DECISION TOOLKIT

A set of tools to support organisations and systems in making value-based decisions for healthcare services

EXECUTIVE SUMMARY

WHAT IS BEST POSSIBLE VALUE (BPV)?

BPV is a decision-making toolkit, designed for both financial and clinical professionals to work together in achieving the best outcomes for the patients and service users. It contains 12 tools and other materials related to healthcare value which support individuals, organisations, and systems make decisions that prioritise value. These tools are particularly useful if a decision involves large number of different stakeholders.

The toolkit consists of three main elements, which can be used together or separately, aimed at improving decision-making:

The **Decision Planning** tools support multi-stakeholder groups in designing and planning a structured decision process that clearly defines the value goal and agrees stakeholder responsibilities up-front

The **Value Generation** tools build on decision planning to generate a rationale for the impact of a decision on outcomes and value, and details the evidence supporting the decision rationale or assumptions

The **Option Priorities** tools allow users to demonstrate that decisions have been prioritised based on maximising outcomes and minimising risk, and not solely on the financial or strategic implications

WHO CAN USE BPV?

Anyone involved in healthcare decision-making, such as commissioners, providers, regulators, and public health organisations can use this toolkit. It is meant to help everyone responsible for deciding how resources are used to adopt a value-focused approach.

BPV tools are flexible and principle-based, and can be customised to fit into existing systems and processes. You can find black templates via the link at the bottom of this page.

WHAT ARE THE BENEFITS OF USING BPV?

- Evaluate choices by considering value and the proven outcomes for those receiving services.
- Make value-based decisions that everyone involved agrees with.
- Show transparency in decisions and demonstrate good organisational governance.
- Save time, effort, and resources by avoiding wasteful decision-making.
- Have a consistent way to measure success across different situations.
- Encourage value-based collaborative decision-making between finance and clinicians

HOW TO GET STARTED WITH BPV?

Familiarise yourself with the tools through this guide and the accompanying resources. Then, find a decision within your organisation or system that could benefit from using BPV. Create a decision-making team and start inviting relevant people to workshops to work through the toolkit collaboratively.

DOWNLOAD BLANK TEMPLATES OF ALL TOOLS HERE

DECISION TOOLKIT

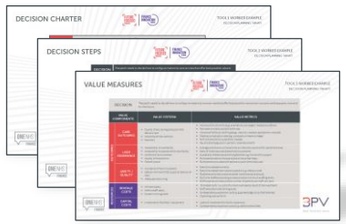
FUTURE FOCUSED FINANCE | FINANCE INNOVATION FORUM

DECISION PLANNING

Helps complex, multi-stakeholder groups to define value objectives and design an effective decision process

WHAT

What is the problem to be solved?
What steps will be taken?
What are the value outcome objectives?

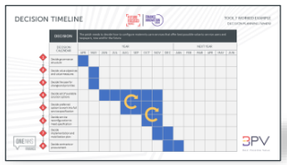


WHO

Who will make the decision at each step?
Who will play the required decision roles?
Who will perform or enact the decision?

WHEN

When will each step be decided?
When will the decision be completed?
When will the decision be performed?



HOW

How will the decision be made?
How will steps in the process be completed?
How will communication take place?

VALUE GENERATION

Builds on decision planning to model value and assess available evidence for the value outcomes generated

VALUE BUILDING

What is the main case for change?
What value outcomes will be generated?

EVIDENCE LOG

What assumptions have been made?
What evidence supports value delivery?

OPTION PRIORITIES

Demonstrates that planned decisions are prioritised based on maximising outcomes and minimising risk

VALUE COMPARISON

Which of the available options generates the most value?

VALUE PRIORITIES

How do value and risk compare?
Which options should be prioritised?

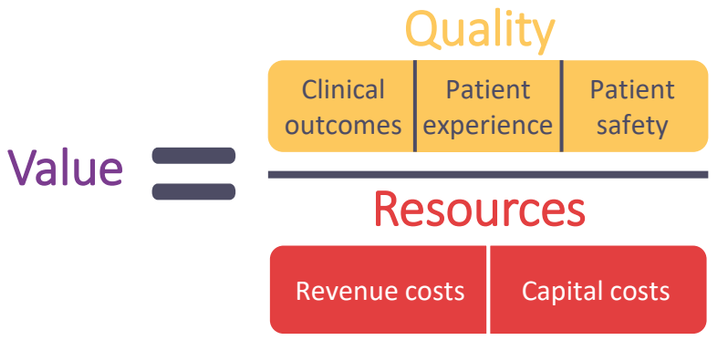
[DOWNLOAD BLANK TEMPLATES OF ALL TOOLS HERE]

ONE NHS FINANCE

3PV Best Possible Value

THE VALUE EQUATION

Value in healthcare is often illustrated with the 'value equation', which demonstrates the classical value for money relationship between quality and cost. BPV expands the value equation to include the key components of quality used in healthcare:



Maximising value means either improving outcomes delivered without raising costs, lowering resources consumed without compromising outcomes, or - ideally - both.

VALUE PRINCIPLES

The value equation is intended to apply a single, common definition of 'best possible value' and provide a common goal for all decision-makers; it acts as an anchor point to link discussions in multi-disciplinary teams, and to ensure that all parties can unite in identifying the right issues from the start. The value equation is used throughout the decision toolkit as the basis for effective decision-making, and to compare options in a consistent and measurable manner.

Our philosophy, thinking and linked tools are all driven by the 'POETIC Vision' which provides a set of unifying principles that value-based services may aspire to:

PATIENT-CENTERED	Services are designed around patient and population need
OUTCOMES-DRIVEN	Unifying outcome objectives are clearly defined and agreed
EVIDENCE-BASED	Services are designed using best practice to reduce variation
TEAM-ORIENTED	Multi-disciplinary teams share value-based decisions
INTEGRATED	System-wide primary, secondary and social care integration
COST AWARE	Value for money is realised whilst being clinically governed

DECISION EFFECTIVENESS

To deliver better value we must have an effective decision-making process and be able to reach agreement about the desired outcomes of decisions. International studies of high-performing organisations show that places that are effective at making decisions have a higher return on investment and have staff that are much more likely to recommend their organisation as a good place to work.

The key measures of an effective decision are:

QUALITY +	SPEED +	YIELD	− EFFORT
How often do you choose the right course of action?	How quickly do you make decisions relative to stakeholder expectations?	How often do you execute decisions as intended?	Do you put the right amount of effort into making and executing decisions?

The health service as a whole scores fairly typically against industry in terms of quality and yield, but we can be slow to make decisions and often put too much effort into reaching agreement.

LIST OF THE TOOLS

The BPV toolkit has been developed to support organisations and systems in making effective, participative decisions. There is a single point of accountability for making a decision and input is taken from those with relevant knowledge and expertise. The Value Equation is applied throughout.

An example of each template for a scenario detailing a collaborative decision about maternity services within a local patch of organisations can be found here.

	TOOLS	DESCRIPTION
WHAT	1 Decision Charter	Define the main decision and key outcomes required
	2 Decision Steps	Break the main decision down into sequential steps
	3 Value Measures	Agree the value criteria and metrics to monitor
WHO	4 RAPID Roles	Assign roles and responsibilities for each Decision Step
HOW	5 Key Actions	Summary of issues and actions for each Decision Step
	6 6Cs	Details and relevant forums for each Key Action
WHEN	7 Decision Timeline	Decision process calendar with key milestones
VALUE	8 Value Building	Establish a case for change and supporting assertions
	9 Evidence Log	Assess the available evidence and set targets
OPTIONS	10 Scoring Rationale	Establish value scoring mechanisms and tolerances
	11 Value Comparison	Compare and rank the value generated by options
	12 Value Priorities	Prioritise the available options using value and risk

APPLYING THE TOOLS

STEP 1: SELECT A DECISION

These tools can be applied to any decision type, for example:

Allocation - we need to decide where to prioritise resources for best value
Dis/investment - we need to decide how to configure infrastructure for best value
Service delivery - we need to decide how to structure services for best value
Innovation/risk - we need to decide our innovation and risk appetite for best value

The size, nature and timing of the decision will need to be considered, and whether BPV is suitable to help make a more effective decision in each case. For example,

- is there a decision coming up that will benefit from good decision planning?
- has a decision in progress become 'stuck' that needs some process clarity?
- has a previous decision gone badly that BPV could be retrospectively applied to, could this be used to demonstrate how future decisions might run more smoothly using these tools?

It can be helpful to have individuals from within the organisation(s) acting as:

Champions – builds stakeholder commitment and engagement; this could be an executive sponsor ('top down') or a Value Maker ('bottom up'), or both.

Facilitators - leads and facilitates workshops to support participants in completing templates, and trains others in the theory and application of BPV.

Co-Ordinator - runs and administrates the process between meetings and writes up workshop output; this could be a project manager.

STEP 3: IDENTIFY STAKEHOLDERS

Engagement from a balanced set of stakeholders is critical when working through the process; clinicians should be involved as much as possible.

Other desirable participants include finance business partners, project or programme managers, analysts, colleagues from local networks (including arms-length bodies), and patient and public representatives.

STEP 4: ARRANGE WORKSHOPS

Workshop sessions can be set up by the co-ordinator, led by the facilitator, and promoted by the champion. Stakeholders with relevant input to the decision are invited to the workshops where they collectively complete templates for the decision. The number and content of workshop sessions may be dependent on the size and nature of the decision and local circumstance. Sessions for 3 hours are suggested:

- Workshop 1: Overview of BPV and first WHAT template
- Workshop 2: Complete WHAT and WHO templates
- Workshop 3: Complete HOW and WHEN templates

Feedback from our demonstration sites suggests that just the WHAT and WHO tools are beneficial for small- to medium-sized decisions. Additional time to work through the Value Generation and Option Priorities tools may also be required. The decision team will need to be flexible in how they interpret and apply the tools to suit their organisation (or system) and particular decision.

The Finance Innovation Forum is currently using this toolkit to develop and publish an end-to-end BPV Framework to support teams in value-based decision making and decision impact assessment. Until this Framework is available, we encourage organisations to apply combinations of these tools to support their local decision making. Below are instructions on how organisations can do this simply in a framework format.

APPLYING THE TOOLS

We found that much of the benefit of the toolkit can be gained from simply inviting a diverse group of stakeholders (e.g. finance and clinical colleagues) to sit together and discuss the concept of value in their services. The conversation that is generated by the BPV tools can offer fresh perspectives and drive innovative thinking.

Applied as a single process these tools are best suited to decisions being planned and made from scratch. For those decisions which are in 'midstream' it is crucial to determine at the outset how much progress has already been made and which tools are relevant.

Specific aspects may require multiple iterations of certain tools in order to lock down the optimum output, for example, agreeing the best possible value criteria and metrics.

Any sessions should ideally be limited to 10 to 12 people to allow effective facilitation and positive engagement.

Make sure everyone's expectations and understanding of what the process is and isn't intended to achieve are managed:

- it isn't a means of structuring analysis or building a business case, and doesn't replace existing business case or project management models;
- it isn't a guide to negotiating with stakeholders;
- it isn't a methodology to evaluate results after a decision has been made;
- It isn't a means of generating solutions.

KEEPING UP MOMENTUM

For a specific decision, BPV will result in a set of completed tools. This means that everyone involved is clear about what the decision process will entail. Stakeholders will have signed up to the contents of the tools. Good up-front planning will mean that the decision can be driven forward as agreed.

You can use some of the BPV tools in the business case (for example, the Value Measures, RAPID Roles or Value Comparison) to illustrate how the decision has been planned and the value rationale behind the options considered.

Having demonstrated and proved the concept of BPV with a single decision, your organisation or system may wish to apply the tools on a more regular basis to other decisions. The speed and ease with which the tools are applied will increase with each iteration as more colleagues become familiar with the approach.

After the decision is complete, you may wish to run a 'lessons learned' session and discuss a change management plan for rollout and sustained use of the tools.

The best way to learn how to apply the tools is to work through a decision in practice with your group.

TOOL 1: DECISION CHARTER

AIMS

- Establish and agree the key issues under consideration (the 'known knowns')
- Establish and agree the main decision (in the form 'we need to decide…')
- Establish and agree the key outcomes required (in terms of maximising value)

INSTRUCTIONS

- What is the situation? This is a set of non-controversial, factual observations about the context / subject that all those involved in the decision agree with
- What is the complication to this situation? These are challenges, points of contention, areas of change and the 'so what' of the situation
- Use the situation and complication to generate the key decision that the group is trying to make. The group needs to agree the precise decision subject and scope
- What are the key objectives? These should be considered in the context of maximising value and focusing on the outcomes and impact for service users
- What constraints need to be addressed in relation to the decision? These set the broad envelope within which the decision needs to be made.

TOOL 2: DECISION STEPS

AIMS

- Break down the main decision into logical, sequential steps
- Establish and agree the key milestones in the process ('we need to decide…')

INSTRUCTIONS

- Aim to have no more than 8 sub-decisions
- Steps should be written in sequential order
- Steps may have iterative elements
- Deciding Value Measures is ideally an early decision step
- Consider using or applying existing organisational business processes such as those used by your Project Management Office or steps used by previous BPV cases for similar decisions.

'Question Fanning' by idenk may help groups widen or narrow the scale and agree the scope of their main decision

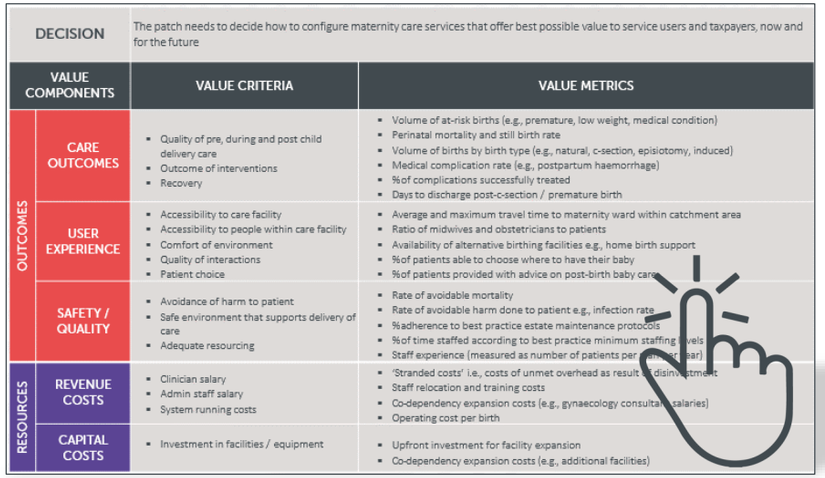
TOOL 3:
VALUE MEASURES

AIMS

- Establish and agree the value metrics that will be used to represent the key outcomes required as set in the Decision Charter
- Establish and agree the priority 'must have' outcomes

INSTRUCTIONS

- Outcomes must always be considered from the perspective of the service user
- Value criteria should align with the key outcomes selected in the Decision Charter
- When choosing metrics, only choose those where data is relevant and accessible
- Evidence for the metrics should be relevant and accessible
- If a long list of metrics are identified, highlight those which you believe are the most important to progress your decision and which you will focus on going forward.



DECISION		The patch needs to decide how to configure maternity care services that offer best possible value to service users and taxpayers, now and for the future	
VALUE COMPONENTS		VALUE CRITERIA	VALUE METRICS
OUTCOMES	CARE OUTCOMES	▪ Quality of pre, during and post child delivery care ▪ Outcome of interventions ▪ Recovery	▪ Volume of at-risk births (e.g., premature, low weight, medical condition) ▪ Perinatal mortality and still birth rate ▪ Volume of births by birth type (e.g., natural, c-section, episiotomy, induced) ▪ Medical complication rate (e.g., postpartum haemorrhage) ▪ %of complications successfully treated ▪ Days to discharge post-c-section / premature birth
	USER EXPERIENCE	▪ Accessibility to care facility ▪ Accessibility to people within care facility ▪ Comfort of environment ▪ Quality of interactions ▪ Patient choice	▪ Average and maximum travel time to maternity ward within catchment area ▪ Ratio of midwives and obstetricians to patients ▪ Availability of alternative birthing facilities e.g., home birth support ▪ %of patients able to choose where to have their baby ▪ %of patients provided with advice on post-birth baby care
	SAFETY / QUALITY	▪ Avoidance of harm to patient ▪ Safe environment that supports delivery of care ▪ Adequate resourcing	▪ Rate of avoidable mortality ▪ Rate of avoidable harm done to patient e.g., infection rate ▪ %adherence to best practice estate maintenance protocols ▪ %of time staffed according to best practice minimum staffing levels ▪ Staff experience (measured as number of patients per staff per year)
RESOURCES	REVENUE COSTS	▪ Clinician salary ▪ Admin staff salary ▪ System running costs	▪ 'Stranded costs' i.e., costs of unmet overhead as result of disinvestment ▪ Staff relocation and training costs ▪ Co-dependency expansion costs (e.g., gynaecology consultant salaries) ▪ Operating cost per birth
	CAPITAL COSTS	▪ Investment in facilities / equipment	▪ Upfront investment for facility expansion ▪ Co-dependency expansion costs (e.g., additional facilities)

This template links to the Value Building tool which you may wish to incorporate into discussions at this time if adjustments to the base value components are required

TOOL 4:
RAPID ROLES

AIMS

- Agree RAPID roles for stakeholders for each Decision Step

INSTRUCTIONS

- List stakeholders that hold power to influence the decision across the columns (e.g. individual roles, committees, boards or representative groups);
- List the Decision Steps as rows;
- Only one Decide for each decision step;
- Only one Recommend for each decision step;
- Few Agree, if any at all;
- Only Inputs that have something valuable to add;
- If roles are held by groups, clarify how sign-off will be reached.

INTRODUCTION TO RAPID

The RAPID model clarifies the accountability that different stakeholders have in a collaborative decision. Assigning a role - recommend, agree, perform, input or decide - combines the benefits of expert input with a single point of authority for progressing a decision; it ensures that everyone is clear and agreed about their responsibilities.

Stakeholders may be organisations, boards, departments, teams or individuals. Roles can shift throughout the Decision Steps depending on the decision stage or context.

TOOL 5: KEY ACTIONS

AIMS

- Establish and agree the activities needed to complete each Decision Step

INSTRUCTIONS

- The activities could be such things as data gathering, analysis, meetings etc
- Order the Key Actions sequentially, noting any feedback loops required.

TOOL 6: 6Cs

AIMS

- Establish and agree the details and relevant forums for each Key Action

INSTRUCTIONS

- **Criteria**: What are the criteria to evaluate the options/make a decision?
- **Critical Steps**: What Key Actions are needed?
- **Choices Considered**: What are the choices that need to be made?
- **Committees**: Which groups need to be engaged?
- **Communication**: How will this decision be communicated to the relevant parties?
- **Closure**: How will we know that closure has taken place? How will we practically mobilise to implement this decision?

TOOL 7: DECISION TIMELINE

AIMS

- Establish and agree a decision timeline with Decision Steps as key milestones

INSTRUCTIONS

- Consider how long it will take to complete each of the Decision Steps
- Refer back to the Key Actions identified for each Decision Step to inform the estimation of the amount of time required
- Work can take place in parallel and may be iterative
- Strike a balance between pace and realism, informed by past experience.

TOOL 8: VALUE BUILDING

AIMS

- Establish and agree a main hypothesis or case for change
- Establish and agree sets of assertions for each component of the main hypothesis

INSTRUCTIONS

- Outcomes must always be considered from the perspective of the service user
- Lay out the main hypothesis or case for change, e.g. ‘we should perform action X because of Y’
- For each value component, generate a set of assertions that you believe are necessary to support the case, e.g. ‘action X will benefit value component Z by…’
- Refer to the Value Measures and outcome objectives previously decided.

TOOL 9: EVIDENCE LOG

AIMS

- Establish the availability of evidence for each assertion
- Set targets for improvements to each value measure

INSTRUCTIONS

- Carry forward the assertions from the Value Building template
- Briefly describe the evidence that supports each assertion
- Indicate the next steps to gather any further evidence that is needed for greater confidence (and who will provide it and when)
- Set targets for each value measure – targets should be SMART:
- S – specific (relating to value criteria),
- M – measurable (relating to value metrics),
- A – attainable (relating to evidence base),
- R – relevant (relating to value components),
- T – time-based (how often metrics will be measured).

TOOL 10:
SCORING RATIONALE

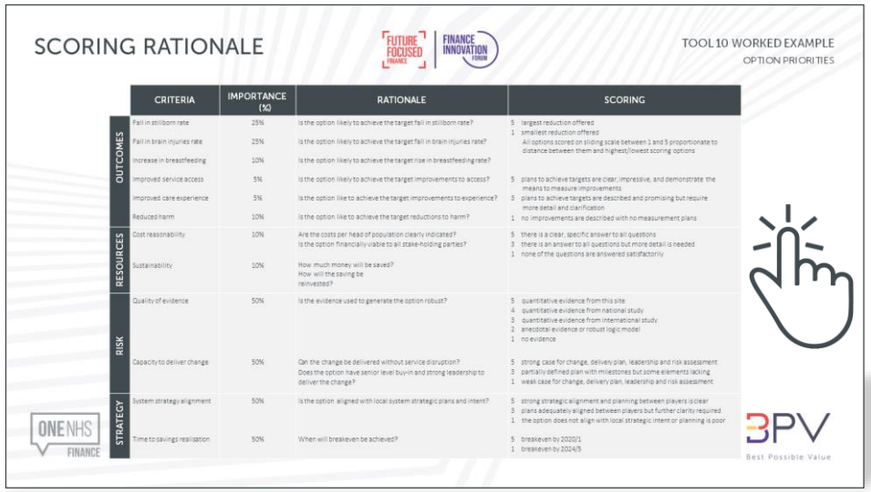
AIMS

- Establish the scoring mechanisms and tolerances that will be applied to the available options

INSTRUCTIONS

- Refer to example scoring mechanisms and tolerances or case studies;
- Apply a mechanism for scoring each value component against:
  - value outcomes and confidence
  - risk
  - strategic considerations.
- Indicate tolerances for each scoring component
- Clearly indicate and agree tolerances, i.e. unacceptable scores
- Clearly indicate how scoring logic can be consistently applied across options.

You may wish to include the agreement of value and risk tolerances as part of the Decision Steps process (Tool 2).



TOOL 11: VALUE COMPARISON

AIMS

- Assign scores to each of the value components
- Compare and rank the value generated by available options side by side

INSTRUCTIONS

- Refer to the Scoring Rationale guidance or rank options and assign a quintile
- Briefly indicate the factors that have led to this score being assigned
- Ensure scores for all options for value, risk and strategic considerations are populated and correctly assigned
- Populate the financial implications (e.g. investment amount or savings expected)
- The BPV Option Priorities spreadsheet ranks each available option.

TOOL 12: VALUE PRIORITIES

AIMS

- Prioritise the available options by value, risk and strategic considerations
- Produce a rationalised recommendation based on option rankings and priorities

INSTRUCTIONS

The BPV Option Priorities spreadsheet (download below) calculates and maps the relative score for each available option:

- value (y axis)
- risk (x axis);strategic factors (RAG status); and,
- financial implications (bubble size).

Summarise the findings including a short rationale statement, for example:

- Invest / do not invest in options based on rankings;
- Combine and accept / reject clusters of options;
- Develop risk mitigation or value improvement plan;
- Seek resolution to unfavourable strategic consideration scores etc.
- Clearly indicate the basis on which the recommendation has been made;
- Clearly articulate the decision to be made, action requested, or response required.

Both tools are used through the BPV Option Priorities (.xlsx) you can download this tool here

WORKED EXAMPLES

A worked example of a dis/investment decision for improving the value of local maternity services in 2019

DECISION CHARTER

SITUATION	▪ Maternity services are currently available in five different locations across the area ▪ The service is commissioned by two CCGs and offered by two provider trusts ▪ Demand for maternity services across the geography of the patch is changing and forecast to continue to do so, largely due to changes in population demographics and the evolving care expectations of service users
COMPLICATION	▪ Some of the sites are financially unsustainable and some are unable to meet changing demand ▪ An opportunity to make dis/investment in infrastructure is available given recommendations from Better Births ▪ The decision team now need to agree how to proceed in order to maximise value for service users ▪ The providing trusts need to decide how to respond to and implement the commissioning changes
DECISION	• The patch needs to decide how to configure maternity care services that offer best possible value to service users and taxpayers, now and for the future
OBJECTIVES	▪ Best possible value for service users goal (considered in terms of outcomes, patient experience, safety and cost) ▪ Service should strive to reach 'best in class' ▪ Offer services in good standard facilities ▪ Avoid critical shortages of service users and staff
CONSTRAINTS	▪ Must be acceptable to all key stakeholders including patients/public, clinical staff, financial staff ▪ Public input must be taken into option appraisal and choice of preferred option ▪ Must align with commissioning strategy and allocation decisions ▪ Must consider all viable options and must not destabilise providers beyond their ability to cope

Download templates and instructions for all tools

Best Possible Value

DECISION STEPS

DECISION	The patch needs to decide how to configure maternity care services that offer best possible value to service users and taxpayers, now and for the future

1. Decide governance structure
2. Decide value objectives and value measures
3. Decide the case for change and priorities
4. Decide set of available solution options
5. Decide preferred option to work into full-service specification
6. Decide service reconfiguration to meet specification
7. Decide implementation or mobilisation plan
8. Decide contracts or procurement

Best Possible Value

VALUE MEASURES

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Best Possible Value

RAPID ROLES

TOOL 4 WORKED EXAMPLE

DECISION PLANNING (WHO)

DECISION	The patch needs to decide how to configure maternity care services that offer best possible value to service users and taxpayers, now and for the future

R Recommend A Agree P Perform I Input D Decide

	STAKEHOLDERS →	NHS England	Regulators (e.g. CQC, NHI Improvement)	Local Authority / Public Health	Overview and Scrutiny Boards	CCG Board	Programme Board	Programme Board Chair / Lead CCG rep	CCG Head of Finance	Trust Chief Executive or Equivalent	Trust Board	Trust Head of Finance	Trust Head of Medical	Trust Head of Nursing	Trust Service Lead	Service user reps (e.g. PPI)	Others (e.g. politicians)
1	Decide governance structure					D		R									
2	Decide value objectives and value measures					D	A	R							I	I	
3	Decide the case for change and priorities	I	I	I	A	D	A	R	I		A						I
4	Decide set of available solution options					D	A	R			A	I	I	I	I		
5	Decide preferred option to work into full-service specification					D	A	R			A				I	I	
6	Decide service reconfiguration to meet specification					A				R	D	I	I	I	A	I	
7	Decide implementation and mobilisation plan		A			A	A	P			D	R	A	A	P		
8	Decide contracts or procurement					D	A	R		A		P			P		

Download templates and instructions for all tools

Best Possible Value

KEY ACTIONS

DECISION	The patch needs to decide how to configure maternity care services that offer best possible value to service users and taxpayers, now and for the future

1	Decide governance structure	Map out decision and governance pathway	Identify function leads (clinical, finance etc.)	Map out potential scope of key layers	Agree other roles and responsibilities	Communicate roles and responsibilities	
2	Decide value objectives and value measures	Gather expert input and engage relevant stakeholders	Describe objectives, define value and constraints	Define value measures in line with strategy	Review evidence and produce summary document		
3	Decide the case for change and priorities	Review Right Care, Carter, etc. priority recommendations	Review recommend-actions in line with local strategy	Draft strategic outline case in line with value objectives			
4	Decide set of available solution options	Seek best practice, evidence or ideas for option set	Document long list of options	Collect and assess data and evidence	Review and sense check assumptions	Create and communicate options shortlist	
5	Decide preferred option to work into full-service specification	Agree decision pass/ fail value criteria	Gather expert input and engage relevant stakeholders	Assess priorities in terms of value and risk	Generate and communicate recommendation		
6	Decide service reconfiguration to meet specification	Perform service review to identify case for change	Draft strategy and outline business case	Analyse risk and investigate funding options/impact	Options negotiation between trusts	Produce and submit final business case	Communicate response to commissioners
7	Decide implementation and mobilisation plan	Create benefits realisation plan	Gain necessary regulatory approval	Align with suppliers and workforce	Develop and communicate mobilisation plan		
8	Decide contracts or procurement	Review guidance	Formulate terms of contract	Negotiate contracts or agree Procurement model	Allocate owners and workstreams	Develop risk and issues log	

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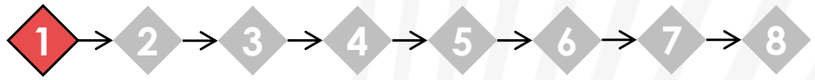
Best Possible Value



1 DECIDE GOVERNANCE STRUCTURE

RAPID ROLES	D	R	A	I
	CCG Board	Programme Board Chair / Lead CCG representative	N/A	N/A

CRITERIA	CRITICAL STEPS	CHOICES CONSIDERED	COMMITTEES
• There should be a clearly defined governance structure based on: – Geographic dominance – Expertise – Capacity • They should be adequate clinical input to the decision	• Map out decision and governance pathway for entire decision process • Identify function leads (e.g., clinical, finance etc.) • Map out potential scope of key players • Agree other roles and responsibilities • Communicate roles and responsibilities	• Create a new committee? • Designate a lead organisation? • Work as separate organisations? • Borrow/procure project staff?	• Programme Board: commissioning-led Board made up of cross stakeholder representatives • Programme Board Chair is a designated lead from one of the CCGs (ideally lead CCG)

COMMUNICATION	CLOSURE
• Chair to inform CCG Boards • Engage with Competition and Markets Authority (CMA), Overview and Scrutiny Committee and Health and Wellbeing Boards	• Evidence of Project Initiation Document (PID) and Terms of Reference • Develop stakeholder map including 'keep informed' and set up communication team

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DECIDE VALUE OBJECTIVES AND VALUE MEASURES

RAPID ROLES	D	R	A	I
	CCG Board	Programme Board Chair / Lead CCG representative	Programme Board	Trust Service Lead Service user reps (e.g. PPI)

CRITERIA	CRITICAL STEPS	CHOICES CONSIDERED	COMMITTEES
• The objective of the decision should be to maximise value for service users (in terms of clinical outcomes, patient experience and safety) • There should be access to sufficient evidence and data to assess metrics • It should be straightforward / practical to collect evidence and data • Value criteria and metrics should be sufficient to enable robust evaluation	• Gather expert input and engage relevant stakeholders • Describe objectives, define value and constraints • Define value measures in line with strategy • Review evidence and produce summary document	• What value components, criteria and metrics reflect the objectives set out in the Decision Charter?	• Programme Board: commissioning-led Board made up of cross stakeholder representatives • Programme Board Chair is a designated lead from one of the CCGs (ideally lead CCG)

COMMUNICATION	CLOSURE
• Chair to inform CCG Boards • Keep provider trusts informed of rationale behind intention to reconfigure services	• Evidence of decision via final summary paper, signed off by CCG • Engage / inform stakeholders as per communication strategy

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DECIDE THE CASE FOR CHANGE AND PRIORITIES

RAPID ROLES				
	D	R	A	I
	CCG Board	Programme Board Chair / Lead CCG representative	Programme Board Overview and Scrutiny Board Trust Board	NHS England Regulators Public Health / CCG Head of Finance Politicians

CRITERIA	CRITICAL STEPS	CHOICES CONSIDERED	COMMITTEES
• The objective of the decision should be to maximise value for service users • Timing (sequence and pacing) needs to ensure smooth transition • Providers experiencing changes to commissioned services must remain sustainable • Co-dependency impact is acceptable (e.g. clinical, asset, access)	• Review Right Care, Carter etc. priority recommendations • Review recommendations in line with local strategy • Draft strategic outline case in line with value objectives	• What national recommendations have been made? • Which recommendations apply to us in line with our local strategy? • Which recommendations to prioritise?	• Programme Board: commissioning-led Board made up of cross stakeholder representatives • Programme Board Chair is a designated lead from one of the CCGs (ideally lead CCG)

COMMUNICATION	CLOSURE
• Consultation document to stakeholders (audience-specific) • Keep provider trusts informed of rationale behind intention to reconfigure services	• Evidence of decision via minutes issued, agreement in principle • High level business case produced • Engage / inform stakeholders as per communication strategy

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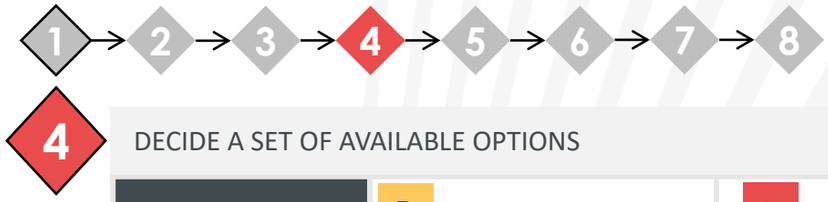

DECIDE A SET OF AVAILABLE OPTIONS

RAPID ROLES							
D	CCG Board	R	Programme Board Chair / Lead CCG representative	A	Programme Board Trust Board	I	Trust Head of Nursing / Medical Trust Head of Finance / Service user representatives

CRITERIA	CRITICAL STEPS	CHOICES CONSIDERED	COMMITTEES
• Options considered must be realistically and appropriately available • Options must be comparable according to agreed Value Measures • Options must consider risk to stakeholders impacted by the change • Outcome of public consultation must be acceptable	• Seek best practice, evidence or ideas for option set • Document long list of options • Collect and assess data and evidence • Review and sense check assumptions • Create and communicate options shortlist	• Where to look for best practice and replicability? • What change targets to set and measure? • Where to find evidence? How to classify evidence?	• Programme Board: commissioning-led Board made up of cross stakeholder representatives • Programme Board Chair is a designated lead from one of the CCGs (ideally lead CCG)

COMMUNICATION	CLOSURE
• 'Keep informed' stakeholders kept appraised of options considered	• CCGs send draft of new contract proposition and high-level business case to providers • Engage / inform stakeholders as per communication strategy

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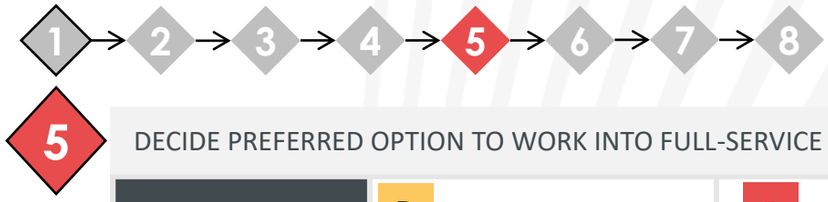

DECIDE PREFERRED OPTION TO WORK INTO FULL-SERVICE SPECIFICATION

RAPID ROLES	D	R	A	I
	CCG Board	Programme Board Chair / Lead CCG representative	Programme Board Trust Board	Trust Service Lead Service user representatives

CRITERIA	CRITICAL STEPS	CHOICES CONSIDERED	COMMITTEES
• Recommended option should be that which maximises agreed outcome objectives compared to alternatives • Preferred option(s) must be deliverable within required time horizon and available resources • Preferred option(s) must include recommendation for mitigating or managing risk to impacted stakeholders	• Agree decision pass/fail value criteria • Gather expert input and engage relevant stakeholders - public consultation • Assess priorities in terms of value and risk • Generate and communicate recommendation	• Dis/invest in sites or capital? • Pace and sequence of change? • Co-dependency of services? • Workforce flexibility? • Pricing and tariff options/implications? • Based on best practice or recommendations?	• Programme Board: commissioning-led Board made up of cross stakeholder representatives • Programme Board Chair is a designated lead from one of the CCGs (ideally lead CCG)

COMMUNICATION	CLOSURE
• Consultation document to all stakeholders - focus on stakeholder engagement opportunity	• Evidence of decision via minutes of CCG Board • Engage / inform stakeholders as per communication strategy

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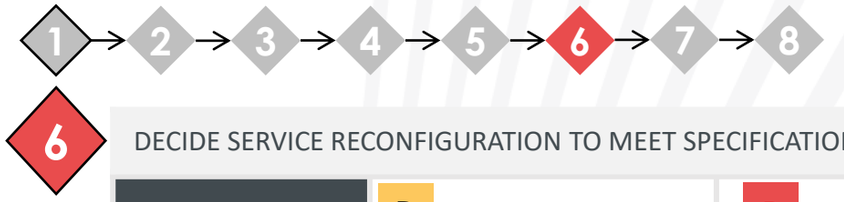
6Cs



DECIDE SERVICE RECONFIGURATION TO MEET SPECIFICATION

RAPID ROLES				
	D Trust board	R Trust Chief Executive or Equivalent	A CCG Board Trust Service Lead	I Trust Head of Medical Trust Head of Nursing Trust Head of Finance

CRITERIA	CRITICAL STEPS	CHOICES CONSIDERED	COMMITTEES
• Reconfiguration must aim to maximise value as per objectives • Financing available to providers • Financial impact of transition is acceptable • Timing (sequence/pacing) needs to ensure smooth transition • Co-dependency impact is acceptable (e.g. clinical, asset, access)	• Perform service review to identify case for change • Draft strategy and outline business case • Analyse risk and investigation funding options/impact • Options negotiation between trusts • Produce and submit final business case • Communicate response to commissioners	• Service reconfiguration options? • Risk share between trusts? • Transitional funding agreements between trusts and commissioners?	• Trust Board • Investment Committee • Procurement Committee • Capital Board

COMMUNICATION	CLOSURE
• Consultation document to all stakeholders - focus on service user impact • Engage regulators if financial impact is over threshold	• Evidence of decision via business case for sign off • Engage / inform stakeholders as per communication strategy

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DECIDE IMPLEMENTATION AND MOBILISATION PLAN

RAPID ROLES				
	D	R	A	I
	Trust board	Trust Head of finance	Regulators CCG Board Prog. Board, Trust Head of Medical /Nursing	Programme Board Chair Trust Service Lead

CRITERIA	CRITICAL STEPS	CHOICES CONSIDERED	COMMITTEES
• Reconfiguration must aim to maximise value as per objectives • Timing (sequence/pacing) needs to ensure smooth transition • Co-dependency impact is acceptable (e.g. clinical, asset, access)	• Create benefits realisation plan • Gain necessary regulatory approval • Align with suppliers and workforce • Develop and communicate mobilisation plan	• Timescale to maintain stability including cost/speed trade-offs? • Workforce migration? • Risk share of residual/stranded costs, repurpose vacated locations? • Integration options? • Delivery line/provider partner options (e.g., joint venture, contract with GPs)?	• Programme Board: commissioning-led Board made up of cross stakeholder representatives

COMMUNICATION	CLOSURE
• Consultation document to all stakeholders - focus on staff and trade unions	• Evidence of decision via minutes of Programme Board • Engage / inform stakeholders as per communication strategy

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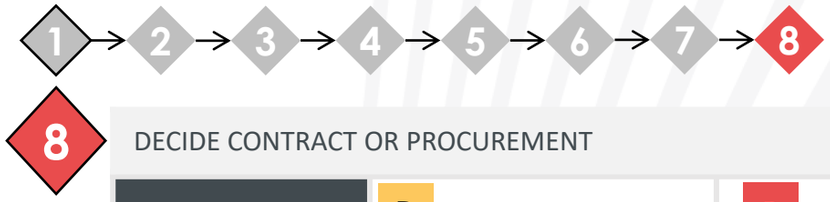

DECIDE CONTRACT OR PROCUREMENT

RAPID ROLES	D	R	A	I
	CCG board	Programme Board Chair / Lead CCG representative	Programme Board Trust Chief Executive or Equivalent	Trust Head of Finance Trust Service Lead

CRITERIA	CRITICAL STEPS	CHOICES CONSIDERED	COMMITTEES
• Reasonability of cost and other strategic considerations • Timing (sequence/pacing) needs to ensure smooth transition • Co-dependency impact is acceptable (e.g., clinical, asset, access)	• Review guidance • Formulate terms of contract (align with strategy): – Service specifications – Outcomes, experience and safety – Tariffs – Cost or risk sharing • Commissioners/providers to negotiate contract(s) / procurement model • Allocate owners and workstreams • Develop risk and issues log	• Sign contract?	• Programme Board - acts as facilitator between commissioner(s) and provider(s) and will need to Agree the final contract • Investment Committee • Procurement Committee • Capital Board

COMMUNICATION	CLOSURE
• Consultation document to all stakeholders indicating final decision -focus on media	• Evidence of decision via signed contract • Engage / inform stakeholders as per communication strategy

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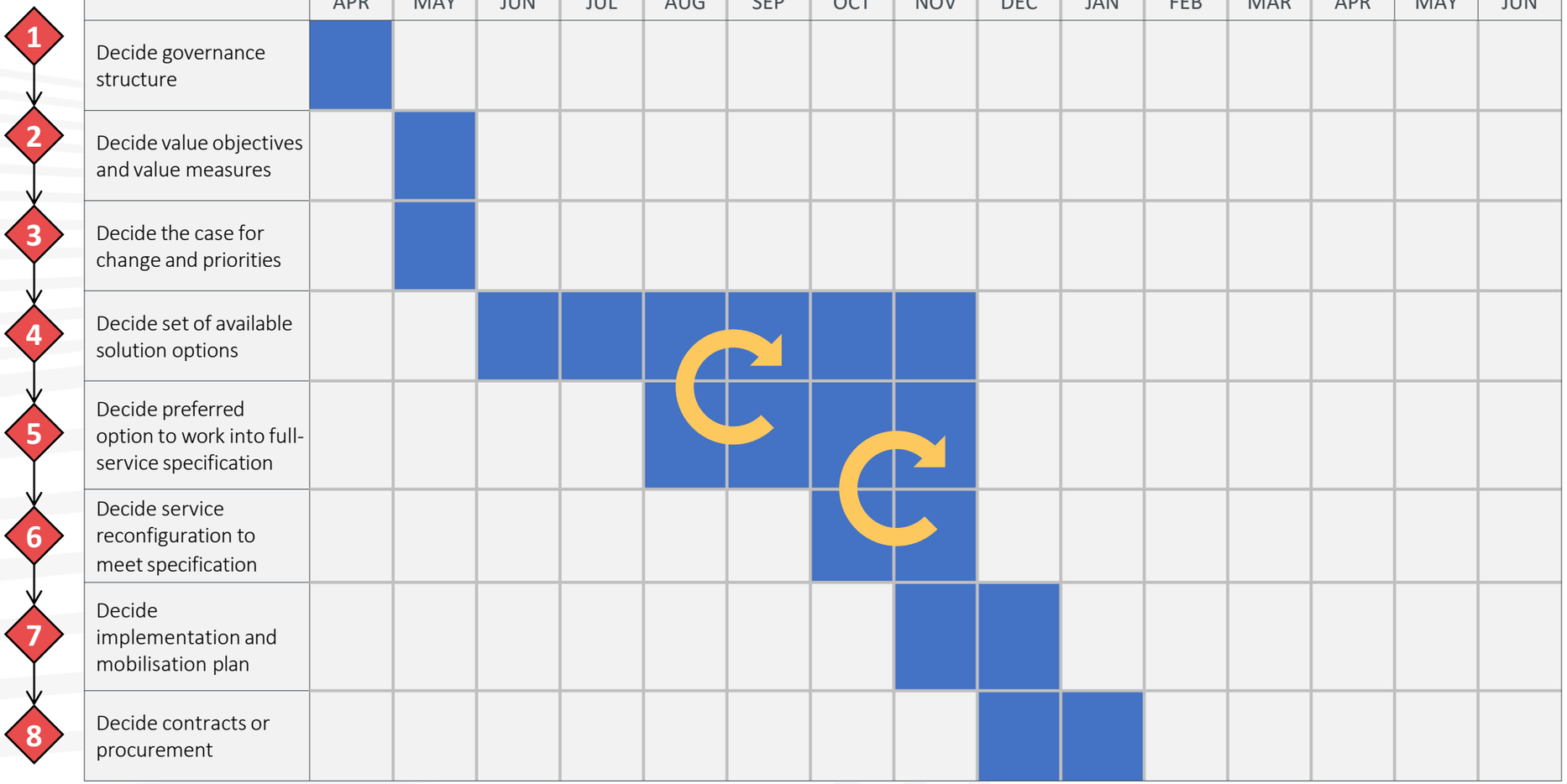
DECISION TIMELINE

DECISION	The patch needs to decide how to configure maternity care services that offer best possible value to service users and taxpayers, now and for the future



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BPV Best Possible Value

VALUE BUILDING

TOOL 8 WORKED EXAMPLE

VALUE GENERATION

Case for change: The option to invest in maternity services is worthwhile because it will generate a long-term positive impact on value for service users and taxpayers. Implementing models of care in line with *Better Births* recommendations will deliver safer, more personalised, kinder, professional and more family-friendly care to service users. This will result in improved care outcomes, better service user experience and choice, and efficient and sustainable services.

Care outcomes will be improved by designing and operating services across organisational boundaries and a culture of learning and continuous improvement	User experience and choice will be improved by designing local services the operate continuity of carer models that reflect the choices women want	Implementing the Better Births recommendations re: choice, technology and safety will reduce harm to service users and improve service efficiency	Investing in this option will be an effective use of resources that will result in a sustainable service that delivers best possible value to service users
▪ Moving to outcomes-based commissioning will drive a greater focus on quality and therefore improved care outcomes ▪ Shared clinical governance will facilitate the efficient transfer of women and babies across organisational boundaries, ensuring the right care in the right place at the right time, thereby improving care outcomes ▪ Joining up hospital and community services, in particular through community hubs, will improve access to services and enable greater personalisation of care, ensuring that complications are detected earlier and therefore improving care outcomes ▪ Improving postnatal care will help parents to care for their baby and give children the best start in life	▪ Collaboration in the design and operation of local maternity systems with improve the variety and availability of choices offered to service users ▪ Introducing personalised care plans will ensure that service user choices are better reflected in the care they receive ▪ Introducing continuity of carer models will enable service users to develop a relationship with a single professional and improve their experience of care	▪ Ensuring the provision of access to all three types of birthplace will result in more women with a lower risk profile choosing to give birth at home and in midwifery units, where care costs are lower than in obstetric units ▪ Electronic care records will make recording and sharing information with service users and care professionals easier and more efficient, reducing the amount of time and effort needed for data processing ▪ Supporting a learning culture will enable care staff to learn with and from each other and lead to continuous service improvement, reduced harm, reduced waste and also reduced litigation	▪ Investment of £XM will enable the patch to rollout the recommended actions to deliver to the Better Births vision and implement and manage the change ▪ Improvements to care outcomes for services users will offer efficiency and productivity cost saving to the area; the project will breakeven within X years and offer annual recurrent financial savings of £XM ▪ Local areas will reinvest any resources at their disposal to deliver the change ▪ Changes will make effective and appropriate use of non-financial resources in line with local system strategy, and staff and public and patient requirements

Best Possible Value

EVIDENCE LOG

	PRIMARY ASSERTION	SUB-ASSERTION	EVIDENCE AVAILABLE	FURTHER EVIDENCE	VALUE METRICS	TARGET
CARE OUTCOMES	▪ Care outcomes will be improved by designing and operating services across organisational boundaries and a culture of learning and continuous ▪ improvement	▪ Moving to outcomes-based commissioning will drive a greater focus on quality and therefore, improved care outcomes ▪ Shared clinical governance will facilitate the efficient transfer of women and babies across organisational boundaries, ensuring the right care in the right place at the right time, thereby improving care outcomes ▪ Joining up hospital and community services, in particular through community hubs, will improve access to services and enable greater personalisation of care, ensuring that complications are detected earlier and therefore improving care outcomes	▪ There is strong international evidence that an outcomes-based approach to commissioning can deliver high quality care and value for money ▪ There is evidence that the components of clinical governance contribute to improving the quality of care for service users ▪ Evidence from *Saving Babies' Lives* (NHS England) shows that early intervention in some key areas can reduce stillbirths and neonatal deaths ▪ Statistical evidence via Right Care	▪ Mental health evidence ▪ Public health evidence	▪ Stillbirth and neonatal mortality rate [data source] ▪ Number of brain injuries occurring during or soon after birth [data source] ▪ Breastfeeding at 12 weeks (proxy for improved postnatal care because improved child health indicators will take years to feed through) [data source]	▪ Fall in stillbirth rate of 50% by 2030 (trajectory to get there) ▪ Fall in rate of brain injured babies by 50% by 2030 (trajectory to get there) ▪ Increase in breastfeeding at 12 weeks by 20% by 2020

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EVIDENCE LOG

TOOL 9 WORKED EXAMPLE (2 OF 3)

VALUE GENERATION

	PRIMARY ASSERTION	SUB-ASSERTION	EVIDENCE AVAILABLE	FURTHER EVIDENCE	VALUE METRICS	TARGET
CARE OUTCOMES	▪ Service user experience and choice will be improved by designing local services the operate continuity of carer models that reflect the choices women want	▪ Collaboration in the design and operation of local maternity systems with improve the variety and availability of choices offered to service users ▪ Introducing personalised care plans will ensure that service user choices are better reflected in the care they receive ▪ Introducing continuity of carer models will enable service users to develop a relationship with a single professional and improve their experience of care	▪ Providing access to services in a larger footprint will increase choice and improve access to services ▪ Evidence of improved experience (and improved clinical outcomes) summarised in report *the contribution of continuity of midwifery care to high quality maternity care* (Royal College of Midwives)	▪ Teams to map services to assess current choice and access to services ▪ Personalised care plans data ▪ Cost benefit analysis to be informed by experience of early adopters and lessons learned feedback	▪ Access to all three types of birthplace [data source] ▪ Experience of choice [data source] ▪ Percentage service users experiencing ▪ continuity of carer [data source] ▪ Care experience [data source]	▪ All sites to provide access to all three types of birthplace to all service users within 2 years ▪ Percentage of service users reporting the ability to choose to improve by 20% by 2020 ▪ Percentage of service users reporting continuity of carer to improve by 20% by 2020 ▪ Friends and family net promoter score to improve by 20% to 2020

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EVIDENCE LOG

	PRIMARY ASSERTION	SUB-ASSERTION	EVIDENCE AVAILABLE	FURTHER EVIDENCE	VALUE METRICS	TARGET
CARE OUTCOMES	▪ Implementing the Better Births recommendations re: choice, technology and safety will reduce harm to service users and improve service efficiency	▪ Ensuring the provision of access to all three types of birthplace will result in more women with a lower risk profile choosing to give birth at home and in midwifery units, where care costs are lower than in obstetric units ▪ Electronic care records will make recording and sharing information with service users and care professionals easier and more efficient, reducing the amount of time and effort needed for data processing ▪ Supporting a learning culture will enable care staff to learn with and from each other and lead to continuous service improvement, reduced harm, reduced waste and also reduced litigation	▪ In 2012 87% of births took place in Obstetric Units, whereas a survey by NCT &NFWI showed that only 25% of women would choose one ▪ *Better Births* highlighted that data collection is an efficiency issue for NHS maternity services ▪ Evidence from Sweden and from North Bristol shows that a good culture in the context of a no blame culture can reduce poor outcomes and lead to a reduction on litigation costs of 50%	▪ What actual level of community births is safe and achievable bearing in mind complications will have a significant influence on choices made ▪ The extent to which this is replicable locally ▪ Missing data / mitigate for survivorship bias	▪ Numbers of births taking place in each setting [data source] ▪ Number of women with an electronic care record [data source] ▪ Number of brain injuries occurring during or soon after birth [data source]	▪ Increase births at home and in midwifery units on a trajectory to double in four years ▪ E-records rolled out to 100% of service users by end of programme ▪ On a trajectory to reduce harm by 50% over four years

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SCORING RATIONALE

TOOL 10 WORKED EXAMPLE

OPTION PRIORITIES

	CRITERIA	IMPORTANCE (%)	RATIONALE	SCORING
OUTCOMES	Fall in stillborn rate	25%	Is the option likely to achieve the target fall in stillborn rate?	5 largest reduction offered 1 smallest reduction offered All options scored on sliding scale between 1 and 5 proportionate to distance between them and highest/lowest scoring options
	Fall in brain injuries rate	25%	Is the option likely to achieve the target fall in brain injuries rate?	
	Increase in breastfeeding	10%	Is the option likely to achieve the target rise in breastfeeding rate?	
	Improved service access	5%	Is the option likely to achieve the target improvements to access?	5 plans to achieve targets are clear, impressive, and demonstrate the means to measure improvements 3 plans to achieve targets are described and promising but require more detail and clarification 1 no improvements are described with no measurement plans
	Improved care experience	5%	Is the option like to achieve the target improvements to experience?	
	Reduced harm	10%	Is the option like to achieve the target reductions to harm?	
RESOURCES	Cost reasonability	10%	Are the costs per head of population clearly indicated? Is the option financially viable to all stake-holding parties?	5 there is a clear, specific answer to all questions 3 there is an answer to all questions, but more detail is needed 1 none of the questions are answered satisfactorily
	Sustainability	10%	How much money will be saved? How will the saving be reinvested?	
RISK	Quality of evidence	50%	Is the evidence used to generate the option robust?	5 quantitative evidence from this site 4 quantitative evidence from national study 3 quantitative evidence from international study 2 anecdotal evidence or robust logic model 1 no evidence
	Capacity to deliver change	50%	Can the change be delivered without service disruption? Does the option have senior level buy-in and strong leadership to deliver the change?	5 strong case for change, delivery plan, leadership and risk assessment 3 partially defined plan with milestones but some elements lacking 1 weak case for change, delivery plan, leadership and risk assessment
STRATEGY	System strategy alignment	50%	Is the option aligned with local system strategic plans and intent?	5 strong strategic alignment and planning between players is clear 3 plans adequately aligned between players, but further clarity required 1 the option does not align with local strategic intent or planning is poor
	Time to savings realisation	50%	When will breakeven be achieved?	5 breakeven by 2020/1 1 breakeven by 2024/5

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VALUE COMPARISON

	VALUE MEASURES		OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5
OUTCOMES	Fall in stillborn rate	25%	4	4	2	2	2
	Fall in brain injuries rate	25%	4	5	2	3	3
	Increase in breastfeeding	10%	3	3	1	2	1
EXPERIENCE	Improved service access	5%	4	4	3	3	2
	Improved care experience	5%	4	4	2	3	3
SAFETY	Reduced harm	10%	3	5	3	2	1
RESOURCES	Cost reasonability	10%	4	3	3	5	2
	Sustainability	10%	3	3	2	3	1
VALUE		100%	3.7	4.1	2.2	2.8	2.0
RISK	Quality of evidence	50%	4	5	3	2	1
	Capacity to deliver change	50%	3	4	4	3	2
RISK		100%	3.5	4.5	3.5	2.5	1.5
STRATEGIC FACTORS	System strategy alignment	50%	3	4	3	1	1
	Time to savings realisation	50%	2	3	3	1	3
STRATEGIC FACTORS		100%	2.5	3.5	3.0	1.0	2.0

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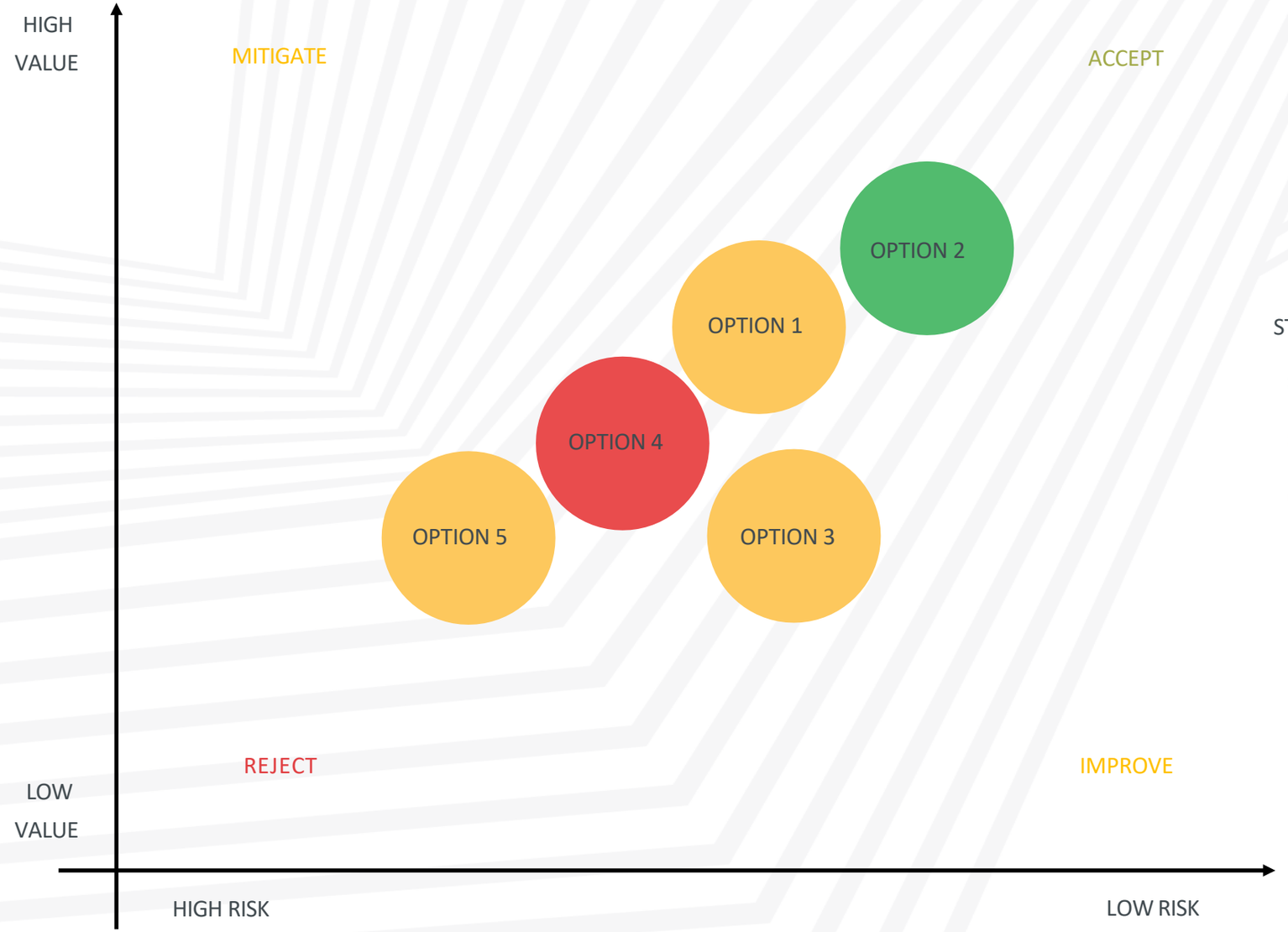
VALUE PRIORITIES

TOOL 12 ILLUSTRATIVE EXAMPLE

OPTION PRIORITIES



STRATEGIC FACTORS

- HIGH
- MEDIUM
- LOW

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ACKNOWLEDGEMENTS

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CONTACT US

If you have any queries, comments, feedback or technical difficulties then please contact finance.innovation@nhs.net

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