

September 2015

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# **A culture of stewardship**

The responsibility of NHS leaders to deliver better value healthcare

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By **Professor Sir Muir Gray**

**Decisions of Value** is a project led by the Academy of Medical Royal Colleges and the NHS Confederation to explore how to balance quality and finance in the NHS. Last year, it brought together a large amount of research to show how factors such as relationships, behaviours and environments influence decisions of value and how this extends beyond Whitehall to the front line. It is now working to develop these findings in a way that represents and supports NHS decision-makers.

**Professor Sir Muir Gray** qualified in medicine in Glasgow and has worked in the NHS since 1972. Sir Muir has held a number of key responsibilities, including being the founding director of both the UK National Screening Committee and the National Library for Health. Sir Muir was also the first person to hold the post of Chief Knowledge Officer of the NHS (England) and served as the co-director of the Department of Health's Quality, Innovation, Productivity and Prevention (QIPP) programme. He is now a consultant in public health, leading the Better Value Healthcare initiative, a lead for the Value Based Healthcare Programme at the University of Oxford, and the author of numerous books on value, including *How to get better value healthcare*.

This briefing is developed from the inaugural NHS Value Lecture given by Professor Sir Muir Gray, which was hosted at the NHS Confederation annual conference and exhibition in June 2015.

**If you want more information about this briefing or the Decisions of Value project, please contact Paul Healy (Senior Policy Advisor, NHS Confederation) on [paul.healy@nhsconfed.org](mailto:paul.healy@nhsconfed.org)**

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## Foreword

Our two organisations have been working together on the theme of value for the last two years. In that time, we've learned a lot about how the NHS is working to meet the tough challenges they face. Our Decisions of Value report made a clear case for understanding cultural factors relating to behaviours and relationships, rather than relying on rules and standards to deliver better value.

Sir Muir Gray is the foremost expert on value and we've been privileged to have worked with him on the issue. This briefing is a snapshot of the enlightened view he has on healthcare and describes how the NHS can change the way it uses public resources over the next five years. It offers a challenge to NHS leaders, yet nothing we've heard or seen so far would suggest they are anything except ready to deliver where they are not already doing so.

We're cautious about suggesting 'the next big thing' and we know that when Sir Muir talks about a new revolution, some people will be wary. There is a real opportunity to align the Five Year Forward View with a strong message about the need for a genuine focus on value in the NHS – not on quality or finance in isolation, rather on the outcomes as a whole for people and the wider population.

We've often heard frustration from NHS leaders at feeling pulled apart by competing priorities to improve quality of care and save money. This is no more prominent than in the current climate in which they will be expected to deliver unprecedented savings over the next parliament. Discussions about value provide a basis to meet this challenge without unacceptable consequences and in a way that demonstrates how the NHS is getting the most from precious resources.

As Sir Muir says, everything in this briefing is happening somewhere. The NHS is having conversations about value every day and it's important that we demonstrate this at a national level. The national framework needs to support local delivery by providing the space to make decisions of value and resist the temptation to encourage a blame culture.

We will continue to work together in this space and explore how to bring clinicians and managers closer together. We hope you find this briefing thought provoking and, if so, we'd be keen to hear those thoughts as part of our work.

**Dr Johnny Marshall OBE,**  
*Director of Policy, NHS Confederation*

**Professor Dame Sue Bailey,**  
*Chair, Academy of Medical Royal Colleges*

The wake of the Titanic was perfect until it was too late to do anything about it. All the dials and the controls were working perfectly, and then they hit the iceberg. One of the principal reasons was that, to save money, the lookouts didn't have binoculars.

The future is like the Manchester Ship Canal – it is something we have to imagine, design, plan and build. It's not like the Isle of Man, a destination awaiting our arrival. In the words of William Gibson, "the future is here, it's just not evenly distributed"

**Everything I write in this briefing I can see happening somewhere and it's going to happen everywhere. This is what we, the leadership of the NHS, have to bring about.**

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## The next big thing

We've had two revolutions in healthcare and they've been astonishing. The first was the public health revolution. What John Snow did with the Broad Street pump wasn't scientific; it was empirical. Snow knew nothing about bacteria because it wasn't discovered until 30 years later. Just like the Industrial Revolution, where James Watt knew little about the physics of steam, Snow just worked out there was some force that could be controlled. The second revolution in healthcare has been the high-tech revolution and it's been fantastic. What's happened in the last 40 years has had an impact on the health of individuals and populations as great as the first revolution. It's been an astonishing period of time.

Yet, at the end of this revolution every country and society faces five huge problems, even after money, technology, good management, investment and education.

### These are:

- unwanted variation
- harm from overuse even when quality is high
- inequity from underuse by groups in high need
- waste of resources through low-value activity
- failure to prevent disease and disability.

So, we need a new approach.

## The future is value

Traditionally, we've looked at institutions and assessed their quality. Even though this continues to be essential, when we look ahead we need to look at population-based measures that relate to value. Quality and value are different. The length of time to get an appropriate test is about quality, and the variation in ultrasound activity is about value. We don't always know what the right level is, but we can demonstrate continuing patterns of variation.

This means more of the same is not the answer, not even better, cheaper, greener, safer versions of the same. What we need is a new paradigm – a paradigm on value. The Decisions of Value report was one of the most encouraging reports of the last decade because the NHS Confederation and Royal Colleges brought NHS leaders together to talk about value.

There are in fact three definitions of value, which I like to call triple value. The first is allocative value, which asks whether we have allocated resources to different groups equitably and in a way that maximises value for the whole population. Then there is technical value, in which improving quality and safety of healthcare increases the value derived from resources allocated to a particular service. Finally, there is personalised value and this relates to ensuring decisions are based on conditions and values of individuals, including the value they place on good and bad outcomes. Let me take each of these in turn.



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## Allocative value

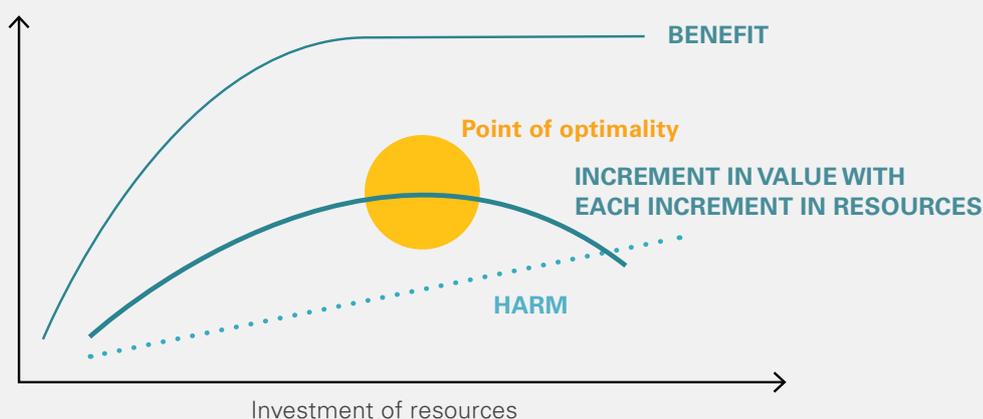
A lot of time is spent debating how much money should be spent on healthcare. When you spend more than 10 per cent of the economy on health, it looks like you start to bite into other public services pretty hard. More importantly though is how much money should be allocated to different patient groups, such as people with cancer or people at the end of their life. Most people on the front line have no idea at all how much we spend by patient group. Mental health, for example, is often described as the poor relation of the health services, yet we still spend £11 billion on it.

Of course, a lot of people will have more than one condition. The way to handle this is to talk about complexity. For example, take an 85-year-old woman with five conditions and 11 prescriptions who is looked after by her 50-year-old daughter with an alcoholic husband. Even though many GPs are terrific at managing complexity, as soon as one of those five conditions gets complicated the neurologists, cardiologists etc get involved. This is not the official language, but is a way of demonstrating the very severe split between generalists and specialists in the last 15 years.

Once we're clear on how much to spend on each patient group, we then need to look at value within each programme budget. For example, what's the right balance in a respiratory budget between how much we spend on COPD compared to asthma? A friend once said they wanted to make investment available for sleep apnoea in their population. I told them to put the COPD people, the asthma people and the sleep apnoea people in a room to make the bid... and then lock the door! When they phoned me a week later to say they were all still in there, I said "don't give them any more water and sandwiches – they will have to make a decision".

Often, there's no way a commissioner can make these decisions because it requires a level of technical detail that clinicians have to accept is their responsibility. This was one of the points that came out of the Academy's great report, *Protecting resources and promoting value* – it's a clinician's responsibility. There are huge variations in the pattern of investment within programmes because particular clinicians have been enthusiasts for a condition in one patch. They have never compared their data with one another on a population basis, so it becomes localised and technical.

### The most important picture in healthcare



## Technical value

The second type of value I outlined was technical value, or so-called 'efficiency'. If the target is 3 per cent efficiency savings then we need to think about this in terms of value. You can have efficient services where you also improve value – this is the traditional approach to efficiency. Quality will always be important but only insofar as it relates to improved good outcomes. I once wrote an article called "Bye bye quality, hello value", agreeing quality was important, but only where it adds value.

Even safety might not represent good value. The biggest example of low-value safety I've encountered is where a decision was made that you could transmit prion diseases through the nail clippers of elderly people getting chiropody. You can imagine the discussion in some room somewhere – "oh yes, there's evidence of this..." So, ten million nail clippers were thrown away every year. What was the value of that? But it was safety, nothing can be too much for safety – yes, it can.

We shouldn't forget that resources are not only about money, but also carbon. I find frontline healthcare staff are often much more motivated by carbon than by money. If you speak about sustainability, people become more focused. Then there is the question of time resources, which is the biggest constraint for frontline clinicians. Increasingly, we also need to think about the time resource of patients, which has been described as "the burden of treatment".

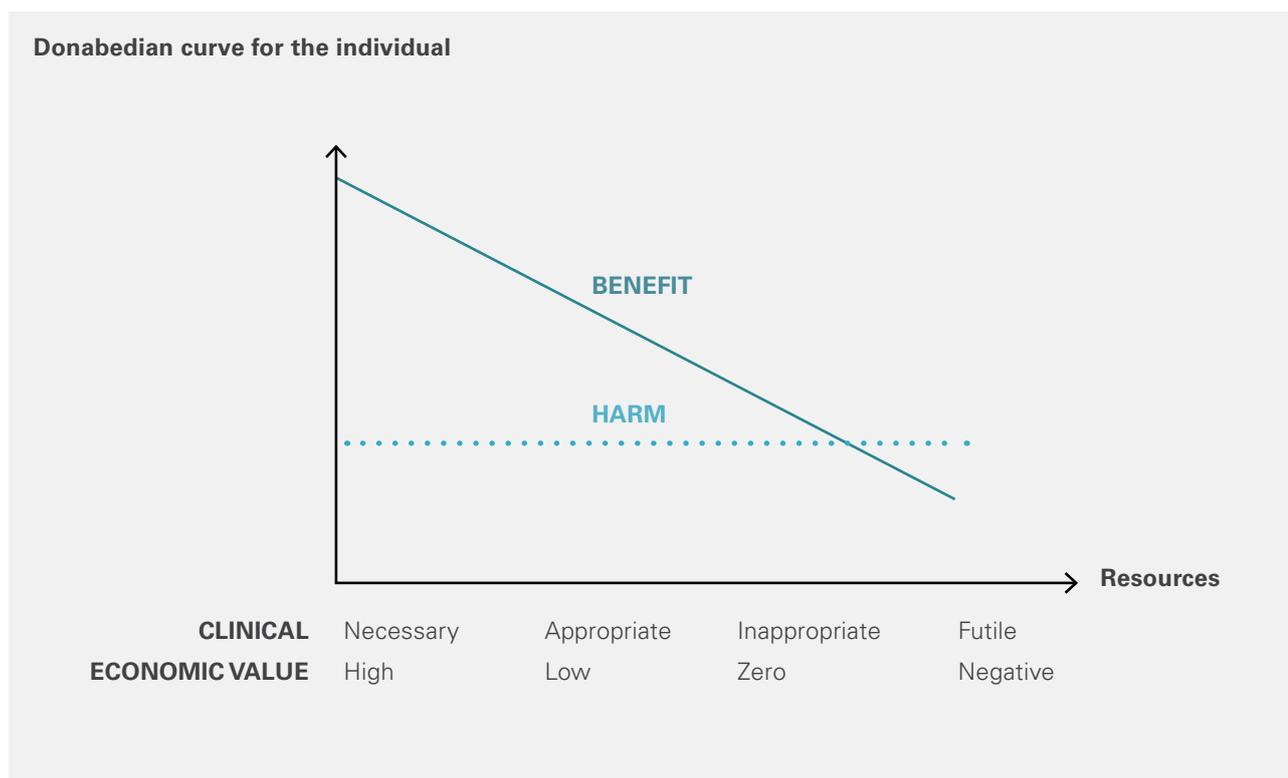
Traditional questions about efficiency are rightly about quality, safety and costs. Another approach is to look at whether resources are being used on the right interventions. Again, this would be a clinician and patient responsibility; in a way, it's the third level of allocative efficiency.

A lot of people are keen to discover ways to improve quality and safety while reducing costs. There is an approach called socio-technical allocation of resources (STAR) that looks to do this by engaging stakeholders in the care pathway to make decisions to shift resources. We're developing an initiative called the IDEAL Collaboration for when surgical innovations creep in. Innovations are often introduced with no randomised control trial evidence because the clinician is rightly doing it for the first time. The IDEAL methods helps look at ways to identify high-value innovations and when something is introduced with no evidence, the person must be entered into a register so we all know what is happening.

The graph above is the most important picture in healthcare. It shows when you put more resources into healthcare, the benefits increase sharply initially and then they flatten off – the law of diminishing returns. This is very clear in screening, for example, because you're dealing with a defined population, although it's the same for anything really. The harms go up in a straight line, although this is not to do with safety.

I want to run a campaign then to change the Hippocratic oath – "first do no harm". The only way to do no harm is to do nothing – all healthcare does harm. Safety and quality changes the shape of the curve, but all healthcare does harm. The more x-rays you do, the more drugs you give, the more operations. Eventually there comes a point when increased resources do not equate to added benefits, which is called "the point of optimality".

The broken leg service works very well. If you've got a broken leg, you get to the right place, but most of healthcare is more complex than broken legs. Evidence shows that hip replacements in the most deprived populations are at about 31 per cent less than in the wealthiest, and knee replacements are at 33 per cent. Who should take responsibility for changing this? It has to be the orthopaedic department.



## Personal value

Perhaps the most important point is whether we are sure that every individual patient is getting what is right for him or her. The above is the Donabedian curve redrawn for the individual. When you start off with treatments like hip replacement or statins, for example, you only offer it to a small proportion of people in the greatest need, so the benefit is high and the harm is low – we call that necessary or high value.

As you do more, the benefits get less. You are not transforming people’s lives in the way that you did, but the harm is still the same, both the probability and magnitude. There may come a point where the lines cross and this would be called negative value or futile care. This is demonstrated by big operations in people with really no prospect of life when there are other ways in which we can help them cope with their remaining years. As the rate of intervention in the population increases, the balance of benefit and harm changes for the individual patient as well as for the population.

## A good steward

The Five Year Forward View is terrific. I’m a veteran of 20 NHS reorganisations, most of which have made no difference at all. I remember one where doctors and the public were reassured we would not notice any change as a result of the reorganisation, and I think that was absolutely the case.

We need to focus on populations, not just referred patients. We need to personalise care in the way I’ve outlined. And we need a new culture, a culture of stewardship. Most management theorists thinking about

the effectiveness of an organisation will give 10 per cent to structure, 40 per cent to systems and the rest to culture. Culture is the set of beliefs and assumptions that permeate an organisation.

Stewardship is holding something in trust for another generation. A good steward leaves the farm in a better condition than they found it. If we screw up the NHS, there won’t be one. This is the message from the Five Year Forward View and I think it is something we, the leadership of the NHS, have to accept.

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**DECISIONS**  
OF **VALUE**

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For more information on Decisions of Value, please visit [www.nhsconfed.org/value](http://www.nhsconfed.org/value)

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