



**Realising
the Value**

Empowering people,
engaging communities

How should we think about value in health and care?



Discussion paper

September 2015

About this paper

This paper is a step towards creating a new articulation of value in co-production with other stakeholders, in order to achieve the wider Realising the Value programme objective of demonstrating the value of people and communities in their own health and care.

The ideas set out in this paper will develop throughout the programme to underpin future activities and outputs of the programme.

Further information about Realising the Value can be found on the back of this paper and on the programme website: www.realisingthevalue.org.uk

This paper was produced by National Voices, reflecting the thinking and input from the wider Realising the Value consortium.

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Introduction

‘Value’ is a contested notion both in the private and public sectors. Both sectors’ definitions are – and have been over recent decades – subject to significant tensions. Traditional ‘profit-oriented’ conceptions of value expressed through classical accounting models have been strongly critiqued, yet continue to have a significant impact on the behaviours of individuals and organisations.

In health care in England, perceptions of value have been dominated by a mix of clinical outcomes, system targets, competition mechanisms and encouragement for single units to act autonomously and be judged as single services. What people using health services value most has not been adequately considered or captured.

However, a number of recent changes are raising the question of whether the current ways of thinking about value in health and care – clinical outcomes and service utilisation – remain sufficient. For example:

- Changing social attitudes have led to notions of wellbeing, quality of life and happiness re-emerging in political conversation as values that society aspires to for its citizens. This has also been recognised within the academic community with wellbeing measures being validated and put into use.
- The growing number of people living with long-term conditions is making it clear that patients are increasingly producers of their own health care. This challenges the assumption of the traditional medical model that the NHS produces value and patients consume it.
- The prevailing understanding of health is re-orienting itself from the question ‘what’s the matter with you?’ to the broader question ‘what matters to you?’ This begs the question of how the value that health services create sits alongside other forms of value.

The long journey of adult social care towards personalisation has pointed the way to a values-based approach which prioritises improved wellbeing, independence, social connectedness, choice and control; one in which people feel supported to manage their own care. The changed and changing nature of the ‘caseload’ of the NHS (long-term conditions, co- and multi-morbidities) would seem to point in the same direction. The health and care systems are, in any case, increasingly aligning through integration programmes and will need aligned concepts and frameworks for achieving and measuring value.

This paper suggests drawing on ideas from public and social value theory. Both lines of thought emphasise that the outcomes chosen must be securely based on ‘responsiveness’ to what relevant groups of people – ‘citizens’, ‘viewers’, ‘stakeholders’ – value, while balancing the need to measure and compare value. This is not a matter of simple opinion surveys but of engagement with those constituencies to work through their priorities (what some public value thinkers call ‘citizens’ refined preferences’). A similar ethic in social care and health is ‘co-production’.

Experience from public and social value theory in other fields indicates that co-produced outcome measures will consist of a mixture of:

- **quantitative evidence:** for example, 5,000 people received the additional learning resources they wanted; a social enterprise helped 30 clients not to reoffend
- **person-reported outcomes:** ‘I learned something from this programme’; ‘I feel confident to return to work’
- **qualitative judgements:** commissioners taking an overall view of how a programme contributes to overall impact based on a wider definition of value.

There are challenges to be addressed with such an approach. Qualitative judgement, exercised by ‘value-seeking managers’, and the outcomes identified by engaged stakeholders will both be programme-specific. So these co-produced outcomes may not be comparable across programmes and, as stand-alone measures, are vulnerable to a critique that they are ‘subjective’ or used for self-justifying purposes.

In real-world situations, co-produced outcomes will be confronted by the legitimacy test identified within ideas of public value: that is, are they convincing enough to continue to secure legitimacy both with the public who value their services and with their elected politicians who determine levels of resources? So another challenge is how to set up effective mechanisms for legitimising what constitutes public value.

This paper considers, therefore, how new frameworks and measures of this wider conception of value can be created to assess financial, social and person-reported outcomes. It sets out how we might establish a broader way of understanding value and value for money in health and care. As part of the Realising the Value programme we want to debate these issues in order to refine, redefine and develop the arguments in this paper.*

* The question of how to assess value from a health economics perspective, both in terms of methods and outcome measures, will be a key component of this thinking as the work progresses.

Throughout this paper, there are a number of questions (summarised on page 18). We welcome your views to help make concrete what a new framing of value in health care can look like. We will specifically engage with the People and Communities Board of the NHS Five Year Forward View (5YFV) to help us complete this work, and to champion the importance of a new framing of value in the NHS of the future.

It is in this context that we are testing the propositions set out in section 1 of this paper for a future, aligned articulation of value in health and social care. We look forward to receiving comments, views, challenges and suggestions.

To feed back on the ideas and questions contained in this paper, please contact the Realising the Value consortium partners on info@realisingthevalue.org.uk

1

Our proposed articulation of ‘value’ in health and care

Questions

- Are the propositions set out in section 1 the right ones to develop?
- Are there any further implications from these propositions that you would like to draw our attention to?
- Do you have suggestions for approaches to thinking about value that capture some or all of these propositions (in addition to those referenced in section 3 of this paper)?
- What challenges do you foresee – and how can they be overcome?

We propose that a future, aligned articulation of value in health and social care will need to take account of and be supported by the following features:

- **Co-produced outcomes:** The articulation should favour and incentivise outcomes that are ‘co-produced’. This means services should enable service users and other stakeholders to identify desirable outcomes to be planned for, and collaborate with them and others to achieve those outcomes.
- **Diverse outcomes:** It should be capable of combining a core of quantifiable and comparable outcomes with others that cannot be aggregated; accepting as legitimate a wider ‘narrative’ for value than, for example, clinical effectiveness or meeting service targets and objectives. Clinical and personal health outcomes will need a new place within this redesigned core of outcomes. They may also need defining more holistically through focusing on the outcomes for the person rather than, or in addition to, the success of a treatment or intervention.
- **Impact from people, communities and services:** This new articulation of value should lead to an approach that emphasises overall ‘impacts’ achieved by people, communities and services combined.
- **Longer-term and person-centred impact:** The impacts identified in this approach are likely to be longer-term and more driven by what is important to the person – for example, wellbeing, independence, social capital, feeling confident and supported to manage their life, health and care.

- **Localisation:** This articulation of value will require a decision-making environment that enables creative and adaptive management and commissioning at the local level. For example, allowing localised judgement on the achievement of the non-comparable outcomes.
- **New measures of value:** National policymakers will need new and updated measures to support this articulation of value. These should incorporate a broader range of tools and measures for wellbeing, quality of life and personal outcomes, which are combined into robust, common evaluation frameworks for health and care interventions.
- **Measuring what matters to people:** such measures must be capable of capturing a ‘full range’ of valued outcomes of services and programmes, with due emphasis on the outcomes most valued by people using services.

In the remainder of this paper we outline how the arguments to support these propositions were developed, and ask further questions for feedback.

2

Context for the value discussion

Questions

- **Are there key concepts of individual and community value we have not referenced in section 2?**
- **Do you know of any significant programmes or services in the NHS that have attempted to account for these types of value over time? Please send us references/details.**

A consensus has been reached that the NHS needs to move away from being a reactive, episodic service, based on a medical model of ‘diagnose, treat and cure’.

Core ‘customers’ of the NHS are now people with long-term conditions, including mental health problems and, increasingly, people with multiple long-term conditions (‘multi-morbidities’). These groups account for the consumption of the majority of NHS ‘inputs’, including funding, consultation time, medication and hospital admissions. Securing greater value for the future NHS is, to a large degree, contingent on better – and different – models of care, support and treatment for these groups, including at the end of life.

There are strong parallels and overlaps with the adult social care caseload of people with increasingly complex needs such as disabilities and frailty.

Increasingly the expectation is that the NHS and social care services will jointly plan, commission and provide services and support people to manage these complex cases and needs. This will require common conceptions of value and aligned mechanisms to account for it.

Evidence has been building over the last two decades about the benefits of both person-centred (or personalised) interventions and the value of the contributions that individuals and the community and voluntary sectors can make to supporting people’s health and wellbeing. However, in the health service these approaches have not yet become part of mainstream ways of working.

The 5YFV, in addressing the future of health and care, calls for new ways of working with people and communities and the use of person-focused interventions as an integral part of new models of care.

This raises the need for a new, cross-system, common understanding of ‘value’. What is the value to society that the provision of treatment, care and support should seek to deliver? How can that concept of value be adapted and developed to include, at its core, the value that citizens and communities most seek to achieve? Moreover, how can it also recognise and mobilise the value that people and communities can themselves deliver? Where can we look for evidence and clues to this, and how can we begin to frame a new model of value that can assist our public services to reshape themselves for 21st century challenges?

The value contributed by individuals and communities

The 5YFV is a significant landmark in its recognition that value is contributed by individuals and communities and that value can be multiplied where public services work in support of them. However, it is not the first to do so, and it builds on the following key milestones: the Wanless Review (2002); Department of Health research on individual engagement (2004); Angela Coulter’s Health Foundation review of patient-focused interventions (2007); NICE guidance on community engagement (2008); NHS England’s participation guidance (2013); National Voices’ evidence review (2014); and Jane South’s report on community development for Public Health England (2015). These reports and others have accrued evidence of the value of engagement over a long period. See Bibliography and related reading at the end of this paper for more details.

There is a growing body of indicators which estimate the economic value of contributions made by a variety of different groups, including:

- **Volunteers:** the value of voluntary activity in the UK has been estimated by the Office for National Statistics (ONS) to be £23.9bn (ONS, 2013)
- **Voluntary and community sector:** this sector had a £40bn turnover in 2012/13 according to the National Council for Voluntary Organisations (NVCO, 2015). Of this, around £13bn may be directly health- or care-related
- **Carers:** the contributions of carers was worth £119bn in 2011 according to Carers UK (Carers UK, 2011) – more than the annual budget of the NHS.

There is also a growing evidence base for the benefits of person- and community-centred approaches.* There is relatively strong evidence of effectiveness, for example, for education and self-management, group-based training and peer support, reflected in control group-based evaluations. However, the majority of the effectiveness literature is still grounded in particular health issues, with results presented in the form of clinical outcomes. Furthermore, while there is an increasing trend for studies to report individual measures of wellbeing such as confidence and self-efficacy, it is not clear how well these measures feed into policymaking both at a national and local level. There is a danger that if

* This evidence base is being assessed as part of the Realising the Value programme and a report of the findings will be published in the autumn of 2015.

these measures are not related to traditional health outcomes they will not be taken seriously. Other approaches are at an earlier stage of evidence generation, such as community development initiatives and the use of personal budgets in social care and health. It could be argued that funding for research is still dominated by the medical model of health care, due to the methodological challenges that evaluating person- and community-centred approaches pose.

People who participate in such interventions can experience greater value from their health and care services, expressed through indicators such as: better experience of services; better knowledge of their conditions and how to manage them; greater feeling of being supported and in control; making decisions about care and treatment that they feel are more appropriate for them; changing health-related behaviours; and, in some cases, better health outcomes.

There is also a benefit to the statutory services when people use resources more appropriately. This can include: using fewer urgent consultations and emergency admissions; more appropriate take-up, for example by attending checks and screening and adhering to chosen treatments; and/or choosing less costly interventions and services.

Some studies show how multiple outcomes can be achieved. For example, volunteer befriending can support the wellbeing of the volunteer as well as the person they befriend; carer support can benefit the cared-for person and the health of the carer. These in turn can create benefits to the 'system' through increased health and wellbeing, improved outcomes and less unnecessary use of resources.

The evidence base is still evolving and there are significant gaps as well as areas of greater confidence of effectiveness. However, these interventions have the potential to represent 'win-win-win' propositions which should be attractive to commissioners, providers and managers as well as to people and communities.

In recognition of this, and from the growing body of people and practitioners who have experienced these approaches directly, there has been a 'build up' of: legislation (Health and Care Act 2012, Care Act 2014); regulation (person-centred care as a 'fundamental standard'); professional adoption (eg Good Medical Practice duties of all doctors); policy; guidance (NHS England Participation guidance, Care Act guidance); practical mechanisms (Joint Strategic Needs Assessments (JSNAs) based on identifying assets as well as needs); and toolkits. All of these require or recommend person- and community-focused approaches.

This situation therefore leads to questions about the barriers to adoption, spread and implementation of person- and community-centred approaches. The assumption in this paper is that one barrier is the system not having built these person-centred and community-focused aspects of value into its frameworks for measuring what matters.

3

Approaches to thinking about value

Questions

- Do you have knowledge or experience of using the approaches described in section 3?
- If so, what lessons from them do you think can be applied in an NHS context?
- What are your thoughts about a triple bottom line approach to value in the NHS: financial value, health value (including health and wellbeing outcomes valued by people), and wider social value (such as employment and social capital)?

Value in the wider economy

Value in health care has some similarities to the discussion of value in wider democratic societies. In shareholder enterprises the most common form of value accounting is 'profit and loss'. In the classical model 'value creation' is defined as the sum of 'outputs' minus the 'inputs' used to create them along the line:

Inputs... Process... Outputs

Over the last half century, this model has been contested through various economic, environmental and social critiques. These often argue for the inclusion of 'externalities' (effects for which enterprises have not conventionally been held accountable) such as damage to the environment. As such they are concerned with 'outcomes':

Inputs... Process... Outputs... Outcomes

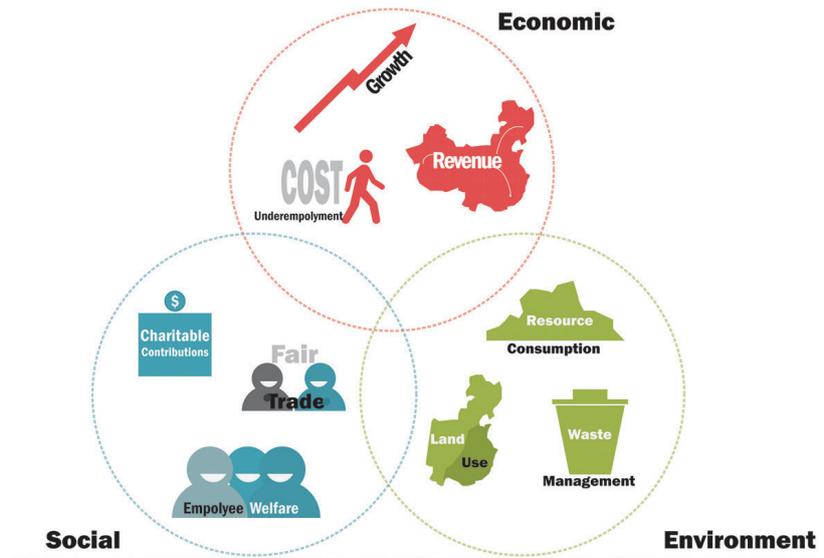
Notably the concern with 'outcomes' runs throughout this value chain. For example, it includes a concern with the input of labour (international labour standards, fair wages), the effects of processes (on the environment or communities) and how the outputs are used (such as whether profit is repatriated).

Taking into account these multiple dimensions of value along the chain, it could be said that these critiques are trying to move towards a conception of the overall ‘impacts’ of the enterprise, as some kind of total sum of its outcomes.

Inputs... Process... Outputs... Outcomes... [Impact]

One increasingly influential model to tackle these concerns is ‘triple bottom line’ accounting. This is a framework that assesses value across financial, social and environmental outcomes, instead of a sole focus on financial outcomes. The triple bottom line is illustrated by the following graphic.*

* Image licensed under the Creative Commons Attribution-Share Alike 3.0 Unported license. https://commons.wikimedia.org/wiki/File:Triple_Bottom_Line_graphic.jpg#metadata



A key question is whether this framework could be adapted to create a triple bottom line for value in health and care: financial value, health value (including health and wellbeing outcomes valued by people) and wider social value (such as employment and social capital).

Traditional conceptions of value in the English NHS

Traditionally, working to achieve value in public services runs two general risks: first, of emphasising the financial bottom line to the exclusion of other considerations of value, such as quality; and, second, of emphasising the priorities of professionals who plan, manage and deliver services at the expense of outcomes valued by people using them.

It is already recognised that activity-based targets and financial rewards focused on providers can fail to deliver taxpayer value for money. In addition, much attention is currently being paid to creating accountability for value beyond individual organisations, for example, through accountable care organisations and outcome-based commissioning. It is important to understand the value these mechanisms are going to deliver so that system incentives and rewards can be designed appropriately.

The NHS has traditionally been driven by professional values based on a medical model of care and its emphasis on clinical outcomes. However, clinical outcomes only recognise the expected effects of specific interventions, without taking account of their overall outcomes in the context of the lives and circumstances of patients. For example, the outcome of a joint replacement operation may be that a new, functioning joint has been successfully implanted, but this does not capture whether there is any improvement in pain or mobility for the recipient. PROMs (person reported outcome measures) are a response to this challenge, but only a small number are in mainstream use, they are primarily designed against professional and provider objectives, and they have had little effect on clinical practice.

New treatments, therapies and devices undergo a technology assessment before approval for NHS use. The assessment methodology does use quality of life considerations expressed through quality adjusted life years (QALY), but there are other methods (eg cost consequence analysis) and outcome measures (eg capability) that could help assess interventions or services. Indeed, some clinical outcomes have a weaker evidence base than might be expected; as the Choosing Wisely campaign in the United States, and campaigns for the disclosure of all clinical trials have highlighted.

A further complication is that clinical outcomes usually relate to specific diseases or conditions, and the standards and guidance to deploy interventions are usually expressed through formal ‘pathways’ of care for the single condition. This pathway approach is increasingly questionable where people have more than one condition. This is not only because of the undue burden of work it puts on the patient in navigating multiple pathways, but because it is possible for people to have multiple medications, consultations and interventions without these being reviewed ‘in the round’.

Recent adaptations of value in the English NHS

More recent policy has recognised some of the challenges discussed above. There has been a shift from ‘targets’ to ‘outcomes’ with the publication of national outcomes frameworks. These have a mix of metrics, some of which are about population health, some about quality of life (for example, domain 2 of the NHS Quality and Outcomes Framework (QOF), for long-term conditions).

The QOF has been reduced in favour of ‘care planning’ for vulnerable older people and permission is available for GPs to move towards other approaches to population health management.

A significant ‘Commissioning for Value’ programme provides each clinical commissioning group (CCG) area with data on its achievement of value, with comparisons made to neighbouring or similar CCGs. This has a small element recognising individual value in the form of shared decisions about treatments. It also recognises the challenge of ‘complex’ patients (those with co- or multi-morbidities) and hints at the use of care planning and supported self-management rather than standard pathways.

Other available ideas on value in health care

This section briefly outlines four concepts of value that may be useful in expanding NHS thinking: the Porter critique; public value; social value; and measuring wellbeing.

The Porter critique

US economist Michael Porter says health care value is too often accounted for at the wrong level – that of the single ‘unit’ of health care, such as a single provider – and in the wrong way, as ‘volume’ (process/activity). In fact, the value to the patient should be measured as a summary of the outcomes achieved by all providers combined over a full cycle of care. This speaks to the current drive for integration in health and care (Porter, 2010).

Porter also recognises the needs of ‘complex’ patients such as those with multi-morbidities or frailty, and argues that for such groups value is an aggregation of many outcomes and points to the need for ‘integrated practice units’.

However his own framing of outcomes hierarchies still rests largely on single-condition approaches, and on an assumption that there is a defined ‘cycle of care’ with beginning and end.

Public value

Public value is a school of thinking developed since 1995, centring on the value-creating role of public service managers. The task of these managers is to use judgement and skills to make the best use of public money. They have to navigate between managing limited resources, securing their continued legitimacy and creating value for the public. They must make ‘value propositions’ and secure support for these, including public support. ‘What the public values’, which may be different from political or managerial assumptions, becomes an important part of the value equation.

Public value adds to traditional measurement domains, such as numbers served, quality and effectiveness and value for money, by also including more emphasis on wider outcomes and impacts, and on ‘responsiveness’ to what matters to people. The BBC adopted a far-reaching public value approach for the current Charter (2006 to 2016) and all BBC activities must serve seven ‘public purposes’ and account for their impacts against them.

Social value

Social value is a way of thinking about the ‘triple bottom line’, particularly in relation to the activities of local service managers/commissioners and non-profit organisations. It gained official recognition and cross-party support in the Public Services (Social Value) Act 2012. This requires public bodies, such as commissioners, to consider the ‘financial, social and environmental wellbeing’ of their area when making spending

decisions. It is seen as a ‘correction’ to over-reliance on tendering, and a way to increase opportunities for the involvement of third sector groups in providing people with services and support.

The Act has been sparsely used by health commissioners. However, social care and other local authority commissioners have used it to develop and support a local market of provision that builds community-level assets such as user-led organisations, social enterprises and mutuals.

With government support (in both England and Scotland), frameworks have been developed to quantify social value, in particular through Social Return on Investment (SROI). This is a type of cost-benefit analysis that focuses on ‘impacts’ rather than outputs or outcomes. Impacts are the sum of all the outcomes minus what would have happened anyway. By calculating the SROI ‘ratio’ an organisation (such as a charity or social enterprise) is able to report that ‘for every £1 spent we returned £x of social value’.

A key difference to standard cost-benefit analysis is that outcomes are identified at the start by working with all stakeholders to generate an agreed set of ‘the outcomes important to us’. While SROI is a useful way to monetise the reporting of returns on social investment, on its own it is only indicative and does not capture all the values served by non-profit organisations. It is therefore best used within a wider narrative.

Measuring wellbeing

Measuring wellbeing has gained official traction as economists, governments and international institutions have sought to go beyond Gross Domestic Product as a measure of the success of countries, and have established indices of ‘happiness’ or ‘wellbeing’ based on the work of Richard Layard and many others. In the UK, the ONS established a programme in 2010 for measuring wellbeing across a range of domains that include ‘personal wellbeing’, ‘our relationships’ and ‘health’.

This national data is broken down by local area geographies for both health and local authorities. This set of measures offers a validated and reliable source of alternative or additional ways to measure the impacts of health- and care-related activities. It was established to improve public policy, but it is not yet clear that it is helping to drive changes in the ways that public services think about and plan to achieve value.

4

Value in adult social care

Questions

- **Does section 4 provide an adequate summary of value in adult social care or are there elements missing?**
- **What challenges do you foresee in aligning social care and health conceptions of value as integrated services become the norm?**
- **If you have worked on this kind of local alignment (for example, as a pioneer) what lessons have you learned?**
- **How can the value of effective clinical interventions be combined with an understanding of how these contribute to wider goals of wellbeing?**

Adult social care has been on a journey over more than two decades from the use of long-stay institutions, through care in the community, to ‘personalisation’ and the creation of a modernised single legislative framework in the Care Act 2014.

This has created a system with many shared values between user groups, third sector organisations, commissioners, system leaders and government. These include a goal (a legal duty in the Care Act) of improving the wellbeing of the population and outcomes (in the national framework) that emphasise independence, choice and control, and people being supported in the way that they want to be.

‘Personalisation’ describes both this journey and some of the interventions, including personal budgets that help to achieve the outcomes. It has many parallels to the emerging interest in ‘person-centred’ care in the health service.

Commissioning has moved (and been forced to move) away from purchasing services on behalf of people through recurring block contracts, and towards ‘shaping the market’ for support so that people can choose their preferred options. The Public Services (Social Value) Act has aided this by giving commissioners permission to develop community capacity to support people. The commissioning role has the characteristics of the public service manager with ‘value-seeking imagination’ discussed within public value literature.

Delivering social value, and doing so in co-production – being responsive to and collaborating with people who use services – is being built into the standards promoted by system leaders.

The social care values of wellbeing, independence, social interaction and feeling supported to have choice and control would also be recognised as important by people with complex health needs and long-term conditions.

This, together with increasingly close collaboration between health and social care bodies at both national and local levels in the drive for integration, seems likely to generate increasing alignment of values and outcomes frameworks between the two services.

Limits to this alignment will remain, however. People with long-term or complex health requirements need them to be met by trusted clinicians, specialists and other health professionals. Their use of statutory health services will therefore remain a significant part of any personalised care plans they develop.

Value systems in health and care must therefore capture the value of effective clinical interventions and partnerships, while moving to incorporate an understanding of how these contribute to wider goals of wellbeing.

5

Conclusions and next steps

Health and care have always sought to provide value. Traditional conceptions of value expressed variously – and often conflictingly – through classical accounting models, system targets, competition mechanisms and encouragement for single units to act autonomously and be judged as single services have dominated perceptions of value. Despite being strongly critiqued, they continue to have a significant impact on the behaviours of individuals and organisations.

What people value most has not been adequately engaged with or captured. The value added by individuals and communities, and the potential to multiply and maximise this by statutory services working in collaboration with them, has not been fully recognised. The current paradigms of value do not appear sufficient for health services today.

This paper suggests reframing value in health and care, drawing on ideas from a number of sources, and in particular from public and social value theory. These approaches emphasise that the outcomes we aim to achieve must be responsive to what relevant groups of people – ‘citizens’, ‘viewers’, ‘stakeholders’ – value.

There will be challenges to be addressed with this approach, as discussed in the introduction to this paper. For example:

- co-produced outcomes will be vulnerable to the critique that they are subjective and programme specific – and therefore not comparable with other programmes
- mechanisms for legitimising what constitutes public value will need to be established and new frameworks and measures of this wider conception of value will need to be created to assess financial, social and person-reported outcomes.

With this paper, we aim to articulate a new understanding of the value of engaging individuals and communities in health and care, and to discuss the challenges in progressing this. We are keen to understand your views and experience across sectors. To kick-start the conversation, a series of blogs will be posted on the Realising the Value website, www.realisingthevalue.org.uk

We hope you will take the time to engage with us and send us any thoughts or examples that can help move this agenda forwards. And we hope the paper will help you in thinking about the outcomes you seek to achieve.

To feed back on the ideas contained in this paper, please contact the consortium partners on info@realisingthevalue.org.uk

We would be grateful for any initial comments on the paper **by the end of October 2015** in order to reflect initial findings via our website and in stakeholder events. We will, however, continue to revise and refine the propositions in this paper as our understanding develops over the course of the Realising the Value programme. Our final programme report will be published in the autumn of 2016.

Summary of the questions asked in this paper

Section 1

- Are the propositions set out in section 1 the right ones to develop?
- Are there any further implications from these propositions that you would like to draw our attention to?
- Do you have suggestions for approaches to thinking about value that capture some or all of these propositions (in addition to those referenced in section 3 of this paper)?
- What challenges do you foresee – and how can they be overcome?

Section 2

- Are there key concepts of individual and community value we have not referenced in section 2?
- Do you know of any significant programmes or services in the NHS that have attempted to account for these types of value over time? Please send us references/details.

Section 3

- Do you have knowledge or experience of using the approaches described in section 3?
- If so, what lessons from them do you think can be applied in an NHS context?
- What are your thoughts about a triple bottom line approach to value in the NHS: financial value, health value (including health and wellbeing outcomes valued by people), and wider social value (such as employment and social capital)?

Section 4

- Does section 4 provide an adequate summary of value in adult social care or are there elements missing?
- What challenges do you foresee in aligning social care and health conceptions of value as integrated services become the norm?
- If you have worked on this kind of local alignment (for example, as a pioneer) what lessons have you learned?
- How can the value of effective clinical interventions be combined with an understanding of how these contribute to wider goals of wellbeing?

Please send your thoughts about these questions to info@realisingthevalue.org.uk

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About Realising the Value

Realising the Value is a programme funded by NHS England to support the NHS Five Year Forward View. The programme seeks to enable the health and care system to support people to have the knowledge, skills and confidence to play an active role in managing their own health and to work with communities and their assets.

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

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

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