Values-Based Commissioning of Health and Social Care

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Preface: Values-based Commissioning

Values-based practice is not another category of commissioning to rank with practice-based commissioning, locality commissioning, or commissioning for outcomes in health and social care. Values-basing is about the processes that can be applied to any form of commissioning, anywhere. This book explores these processes. The UK revolution in commissioning health and social care makes a very convenient backdrop, but not a reason, for a highly topical discussion of what values-basing really means.

Values-based commissioning describes the theoretical and practical demands on clinicians and social care professionals of using stated values to achieve an improved process for filtering the available evidence to achieve improved outcomes for patients and service users. Commissioning is a complex and iterative process that requires commissioners to balance evidence and values so as to achieve the best health and social care appropriate to the needs of individuals.

Health and social care commissioning is a values-driven as well as evidence-driven enterprise. Although there has increasingly been an expectation that the evidence base of commissioning should be made fully explicit, the corresponding values base has by and large been left largely implicit. Values-based commissioning thus complements evidence-based commissioning by providing a skills base and other support processes for working with differences of values that are held by all those engaged in making commissioning decisions.

This book describes the challenge of values-based commissioning (V-BC). For some, that challenge is theoretical – why should V-BC improve the way we commission care, and how will values help? Others will be concerned that there are insufficient resources needed to engage patients and service users regularly in a truly satisfactory way; for yet others, it is not so much their commitment that is in question as the pressure on the health service at a time of severe restraint. There is no doubt the austerity programmes that affect everyone but especially the UK and the USA during 2011–2012 have taken their toll. However, V-BC should not be optional. It should be complementary to evidence-based practice (E-BP)[1] at all times.

What are values? The first thing to say is that the discussion in the book is not too arduous philosophically. That is not to say we should not be rigorous, but there is a lengthy debate to be had, separately, about the role of values, preferences, beliefs and desires, their differences, and their relevance to health and social care, although that is in part covered in Fulford *et al.* (2012, forthcoming), in the same book series. Are some values virtues? Or should values and virtues be kept separate? Are some beliefs values? While, for example, religious beliefs may not be to everyone's liking, they are often strongly held and shape some people's values. Are some desires values? Or are values the consequences, or conversely perhaps, the antecedents of our desires? We are not so much concerned here with what *should* be considered a value, but what *is* practically a value that must be taken into account. In the debate on abortion, for example, there are differing and strongly held values on either side of the argument. To recognise that fact does not necessarily require us to enter the debate about abortion per se!

[1] We will use the term evidence-based practice (E-BP) throughout rather than evidence-based medicine (E-BM) except where the latter is directly appropriate; and we will use the term values-based commissioning (V-BC) except where values-based practice (V-BP) has a more generic feel.

The challenge of V-BC is fourfold. First, there are many values some of which are not usually engaged in health and social care, although they may be part of the wider culture from which patients and service users are drawn. Understanding those values is necessary to ensure that everyone and especially minority groups and cultures are given due weight in all health and social care discussions. Second, values can be written in various ways, but are usually normative statements that affirm how things should be or ought to be, which things are good or bad, or which actions are right or wrong. Values are the principles with which we lead our lives; some are held more firmly than others, but everyone has them!

Third, 'values' cover many aspects of life which impinge peripherally on health and social care; these may not be our most pressing concerns, but sometimes they become much more important for short periods or for small but significant matters. For example, my childcare arrangements may have very little to do with my health care demands; but if the clinic appointment happens to coincide with my caring duties, to which I am committed, the clash may take on more important character at that moment. Fourth, values concern the felt aspects of illness, as opposed to the factual issues of disease; values are an essential component of any serious discussion about health and social care.

Values-based commissioning is thus the reflection of our values in a discussion of the evidence. In Chapter 1 we will note that V-BC seeks a full understanding of recognised individual, group, community and population values with which to develop a picture of the community in relation to a particular health or social care matter. This is then used creatively and comprehensively to reflect the evidence base and to determine the best way to offer care, giving due weight to the values as expressed. As we shall see in Chapter 2, there are many differing values that can be engaged, and the NHS, public health, well-being, and social care reforms demonstrate how important values are.

Chapter 3 is a discussion of the government's reform programme. Whether this will become law, and if it does, how it will be implemented and the problems and opportunities it may bring, are at once of interest in providing the present context *and* irrelevant to effective values-based practice. V-BC is an essential component of health and social care commissioning independent of the current legislative, organisational or policy driven structure of the NHS and local authorities. Readers may wish to skip the discussion if they feel they have sufficient understanding of the government's intentions; or conversely, they may find the discussion of the context illuminating.

Chapter 4 then considers evidence and outcomes, identifying the 'other side of the coin' – evidence-based practice, and the way that E-BP and V-BP (values-based practice) interact. V-BP enables commissioners to identify and make explicit the often diverse values of all those engaged in the process of commissioning, and to map those values onto a carefully prepared framework (Fulford *et al.*, 2012, forthcoming). By drawing on the diversity of values so far identified – Chapter 5 considers the role of community and public engagement in obtaining values – commissioners then have a resource for balanced decision-making within the context defined by the framework. The framework can then be used to engage with a continuing process of evidence-based review, bringing personal, community and professional values into contention with the qualitative and quantitative evidence drawn from the scientific (social, physical and psychological) research literature.

Chapter 6 considers values in public health, especially in relation to enhanced morbidity and mortality from deprivation, and 'prior discriminations' suffered by minority communities. The social determinants of health are often given a specific twist as a result of discrimination by society or individual institutions. Chapter 7 then takes health and social care

together. Integrative commissioning demands a V-BC approach that seeks to link the values of the NHS and social care, patients and clients, clinicians and social care staff. Integrative suggests and anticipates actual integration. We do not need to have wholly integrated systems to pursue an integrative strategy.

Values go wider and deeper than ethics. Values are explicit in some areas of medicine, as we shall see in Chapter 8 on priority setting when we discuss cost–benefit and cost–utility analyses that form the basis of health (and increasingly social care) guidelines (Brown *et al.*, 2005). Existing resources for values-based practice include decision theory, health economics, social science and the medical humanities (Fulford *et al.*, 2002).

Chapter 9 addresses outcomes and the perennial problem of describing an outcome in terms that make it measurable, attractive to policy makers, appropriate for contracts, and meaningful for patients and service users. Chapter 10 takes a long look at market stimulation and market ideology, identifying the appropriate role of the private sector and demonstrating the importance of social enterprise and the third sector. Finally, Chapter 11 considers management and leadership of health and social care. A carefully focussed discussion of the literature on leadership demonstrates that values are indeed inherent to the whole enterprise

Values-based commissioning is the practice of recognising and acting on the differing values held by all those engaged in making health and social care decisions, in order to plan and implement health and social care that is culturally relevant and appropriate, clinically and economically effective, and addresses need in a way that reflects the values of those using and providing care. This in turn requires commissioners to hold a commitment to make explicit their values as well as those of local communities, patients and service users (Jensen and Mooney, 1990; Woodbridge and Fulford, 2004).

The book is embedded primarily in the experience of the UK, particularly England. However, its message applies just as much to other jurisdictions, notably the Anglophone countries (such as Australia, Canada and the USA). For example, the discussion in Chapter 1 on the derivation and deliberation about values and in Chapter 4 on evidence and outcomes apply as much to other countries as to England. Market ideology will appeal to countries with a large private sector, as will Chapter 11, which draws heavily on the US literature. Soundings taken with clinicians in the USA suggest that the theme of this book will have a ready audience, especially among clinicians and medical managers who want to achieve improvements (and cost savings) that are acceptable to patients.

Overall, values-based commissioning reflects not a programmatic approach to commissioning, such as locality commissioning or practice-based commissioning. Rather, it reflects a fundamental need to understand the values of the people served in whatever way commissioning is undertaken. The book will appeal to commissioners of whatever stripe as they struggle with governments' change programmes at a time of austerity. Values-based practice will help to achieve a better and more responsive health and social care programme acceptable to all patients and service users.

Christopher Heginbotham
Priest Hutton

Abbreviations

3Is	Institute for Innovation and Improvement
ADL	activities of daily living
APHO	Association of Public Health Observatories
ASCOT	Adult Social Care Outcomes Toolkit
BME	Black and minority ethnic
CABG	Coronary Artery Bypass Graft
CBA	cost–benefit analysis
CBT	cognitive-behavioural therapy
CCG	Clinical Commissioning Group
CCP	Cooperation and Competition Panel
CEA	cost-effectiveness analysis
CHD	coronary heart disease
CIP	Percutaneous Coronary Intervention
CQUIN	Commissioning for Quality and Innovation
CUA	cost–utility analysis
DALYs	Disability Adjusted Life Years
DCLG	Department for Communities and Local Government
DFLE	disability-free life expectancy
DH	Department of Health
DMU	directly managed unit
E-BM	evidence-based medicine
E-BP	evidence-based practice
ECHR	the European Convention on Human Rights
FOIA	Freedom of Information Act
GP	general practitioner
GPCC	GP Commissioning Consortia
H&WB	Health and Well-being Board
HAQ-DI	Health Assessment Questionnaire Disability Index
HLE	healthy life expectancy
IB	individual budgets
IM	infant mortality
IPU	individual practice unit
JSNA	joint strategic needs assessment
LA	Local Authority
LE	life expectancy
MCDA	multi-criteria decision analysis
MDS	minimum data set
MoH	Medical Officer of Health
MOPSU	Measuring Outcomes for Public Service Users
MSOA	Middle Level Super Output Area
NEET	not in education, employment or training
NIESR	National Institute of Economic and Social research
NIMHE	National Institute for Mental Health, England
OFT	Office for Fair Trading
PbC	practice-based commissioning
PBMA	Programme Budgeting and Marginal Analysis
PbR	payment by results
PCT	primary care trust
PRCC	Principles and Rules of Cooperation and Competition
PSA	Public Service Agreement
QALYs	Quality Adjusted Life Years
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality and Outcomes Framework
RCT	randomised controlled trial
SHA	Strategic Health Authority
SII	slope index of inequality
TPP	total purchasing pilot
UA	Unitary Authority
UDHR	Universal Declaration on Human Rights
V-BC	values-based commissioning
V-BP	values-based practice
VFM	value for money
VM	values matrix
WCC	World Class Commissioning