encouraging self-care, around £150 worth of benefits can be delivered in return’.¹

Individuals also care for others. Over six million people are involved in informal caring, a quarter of them full time, with the total value estimated at £132bn a year – greater than the NHS budget.² They are the biggest ‘workforce’ and deliver the bulk of care.

And people volunteer. Collectively, people come together to provide community support and activities either formally or informally (the vast majority of voluntary and community sector organisations are small, local and not formally funded or professionally staffed¹⁹). Around a quarter of all adults are involved in regular volunteering,³ with the ONS estimating formal volunteering in England is worth almost £24bn per year.⁴

The formal voluntary sector consists of almost 163,000 organisations, with assets of over £100bn, a workforce of 827,000, and a ‘gross value added’ contribution to the economy of over £12bn a year (equivalent to the agricultural sector).⁴

Only a portion of this activity is directly related to health or care, but much of it supports individual and community wellbeing.

Among it, some relatively well-defined person- and community-centred approaches have emerged and been studied. Many of these approaches are described, for example, in a previous report from the Realising the Value programme, *At the heart of health*,¹² and in NICE Guideline 44 on community engagement.²⁰ They include peer support, health coaching, self-management education, group-based

activities such as arts and exercise, and asset-based approaches that help people and communities to develop their strengths and resilience. We note that there is a wide range of such approaches, and that often they overlap and reinforce each other to support people's health and wellbeing.

'Multiplier' effects are a strong feature of the value that is generated. For instance, volunteering can promote the wellbeing of the volunteer, as well as those they volunteer to help; a supported carer is better able to provide good care; community activity can improve the environment for the whole community, as well as benefitting those who are engaged.

What do people value?

In addition to how people create value in health and wellbeing, a second key question is what matters most to people and communities. What are the kinds of outcomes and impacts that people want from working with formal health and care services – and how can they influence the system?

A good experience of care has been recognised as one of these outcomes,²¹ but on its own is more of a service process measure than an outcome. In practice, people do not think purely in terms of their health or their interactions with services, but about their quality of life (and death): they are concerned about the impact their health, and their care, has on their ability to live a good life.²²

These outcomes are often described in terms that are much more familiar in adult social care (where the legal duty now formalised in the Care Act 2014 is not to provide services, but to promote wellbeing in the population). They include:

- being independent
- feeling supported
- being in control of decisions and of support
- feeling connected to others (socially and culturally)
- being able to do the things that are important to them (such as maintaining key activities or caring for others).¹¹

Equity is also an important outcome to people: feeling that everyone has an equal chance of access to health and to the things that support it.

Co-production as a principle and method is key to ensuring that the most important outcomes for any publicly funded initiative can be set **with and by** the range of stakeholders involved, pursuing what matters most to them.

Value frameworks – and techniques for evaluation and measurement – that are capable of capturing all of the valued outcomes and impacts are required. These are likely to consist of financial information such as cost-benefit analyses, other forms of quantifiable data, stakeholder experience and person-reported outcomes, and also qualitative information, bound together by narratives that make sense of all the various outcomes as a whole.

3. What needs to change?

There is now widespread recognition, including by government, of the limitations of classical accounting for the use of public funds, including the risk of rewarding activity and process, rather than outcomes.²³

However, the critiques of value in health care, and their alternatives, often remain focused on services rather than being person- or community-centred (see Annex 1).

As a result of our discussions with stakeholders, the Realising the Value programme has proposed that a future articulation of value aligned across health, social care and community organisations will need to broaden its focus in the following ways:

Value: broadening the focus	
Not only...	But also...
Specific clinical outcomes	Wider health and wellbeing impacts
What the system values, e.g. cost and value for money indicators	What people and their communities value, i.e. the outcomes most important to them
Patient experience, i.e. what direct contact with services feels like	Wellbeing, e.g. quality of life; people feeling supported, in control, socially connected and independent
Immediate outcomes of a single service, e.g. success of a treatment	Outcomes over time of all the services and support a person or community may draw upon
Individual outcomes for the person	Equity in health and wellbeing, with greatest value achieved by targeting people and groups with greater need, lower health literacy, least access etc

In Section 6 we offer a set of ‘value statements’ that integrated local systems could adopt to help make this shift.

4. Future direction of value

In this section we look at what is being done to align the articulation of value with the direction established for the NHS in the NHS Five Year Forward View, as well as what more may need to be done.

The NHS Five Year Forward View argues for ‘a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health’.⁶ As such, it signals that the future of the NHS lies in making good the Wanless report’s proposal that a scenario in which people and communities are ‘fully engaged’ in health is key to the sustainability of health care.¹

The NHS is pursuing this as a twin agenda of ‘sustainability and transformation’. Transformation means a change of culture – testing ‘new models of care’ that forge new relationships with people and communities.

These include the Integrated Personal Commissioning programme. The programme puts people in charge of their own budgets for care and support, based on personalised care planning.

The 25 integration pioneer areas, part of the Integrated Care and Support Pioneer programme, have also forged groundbreaking work in pursuing person-centred, coordinated care. The goals for integrated care are set out in a first-person ‘narrative’ endorsed by all the system-leading bodies, which also revolves around care planning and coordination.²⁴

Integration will be taken further by the Multispecialty Community Provider (MCP) and Primary and Acute Care Systems (PACS) models, two of the five new models of care outlined in the NHS Five Year Forward View. Both of these aim to take a place-based population health approach, based on scaled-up and coordinated primary and community care.

NHS England makes clear that these new models must connect with the voluntary and community sector, and support patient activation and self-care. It states that both models:

‘aim to improve the physical, mental and social health and wellbeing of their local population. They encourage diverse communities to look after themselves by supporting self-care and connecting people to community assets and resources.’⁷ [our emphasis]

Support for the new care models to demonstrate a broad approach to value

Evaluation metrics

NHS England has established an evaluation framework for new care model vanguards that includes core national metrics, plus locally commissioned evaluations.

For MCPs the metrics include quality of life for people with long-term conditions; patient experience of integrated care; and place of death. As the Patient Activation Measure (PAM) continues to spread, PAM scores may also be used.²⁵

Engagement principles

The People and Communities Board has co-developed six principles for engaging with people, communities and the voluntary sector for the new care model vanguards to adopt.²⁶ The Board’s publications suggest ways to implement these, and some possible indicators for measuring progress.

Programme support

The new Empowering People and Communities team in NHS England will provide development support to new care model vanguards seeking to implement the six principles. The newly established Self Care team will likewise promote and support the implementation of person- and community-centred approaches such as those explored by the Realising the Value programme.

System alignment

The National Quality Board (NQB) is leading a project with all the system-leading bodies to agree a single common definition of quality and how to measure it.

What needs to happen next?

Currently the NHS is in a ‘catch-22’ with regard to value frameworks and metrics.

There is reluctance nationally and locally to start new data collections while local areas are occupied with creating Sustainability and Transformation Plans, designing and commissioning new care models, and coping with the increasing demand on NHS services. Hence both the new care model vanguard evaluation framework and, elsewhere, work by the NQB on metrics for a common view of quality, are having to default to the best available measures from existing collections.

Yet, logically, new care models with new purposes (population health), new ways of working with their communities and new cultures of care (engagement and empowerment) will require new frameworks and measures for the value they are seeking to achieve.

Payment and other incentives (such as workforce satisfaction and professional reward) must also be directed to supporting the new ways of working with people and communities. This again requires new value and outcomes frameworks against which to pin the incentives.

To move this agenda forward means beginning now to develop better value measures that will be capable, in three to five years’ time, of capturing whether local areas are securing the outcomes that matter most to people.

This means agreement among the system-leading bodies on the purpose of a new, single, simplified and cross-system outcomes framework.

The system-leading bodies have already backed this in principle. The action plan accompanying their ‘shared commitment’ to engaging and empowering communities identifies the need for:

*‘a better, shared understanding of what good looks like and how to measure it. This must go beyond blunt proxy measures, such as reduced hospital admissions, and help to articulate the broader benefits to the system and to communities in the medium and longer term in a clear and consistent way.’**

In the next two sections, we make **calls to action** focused on reviewing and replacing current outcomes frameworks. We then offer a set of **value statements and pledges** that could be adopted by local areas or New Care Model programme vanguard sites now, as a statement of intent.

* See forthcoming publication on engaging and empowering communities from the Think local act personal (TLAP) partnership: www.thinklocalactpersonal.org.uk

5. Calls to action

- **Build a consensus on replacing the National Outcomes Frameworks.** Many organisations have recently called for a new, simplified outcomes framework, including the NHS Confederation, the Local Government Association, ADASS, the Academy of Medical Royal Colleges, and patient organisations.²⁷ We need consensus about the purpose and content of this new framework – and that needs to be equally led by those local front-line areas (including pioneers and vanguards) that are already trialling different value and outcomes frameworks. As an outcome, a single, simplified, cross-system outcomes framework needs to be created, emphasising the combined impacts of place-based, statutory services working with engaged populations.
- **Base core national measures on the health and wellbeing outcomes that are most important to people and communities.** These could include independence, empowerment, social connection, ability to have a family and community life, and health-related quality of life, together with feeling supported to achieve these, and equity. As part of the consensus building discusses above, both local areas and system-leading bodies should ‘share and compare’ their preferred broad outcome measures with a view to creating an agreed shortlist.
- **Develop a national programme to build commissioners’ skills, knowledge and confidence to commission for comprehensive value (personal, social, community).** This would require a mixture of role- and skills-based awareness and training, and support packages. These could grow out of work that Health Education England and the Social Care Institute for Excellence (SCIE) are leading on the skills for the future workforce, as well as a revised version of the Right Care (Commissioning for Value) programme.
- **Use this programme to ensure widespread use of the Public Service (Social Value) Act in health commissioning.**⁵ Educate and skill up commissioners; support them with tools and guidance; and review and amend performance and accountability frameworks for clinical commissioning groups (CCGs).
- **Train NHS finance officers to work with these new concepts as well as value and outcomes frameworks.** Produce standard methodologies and model reporting templates capable of capturing what matters most to stakeholders across key domains of value. Ensure these are capable of capturing value in both quantitative and qualitative domains, and are reported in narrative as well as factual modes.
- **Produce a method for aggregating personalised and community-level outcomes into population-level data for commissioners and providers.** We emphasise the need for outcomes to be co-produced locally with individuals and communities. It may be feasible for these granular outcomes – for example, from personalised care planning – to be benchmarked against recognisable domains so as to be aggregated into data that commissioners can use. However, a common, recognised method will be required.
- **Research person-centred outcome measures.** It is highly desirable to develop a dedicated national research stream to consolidate research on person-centred outcome measures, and supply these into the initiatives outlined above.

6. Value statements for adoption

Value statements: for adoption by local and national ‘whole systems’ approaches

These statements are intended to help health and care systems that are integrating and redesigning their care models to reconsider how they add value to people’s lives. They also aim to mobilise the value that people and communities themselves can create for health and wellbeing.

We value the creation of health and wellbeing

We value people feeling supported, in control, socially connected and independent

We value the outcomes that are most important to people and their communities

We value people’s contributions (their strengths, time, effort, and skills)

We value sustainable outcomes over time, achieved through working together, as services and in partnership with people

We value equity, and the gains to be made by targeting and tailoring our approaches to people with greater need for our partnership.

Value statements and the six principles

These value statements can be seen as supporting the commitment of new care model vanguards to the six principles for working with people and communities developed by the vanguard sites and the People and Communities Board, which require that:

- care and support is person-centred: personalised, coordinated, and empowering
- services are created in partnership with citizens and communities
- focus is on equality and narrowing inequalities
- carers are identified, supported and involved
- voluntary, community and social enterprise and housing sectors are involved as key partners and enablers
- volunteering and social action are recognised as key enablers.

The approaches these statements could trigger (see ‘Pledges accompanying the value statements’ on page 15) will help articulate the value of, for example, personalised care, support for carers, and working with volunteers and community groups as key enablers of health and wellbeing.

Pledges accompanying the value statements

By adopting the value statements we will:

- Work to understand **the outcomes that matter most** to people and their communities and develop systematic ways to work with them to help **identify their goals** for wellbeing, and the outcomes that are important to them.
- Review our value, outcomes and measurement frameworks to **align them together** and to prioritise the outcomes that matter for people and communities.
- Focus our common efforts less on single services and episodes of care, and more on the **overall impacts** of our work on the sustained wellbeing of people and communities.
- Ensure that the way we value outcomes addresses the **social gradient in health**, through consciously targeting person and community-centred approaches towards people who currently have greater needs, lower health literacy and least good access to health and care services.
- Work to demonstrate and measure the **wider community and social value** of our partnership working with individuals and communities.
- Develop our **workforce** as an asset to help in the design and delivery of person- and community-centred approaches.
- Commissioners: use our **commissioning and market development functions** to ensure that the health and social care economy is able to respond to people's needs for person- and community-centred approaches with an adequate supply of high quality support.

Annex 1: Overview of values concepts and recent actions to help systems of value evolve

We published a discussion paper in September 2015 that reviewed various systems of value and their relevance to the *NHS Five Year Forward View*. You can find a summary of that discussion below.

Current values concepts and alternatives

The dominant explanation of value creation comes from shareholder capitalism, where value is defined as ‘outputs’ minus the ‘inputs’ necessary to achieve them. This concept continues to influence public sector accounting. For the health system, the inputs are cash and system resources, and the outputs (or outcomes) are usually measured either by clinical intervention or at the level of the specific service.

Accounting based on this kind of system does not recognise the inputs made by people and communities (e.g. their time, effort, organisation or outlay of funds) or focus on the outcomes that are most important to them, which are usually expressed in terms of quality of life and wellbeing.

Various attempts have been made to critique and go beyond these systems. These are outlined in our discussion paper* and so only brief summaries are offered here.

Applied critiques

Triple bottom line accounting developed from efforts to get corporations to become more responsible and sustainable. It covers the three domains of economic, environmental and social outcomes. **Integrated reporting** is similar in proposing that the value an enterprise creates is not just for shareholders but for ‘stakeholders, society and the environment’.

In health care a ‘triple bottom line’ has developed that tries to mix outcome indicators for care effectiveness, safety and patient experience (reflecting the Darzi definition of ‘quality’ that was enshrined in the 2012 Health and Social Care Act). Its limitations include the tendency for cost-effectiveness to continue to be the dominant metric, while patient experience has less force/power; and the fact that the outcomes that matter most to people are not necessarily the experience of care but the impact on their own lives away from the care system.

Social auditing is another attempt to take social value and build it into the fabric of formal accounting for results. Its advocates note that it ‘allows the robustness of wellbeing reporting to be independently verified.’

Shared value is an attempt by Michael E Porter of Harvard University to think about ‘creating economic value in a way that also creates value for society by addressing its needs and challenges’. Porter’s critique of value in health care suggests emphasising outcomes for the patient (not measuring activity or process) and accounting for this at the level of bundled or integrated services, not at the individual service unit level.

* For a fuller exploration of this discussion, see *How should we think about value in health and care?*. Available from www.nesta.org.uk/publications/how-should-we-think-about-value-health-and-care

However, Porter remains service-centred, defining value as ‘health outcomes achieved per dollar spent’. He also continues to assume that, albeit at a bundled level, there is still a defined ‘cycle of care’ with a beginning and end, rather than a continuous effort to engage with populations.

Public value is a stream of thinking about the best ways for public service managers to use public funds. Although still service-centric, it moves towards co-production by recognising that managers’ actions must have ‘legitimacy’, derived both from the permission given by elected politicians and from ‘responsiveness’ – that is, working continuously to engage the public so as to be sure that public services value and produce what the public most values.

Public value also emphasises that service-level ‘outcomes’ are not adequate metrics on their own. Public services should be concerned with **impacts** – that is, the cumulative effect of various outcomes taken together, as experienced by the population reached. In health and care, this might be the cumulative impact on wellbeing, for instance.

Public value has been adopted and applied to its operations by the BBC for the Charter period 1996–2016, but has not widely been applied to health. The public value assertion that quantitative reporting alone cannot do justice to a wide range of impacts, and therefore that the value judgement of professional managers is also crucial, has been widely critiqued for being open to managerial manipulation.

Personalised but benchmarked indicators

In responding to our discussion paper, organisations with experience of developing indicators for personalised care and support in housing (HACT), health (the ELC Programme) and other community programmes (the Social Auditing Network) insisted that it is possible both to co-produce tailored outcomes with people and communities **and** to benchmark these against evidence-based domains, making them comparable rather than subjective.

Recent actions by government and the NHS

The 2010–15 coalition government recognised the need to move away from measuring activity/process in the NHS and to emphasise outcomes. The following initiatives, either from government or the NHS itself, have sought to help systems of value evolve further.

National Outcomes Frameworks: These offer an interlacing system for tying commissioning impact back to outcomes for the NHS, public health and social care. They were intended to set the principal accountability framework for local action. In health care there is a complex mix of clinical and service outcomes with those that reflect quality of life (for carers and people with long-term conditions). The complexity and multiplicity of metrics, the difficulties of attribution, and the tendency of the NHS to respond to other measures of success, have all undermined the utility of these frameworks.

Measuring wellbeing: Under the coalition government the ONS established a comprehensive approach to measuring wellbeing based on population data and surveys. It is intended to help drive all areas of policy to ensure that economic success actually helps people feel better off (rather than being crudely measured by GDP). It includes personal wellbeing and health metrics but has yet to have significant effect as a measure of local health areas’ success.

Social value: The Public Services (Social Value) Act 2012 requires all public service commissioners, when purchasing services, to consider the social, economic and environmental impacts of their decisions. It aims to help smaller local enterprises, including voluntary and community sector organisations, to compete for commissions. It has been used by some social care directorates to stimulate a market in personalised care. It is little known, and little used, in health care.

Social return on investment (SROI): This has also been strongly supported by government as a method of capturing the value of non-financial outcomes. It emphasises co-production with all stakeholders from start to finish of a given programme, so as to deliver the outcomes important to people and communities. Some SROI networks and organisations have developed sophisticated indicator frameworks. But SROI has not been widely adopted in formal statutory sector measurement and is usually applied to one-off projects or programmes.

Modified Quality and Outcomes Framework (QOF): There is recognition that the QOF for primary care rewards highly specific, often activity-based achievements. As a result, there is some momentum towards removing part or all of the system in favour of rewarding GPs for taking population health responsibilities.

The Right Care Programme: This NHS England programme is intended to be the key vehicle to deliver the efficiencies the NHS needs by 2021, mainly through its 'Commissioning for Value' advisory packs for CCGs. These aim to reduce variation in spend, particularly on 13 common patient conditions. The programme includes discussion of 'what patients value'. It uses quality of life indicators, and recognises the need to change care models for 'complex' patients with several long-term conditions. However, the latter are seen as only around 2% of the patient population, and the overwhelming focus is on value for money along single disease pathways. The programme is NHS focused and does not take account of the movement towards integrated care in all areas.



Realising the value: Ten key actions to put people and communities at the heart of health and wellbeing

Key learning and recommendations from the Realising the Value programme, based on what we think it means to realise fully the value of people and communities at the heart of health and wellbeing.



At the heart of health: Realising the value of people and communities

This report explores the value of people and communities at the heart of health, in support of the NHS Five Year Forward View vision to develop a new relationship with people and communities.



Making the change: Behavioural factors in person- and community-centred approaches for health and wellbeing

Drawing on robust studies of what influences behaviour, this report sets out a number of factors that can lead to greater involvement in self-care.



Spreading change: A guide to enabling the spread of person- and community-centred approaches for health and wellbeing

Guide to how behavioural science can help spread the take-up of person- and community-centred approaches to health and wellbeing.



Making it happen: Practical learning and tips from the five Realising the Value local partner sites

Catalogue of practical learning and examples of good practice from the five Realising the Value local partner sites.



Supporting self-management: A guide to enabling behaviour change for health and wellbeing using person- and community-centred approaches

Guide to how the science of behaviour can help people to self-manage their health and wellbeing.



New approaches to value in health and care

Calls for action to ensure that the approach to understanding, capturing, measuring and assessing value in health and care takes full account of value as it is experienced and created by the people and communities with whom formal systems seek to work.



What the system can do: The role of national bodies in realising the value of people and communities in health and care

How national bodies can best remove barriers to progressing person- and community-centred approaches for health and wellbeing.



Impact and assessment: Economic modelling tool for commissioners

Economic model, in the form of an excel spreadsheet, a user guide and a report, to help commissioners evaluate the potential impact of investing in person- and community-centred approaches for health and wellbeing in their local area.

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About Realising the Value

Realising the Value was a programme funded by NHS England to support the NHS Five Year Forward View. It ran from May 2015 to November 2016. The programme sought to enable the health and care system to support people to have the knowledge, skills and confidence to play an active role in managing their own health and to work with communities and their assets.

There are many good examples of how the health and care system is already doing this. For example, recognising the importance of people supporting their peers to stay as well as possible or coaching to help people set the health-related goals that are important to them.

Realising the Value was not about inventing new approaches, but rather about strengthening the case for change and identifying evidence-based approaches that engage people in their own health and care. It also sought to develop tools to support implementation across the NHS and local communities. But putting people and communities genuinely in control of their health and care also requires a wider shift. The programme therefore considered the behavioural, cultural and systemic change needed to achieve meaningful transformation.

www.realisingthevalue.org.uk

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