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Christopher Heginbotham
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Chapter 1

Values-based practice in health and social care

Purpose and scope

This book is intended to assist all those charged with commissioning health and social care in the UK and in other jurisdictions that have similar organisational arrangements. The term 'values-based commissioning' begs for definitions. These are discussed in some detail in this chapter and elsewhere. At this point it is worth clarifying the broad purpose and scope of the book.

Commissioning is a complex, iterative process that ensures that health and social care provision for a population is clinically and cost-effective and appropriate to the needs of the people for whom it is intended. Commissioning is not simply planning or procurement. Commissioning has a number of stages described in different ways by various authors, and in different countries and jurisdictions, but all contain something along the following lines.

Commissioning has a cyclical form that begins with assessing the health and social care needs in the communities served; consults and involves patients and the public alongside community, patients and service user organisations; defines the care outcomes appropriate to the population served; identifies the types of interventions (medical, surgical, social or psychological) that may be appropriate to the conditions to be treated or ameliorated; gathers information on all those providers that may be able to or wish to contribute a component of the care pathway (subject to some over-arching policy on the use of NHS providers); invests in capacity-building organisations to provide tailored and effective care; encourages all reasonable providers to become involved through ensuring that contracting processes are fair and transparent; develops acceptable risk-sharing arrangements; and establishes feedback processes that catalyse further innovation and engagement of patients and the public.

Each of the nested clauses in the previous paragraph can be 'unpacked' and are considered in much greater detail in the following chapters. It can be seen at once that commissioning is not simply a matter of contracting or procurement. It is rather a process of needs determination and then finding the best, most cost- and clinically or professionally effective solution. This may mean using existing NHS or local authority services, or it may require community groups to be encouraged to offer culturally relevant and appropriate solutions to local needs. It may mean using the private sector, or third-sector organisations that are increasingly important partners in offering tailor-made personalised care for specific needs within those communities. Social enterprises offer alternative prescriptions. The challenge is to balance the needs of the majority, and thus the cost-effectiveness of care with offering person-centred services that address individual need.

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Values-based commissioning

If commissioning is a complex and iterative process, what do we mean by 'values-based' commissioning? Health and social care commissioning is a values-driven as well as an evidence-driven enterprise. However, whereas 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.

It should be obvious that, if (for the moment) the definition of commissioning given above is accepted without argument, it raises a number of important questions about 'how we know what we know' and the basis for making judgements about what we are told or learn from the processes described. For example, as commissioners, how do we decide that a 'need' is something that we should consider our responsibility to do something about, or to ignore, or to find a non-NHS or health care response?

We are immediately in the familiar, albeit still far from straightforward, territory of deciding whether this 'need' should be met. Is this normative need (for example, something that medicine might consider a standard condition-treatment option); is it required in comparison to those who do have this 'need' (for example, in relation to health inequalities); is it a 'felt need' from the perspective of the person who claims that need; or an 'expressed need' which may or may not be a 'want' rather than a necessity (Bradshaw, 1972)?[1] We can only really get to the root of these linked questions if we consider carefully not only the (objective) evidence base for the need (for example, epidemiological evidence) but also the reasons why people feel or express their need. In other words, the values that they hold and which they bring to any discussion about need. As Jane Hirshfield put it, '[W]e are psychologically made visible by our desires' (Hirshfield, 2008, p. 21).

Values-based practice enables commissioners to identify and make explicit the often very diverse values of all those involved whether as commissioners, as providers or as users of services. This diversity can then be mapped onto an explicit, carefully prepared framework that includes not only ethical values but also the needs, wishes, aspirations, strengths and resources of the services, the community and individuals. By drawing on the diversity of values so far identified, commissioners then have a resource for balanced decision-making within the context defined by the framework, which is why the way that framework is defined is so crucial. The framework can then be used to engage with an 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. Fulford *et al.* (2012, forthcoming) describe the framework and process in detail.

Values go wider and deeper than ethics. By patient values we mean the unique preferences, concerns and expectations each patient brings to the clinical encounter and which must be integrated into clinical decisions if they are to service the patient. The common feature of values, which is what makes them directly relevant to medical decision-making, is that they are 'prescriptive' or 'action guiding' (Hare, 1952). So values are explicit in some

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[1] Bradshaw (1972) described these four types of need in a now classic paper that has been referred to frequently over the years.

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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).

Current policy priorities driving the need for values-based as well as evidence-based commissioning include primary care-led (perhaps better described as clinician-led commissioning, in which commissioners will have to engage with widely divergent cultural values), integrative commissioning of health and social care that recognises the special contribution of families and communities, and the personalisation of services (the basis of which is individually defined needs). Values-based commissioning is effective in such contexts not because it allows everyone's expectations to be satisfied, but because it provides a process that is seen to be transparent, fair and balanced. Values-based commissioning is successful to the extent that everyone feels their voice has been heard.

It will by now be apparent that 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 make explicit their values as well as those of local communities, patients and service users (Jensen and Mooney, 1990; Woodbridge and Fulford, 2004).

Values differences

The values that people hold differ enormously: what may be important to one person may be of little significance to another. V-BC provides a framework for commissioners and commissioning practice that recognises the diversity and multiplicity of values, and raises awareness of the way values relate, interact and impact on experiences, actions and relationships in health and social care commissioning. Sometimes values are seen as synonymous with ethics. However, values are much wider than ethical principles even though ethical considerations matter greatly in health and social care. Values cover what is valued by all those who commission or use health services. This includes not only ethical values (or principles) – justice, best interests, not doing harm, autonomy – but also wishes, desires, beliefs, ideals, or needs, in addition to ideas on quality of life, self-fulfilment, flourishing, and well-being (Woodbridge and Fulford, 2004).

V-BC draws on the insights of V-BP, which identifies differences in values as crucial to effective clinical and professional practice (Woodbridge and Fulford, 2004). Clinical, social and organisational values differ between professional groups, commissioning organisations, patients, service users and the general public. Where values are common, there is less likely to be disagreement about decisions on health and social care provision; where values differ, there is an opportunity to debate those differences and use the debate to focus on possibly contentious matters that require resolution before complex, challenging and difficult decisions can be taken. Where values conflict, there is an opportunity for learning, for sharing the reasons for those differences, for greater understanding, and for achieving a resolution acceptable to all parties.

The practice of medicine, health and social care is *always* values-driven, even if those values are not made explicit. Decisions on allocating resources to services, or individual treatments, are not value-free. Often, the values that underpin a public service are those of a dominant professional or cultural group; sometimes they are informed by individual concerns and prejudice; sometimes they are enforced by and embedded within legislation. V-BC provides a powerful context for commissioning health and social care, where the values of clinicians, managers, organisations, patients and service users may differ. V-BC recognises diversity and difference and emphasises the importance of making values explicit in order to highlight differences in the ways that patients and service users can expect to be treated. Real and effective commissioning (and, for that matter, de-commissioning) can only be achieved through an authentic understanding of the values held by the community.

While some values are universal (such as the right to life, or freedom from torture or degrading treatment), even these values can be contentious in health care. The right to life cannot be considered a right to be kept alive at any cost. V-BC catalyses a debate about the values to adopt in any culture or community when making decisions about the most appropriate forms of treatment, care or support to offer a patient or family.

Values-based commissioning encourages recognition of diversity and difference – by income level, ethnicity, age, gender, disability, faith and sexuality – and through differing perspectives or cultures, personal motivations, strongly held beliefs (religious, cultural, political, or familial). Values may differ but individuals often hold coherent albeit complex, and over-lapping, value sets. Values are not static. Differing values may not indicate competing interpretations but complementary aspects of a highly complex concept. They vary over time and place for individuals and communities. What is considered right at one time or place may be thought wrong at another. VBC requires robust processes of community and individual engagement that go beyond tentative public involvement strategies. True engagement places communities centrally in the commissioning process working as genuine partners with professional staff and commissioning organisations.

Shared decision-making

Values-based commissioning is not the same as shared decision-making. The latter is an important part of provider-side practice that enables patients and service users to become involved in decisions about their care in a well-informed way. Shared decision-making is a process ‘in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient’s informed preferences.’ It involves ‘evidence based information about options, outcomes and uncertainties . . . with decision support counselling and . . . recording’ (Coulter and Collins, 2011). The emphasis on evidence in this definition suggests that this is one half of the field, that of evidence. Shared decision-making enables that part of the equation to be made real. However, it does little to ensure that patients’ values are understood or used in the determination of treatments. This is acknowledged in the breach, so to speak, by Coulter and Collins in the way they describe shared decision-making always as ‘preferences’ and never as ‘values’. Preferences flow from understanding the evidence; values from inner beliefs and motivations.

There is good evidence from a number of studies that patients and service users who are fully engaged in decisions about health and social care have better outcomes. The distinction between shared decision-making, self-management support and personalised care planning is that they have similar philosophies rooted in a concern to use the evidence as wisely as possible. What matters are the practical nuts and bolts of self-management and care planning rather than the underlying attitudes and values that are brought to the table. Patients and service users want more information in a clear and simple, jargon-free manner. It must be available immediately and at all stages of the patients’ and service users’ care and treatment

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pathway. Using the evidence and information as decision aids or recognition of decision points in the pathway is a valuable approach to evidence. What is then required is a structured values-based process that builds on the mechanisms of care (the disease element) to add the human element (the feelings of illness or well-being).

The growing complexity of values in health and social care is due to a number of factors, some that are general to society as a whole and some specific to medicine or social work, health sciences (such as epidemiology) or social sciences (such as cultural studies). Progressively, patients and families are engaged more in decision-making with clinicians ('voice and choice'); the increasingly wide treatment options created by advances in science and technology are strongly value-laden. Multi-disciplinary teamwork suggests that there is no one dominant narrative, which necessitates all professions to have their say (Fulford *et al.*, 2002).

Fact-value distinction

Not everyone agrees with the desirability or acceptability of fact and value (e.g. Putnam, 2002). An ordinary 'distinction' between fact and value does not have only one meaning – it is not unambiguous. We can have a range of differing interpretations depending on the partitioning of the values space, and the nature of the value judgements. On the other hand, a 'dichotomy' presupposes a division into two parts or categories, particularly when they are acutely differentiated or divergent. In our scheme, fact and value are not so sharply distinguished. Indeed, fact and value are entangled to a noteworthy extent and derive part of their meaning from each other. Scientific research depends on values; values are shaped by evidence. Much of our descriptive language confronts notions of 'fact' and 'ought to shake the confidence of anyone that there is a notion of *fact* that contrasts neatly . . . with the notion of "value" supposedly invoked in . . . "value judgements"' (Putnam, 2002, p. 26).

Values are used to describe 'qualities that guide our actions and subject our (human) activities to be worthy of praise or blame' (Sadler, 2004). They are not context-free: a decision on whether to treat a statement as implying a value judgement depends significantly on context and the way that enables an interpretation. 'Thick' value terms also 'exhibit a complex mix of factually descriptive and evaluatively descriptive meanings' (Sadler, 2004, p. 31), which must be considered carefully in actual practice. Similarly, there may be value-related consequences to particular choices within a theory or classification.

Values come in many sizes and shapes. Epistemic values are related to rationality and are concerned directly with evaluation of scientific theory (see above the idea of 'entanglement', and in Chapter 4 on rationality); this contains words such as coherence, precision or simplicity. Ethical values are those pertaining to moral or immoral conduct, using words such as autonomy, beneficence, malfeasance or justice. Pragmatic or utilitarian values concern the economic or efficient use of resources, with terms such as well-organised, competent or cooperative. Ontological values are highly relevant to the self and to ideas of time and causality; they are 'deeply presupposed' (Sadler, 2004, p. 38) and because of this are relevant to psychiatric disorders especially. Finally, aesthetic values are those that tell us something about beauty and proportion, but may also include 'economical' and 'resourceful' where those terms are affective rather than pragmatic. This is not a hard and fast taxonomy, but rather a description that suggests ways of viewing values and their use in practice.

When we use values, particularly in determining the right way to provide care, or in obtaining a population perspective on a service, the words we use offer a clue to the

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appropriate way to behave and deal with the presenting problem. This will be especially true in challenging the available evidence with a set of epistemic beliefs about the underlying science or in deciding that a study was not undertaken ethically, for whatever reason. More importantly, both for groups and individuals, ontological values will be brought into play. Where a concept is highly contentious (for example, community treatment orders in psychiatry) then these concepts will be important precursors to understanding the correct way to use the evidence in the light of an individual's set of principles, beliefs, aspirations, hope and goals. Indeed, values-based practice is based on theoretical work undertaken in analytic philosophy concerned with the meanings and implications of value terms (Fulford, 1989).

One set of values that we have not touched on are spiritual and personal values. Spiritual traditions challenge the self-centred and material culture, but 'offer an alternative system of values-based on selflessness, compassion and wisdom' (Rubin, 2007, p. 147). Being poor is not a virtue, but affluence does not resolve fundamental emotional and spiritual problems. 'A world of timeless egos adopting and discarding styles of self-presentation and self-assertion, is a social as well as philosophical shambles' (Williams, 2000, p. 49). Ontological values will thus include those that apply to particular cultures and communities. In the West there is, compared to many cultures in other countries, an astonishing degree of individualism (Conway, 2007). Whether smart men in the city dressed in suits, or the young teenagers with expensive trainers and hoodies, each is a tendency to re-establish a tribe of sorts. Conversely, the tribal nature of societies as far apart as Libya or Pakistan provide a different way of interpreting values with collective agreements that may tend to conservatism but with a degree of coherence. The multi-cultural and multi-ethnic society demands that we recognise differing and diverse values in deciding on the evidence we use and the care we give.

Ten principles of values-based practice

Commissioning health and social care includes the functions of identifying need, determining ways of meeting that need, engaging with patients and service users, negotiating with providers or suppliers, capacity-building local organisations and communities, and making decisions on which services, at what quality and in what quantity to fund. The current and continuing emphasis on personalisation demands recognition of the differing values held by recipients of personalised care packages. As health and social care moves inexorably towards individual health or social budgets, V-BC will be a necessary underpinning of the process of determining the financial and service response.

Values-based commissioning is the essential requirement of acceptable and legitimate health and social care development. Focusing on the values of all those involved in determining the most appropriate health and social care for a community will ensure the widest acceptance and legitimacy of the increasingly tough decisions required. One reason for this is the distinction between the value of health (value-in-use), and the value of health care (value-in-exchange) (Mooney and McGuire, 1988, p. 7). It is 'only the consumer/patient who can attach a value-in-use to health status' (Mooney and McGuire, 1988). In other words, the outcomes of care can only really be known to the patient. The treating clinicians will have an informed view, but the feelings as well as the evidence can be assessed fully by the patient alone, but with some help and support.

As we have seen, V-BP aims to support balanced decision-making within a framework of shared-values practice based on mutual respect and relying for its practical effectiveness on good process rather than pre-set right outcomes (Fulford *et al.*, 2012, forthcoming). Values will usually be in tension or conflict, and V-BP provides the skills and other resources for balanced decision-making in individual cases. However, what about the case of groups or communities? How do we use V-BP for making priority decisions or resource allocation between conflicting groups with differing values?

First, of course, we must recognise that V-BP and its sister, evidence-based medicine (or practice; E-BP) are two sides of the same coin. As Fulford *et al.* (2012, forthcoming) suggest, V-BP and E-BP must be carefully weighed and made reciprocal. They quote the National Institute for Mental Health, England (NIMHE) Values Framework which is itself based on two parts: a first half that provides an important guide to NIMHE's work, and a second part that sets out those values held to be of especial importance to NIMHE and mental health service development. The first half is three R's of V-BP: recognition, raising awareness, and respect. 'Recognition' is concerned with the proper balance of evidence and values; raising awareness concerns diversity; and respect is a direct reference to the basis of V-BP as a foundational programme. 'Recognition' goes beyond the importance of noting and acting on both values and evidence, towards, as we will see in Chapter 5, a recognition and acceptance of diversity and difference.

The 10 principles of V-BP demonstrate that, as so often, it is good process that makes for good decisions (Fulford, 2004). They are:

- four principles of clinical skills,
- two principles of relationships,
- three principles of science and values together, and
- a final important principle: 'dissensus'.

The four principles of clinical skills are:

- awareness of values – the importance of accepting and addressing the tension and possible conflict of values;
- reasoning – about values and evidence, with patients or service users, and understanding their views, aspirations, background, culture and information;
- knowledge – recognising that values are important even to someone who a professional person might consider to be 'beyond the pale', such as a heavy smoker with cancer but who refuses to quit smoking; and
- communication skills – perhaps a crucial and obvious requirement of values-based practice.

The two principles about relationships are concerned with the quality of professional relationships with service users, and thus cover:

- person-centred care, which is determined by and contributes to values-based practice; and
- multi-disciplinary practices and teamwork, which includes all those who have a locus in the process.

The further three principles are practical and may be 'red flags' in the process (Fulford *et al.*, 2012, forthcoming).

- The two-feet principle recognises that all decisions are based on the two feet of evidence and values. If a problem seems to be no more than checking or establishing the facts then there is probably a difficulty with values.

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- The squeaky-wheel principle suggests that we notice values when they become problematic. In fact this is one of those principles that is important because it sums up the core issue at the heart of V-BP – that it is where values are in tension that the work gets done. As Fulford *et al.* (2012) suggest, however, this also 'flags' for us that, most likely, if the problem appears to be one only of values, then we may have missed something to do with the evidence.
- The science-driven principle draws attention to the importance of both facts and values together, and suggests that especially, although not exclusively, for hi-tech medicine it is essential to look out for hidden facts and values.

Finally, the tenth principle is 'dissensus' (Fulford, 2011b). Dissensus is 'agreeing to disagree', an outcome that is peculiar to values-based practice. Undertaking values-based commissioning requires that clinical commissioners (general practitioners (GPs), nurses, hospital doctors, etc.), patients and service users and their families, and the community in various guises, are all involved in the process. However, at the end of the day, not all values can be brought into the equation. Some values may be held over, not discarded but retained to be balanced by another subject on another day. There is no harm in this, if everyone accepts the process, which must of course be seen to be fair, open, transparent and honest.

Facts and values

While we have little space to go into details about the reasons for facts and values, there is no doubt that the history of this process is filled with attempts to dismantle the edifice created. More importantly, the divide between facts and values has a long and credible history, especially the idea that a value can be constructed from a fact (rather than vice versa). Hume (2000) noted that arguments often proceed by making factual statements only to end with a conclusion about values. To Hume this was 'altogether inconceivable'. Similarly, Moore (1903, reprinted 2000) suggested that it is a 'mistake to analyse an ethical statement by defining good in a way that points to any natural property' (described in Orr, 2011). For almost 300 years there has been an austere discouragement for the idea that facts and values might be related too closely.

There are those, as we have seen, who believe that the distinction has no (or little) reasonable basis (Putnam, 2002). However, by and large, the difference is not only useful, but essential to a proper analysis of why we do things in the way we do. More importantly it is the range and nature of facts and values that provides the opportunity to develop a process of priority-setting and resource allocation. Fulford (2011a) has shown that the practice of evidence-based and values-based practice are two halves of the same field. On the one half is disease – a set of facts – and these 'cash out' as a failure of function (of the body). So, if deterioration occurs, caused by something such as renal disease, then the failure that results is loss of renal function. This is the consequence of focusing on fact. The fact of the disease leads to a failure of some bodily function. The other half of the field is 'illness', an evaluative not a factual term. This 'cashes out', as Bill Fulford describes it, as failure of 'action'. An illness is a 'feeling' of being ill, a term that identifies the person as 'under the weather'. A person may feel ill and may or may not be diseased, or at least not seriously. Conversely, having a 'disease' denotes a bacterium or a virus that can be cultured, or a tumour or other lesion, and does not necessarily mean you feel 'ill'.

That is all very well for a bacterium or a virus, but what do we say to a disease such as coronary heart disease or, rather differently, a broken leg. The former is based on diagnostic tests that can show the presence of narrowed arteries – a fact; the latter is, of course, by

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Table 1.1 Facts and values.

	Facts	Overlap (entanglement)	Values
No disease	No disease entity	Challenges to the way disease is measured	Feeling of illness
Disease	Disease entity such as evidence of a bacterium or virus	Challenges to the way feelings are described	May not feel ill but may have latent disease

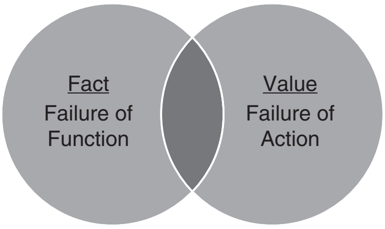

Figure 1.1 Fulford's 'full field' approach to the fact-value distinction.

definition a 'fact'. These situations may still make the person feel unwell, and indeed may be serious, but they have a definite basis in fact. More difficult are those situations where I may have a serious illness but do know it. An early cancerous growth may not manifest for months or years, and in the meantime I feel well even though I have a serious disease. On the other hand, I may feel ill as a result of drinking too much alcohol the night before, but I do not have a disease (assuming I am not an alcoholic or suffering from a hepatic disorder). See Figure 1.1.

The importance of values-based practice is that it recognises the interplay of the two sets of data, the factual and the evaluative. The 'full field' approach thus generated provides a number of opportunities. In the first place it suggests that the two halves of the field overlap and that a number of insights emerge at the intersection that is generated. These can be represented by Table 1.1.

Second, in some cases (for example, mental illness) we can consider other elements such as capacity to consent or refuse treatment. The term 'action' suggests 'agency', an ability to make decisions for oneself. This may be affected, to the extent of attenuating the person's decision-making responses, by a feeling of illness even if there is no evident disease entity. Conversely, the effect of a proven disease may not have the necessary implications of reducing the ability to make a decision. Indeed, this distinction has caused untold difficulties with patients over the years.

Third, being 'ill' may be a smokescreen to hide behind when there is no disease present. 'I feel ill' has been used for centuries as an exculpating reason not to do something. This can be useful 'in the limit', but does not assist us in devising an effective values-based practice.

Values-based commissioning thus reinforces the desire to identify disease (or its equivalent in social care) from the feelings of illness where there is no disease present. As we have seen, 'feeling ill' translates into a failure of action, either deliberately or involuntarily; being 'diseased' requires some form of care, although that may be relatively simple, such as offering personal pastoral support. It is here that we come to the crux of the full field system. It does not suggest that health deals with treatment, and social care with evaluative positions. Rather social care and health both have factual and evaluative dimensions.

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Table 1.2 The interplay between the fact–value distinction and health and social care.

	Health	Social care
Facts	Identifiable disease entity or other factual description	Lack of aids to daily living (money, housing, transport, etc.) ('I cannot cope because . . .')
Values	Illness or other feeling that may or may not require intervention	Needs assessment (normative, comparative, felt, expressed) ('I feel unable to cope')

Table 1.3 Facts and values in relation to individual and population perspectives.

	Individual	Population
Facts (disease)	Shared decision-making	Public health
Values (illness)	Personal values-based commissioning	'Proportionate universalism'[2] based on population values

Table 1.2 also throws into relief the nature of this distinction. Facts are facts, although they may be disputed, but values often have a factual aura. In health and social care we note that the person's situation is a result of some decision(s), perhaps recent, perhaps from many years ago, that has left the person with a feeling of illness or not coping. The evidence base is often thought of as evidence-based medicine (E-BM), but must surely for these purposes be widened to evidence-based practice (E-BP); that is, both evidence of what works in medicine (an amalgam of science and human values), and in social care (an amalgam of responsible opportunities and social action).

The nature of local authority Health and Well-being Boards proposed by the government will thus grapple with a complicated mix of health and social care facts and values. It does not follow that 'health' provides E-BM and 'well-being' (or social care) offers ways in the community to address lifestyle concerns. Health (the NHS and private and voluntary companies) offer a range of evidence- *and* values-based approaches; social care offers well-being interventions alongside traditional social care, but based on an assessment of the evidence of what works (and how well it works) and the values of individuals, groups and communities. How those values are determined, and the ways in which they can be used is, the subject of Chapter 2. Health and social care resources need to be pooled and aimed in the first instance at cost–benefit-proven universal and targeted population benefits. What is left can then be used to tackle a range of values-based opportunities, some of which, but not all, will have an evidence base.

Most importantly, viewing E-BM through a values-based lens will enable evidence to be assessed by those who will be most affected. How that will be done is a matter of some conjecture, but in Chapter 7 we will offer some suggestions, especially on the way that NICE Guidelines can be used to treat patients and can be over-ridden where patients and service users have good reasons to want something else. See Table 1.3.

Values-based practice is thus implicitly tied to outcomes and to outcomes-led commissioning. As we consider the interplay of values and evidence, it becomes apparent that we must consider the outcomes that we can achieve from the interventions that we agree. If the

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[2] We will discuss proportionate universalism in Chapter 7.