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Value based procurement

An alternative approach to total cost reduction, improved efficiency and enhanced patient outcomes in the NHS

'A framework for delivery'

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1.0 Executive summary

Health systems across the globe are faced with unprecedented challenges in respect of rising demand and increasing patient expectations; set against a back drop of diminishing financial resources. This report proposes that healthcare procurement professionals have a significant role to play in addressing these issues and can deliver improved patient outcomes, increased savings opportunities and wider operational efficiencies through the application of the principles and practices of 'Value Based Procurement' (VBP).

The adoption of a value approach is supported within the publications of; "Next steps on the NHS five year forward view" (NHS England, 2017), "Operational productivity and performance in English NHS acute hospitals; unwarranted variation" (Carter review, 2015), the NHS RightCare programme and the introduction of the DH Future operating model. A core principle of VBP is the need to adopt a long term strategic view and a recent statement from the Prime Minister (27/3/18) supports this direction of travel.

From the perspective at a Hospital (NHS Trust) level, current price-focused procurement practices, adversarial supplier relationships and short term thinking are partly the result of the existing financial regime which has a constrained focus on "in-year" product savings targets - rather than the ability to optimise cost reduction through a more holistic approach and deliver a reduction across the whole patient pathway.

This report proposes a framework that enables organisations to recognise and apply the benefits and principles of VBP, initially focusing on pathway savings and efficiencies with a view to developing mature systems and cultures that can capture and deliver long term benefits through improved patient outcomes:

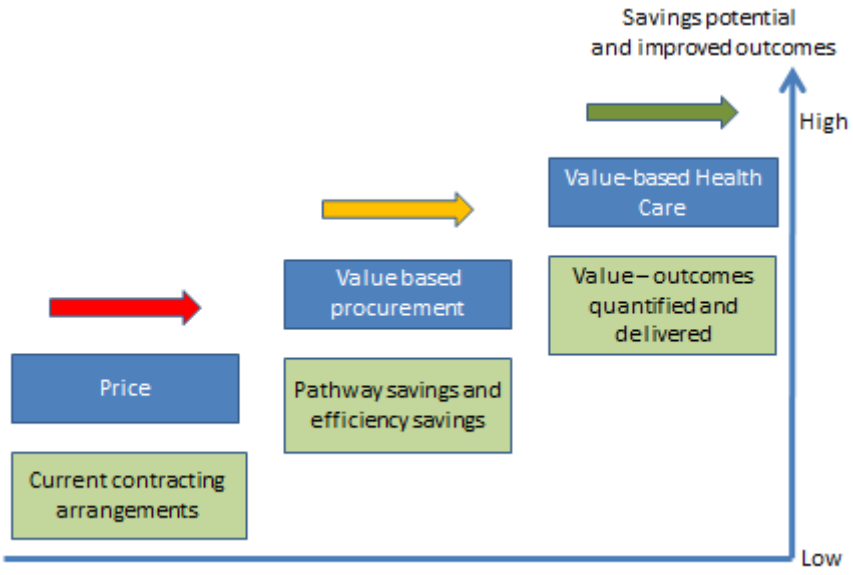


Fig: The move from Price to a Value-based healthcare approach

VBP can be adopted by focusing on:

1. Introducing procurement targets that are based on patient pathways and efficiency improvements.
2. Optimising value within existing contracts through the adoption of supplier relationship management.
3. Ensuring pre-tendering activity for new contracts, specifications are developed that identify areas of value across patient pathways.
4. Embedding VBP principles into tenders and assessing against these strategic measures.
5. Prioritising post contract work with suppliers to manage risk and deliver value.

It is acknowledged that change is never easy. Even when the benefits and principles are not disputed, the actual transition to something new can be difficult, emotionally challenging, and complex. In the NHS with such demanding financial pressures, resource constraints, and the sheer criticality of the service, the fear of failure is palpable. These fears and demands to make savings are acknowledged, but the current short term approach to driving cost ever lower is not sustainable.

We envisage all stakeholders in health systems across the world working together towards the achievement of value – that is achieving the outcomes that matter to people at the lowest possible cost. Procurement is a central part of this – the suppliers of products and services will need to demonstrate how their products and services improve value. Additionally, they will need to support health systems in capturing data in real time to eventually demonstrate how they are contributing to the achievement of value, such that we develop mechanisms of accountability where reimbursement of suppliers is linked to the value that is achieved in real-time.

If we only focus on short term, margin reductions, we risk losing those suppliers that invest in product and service innovation to improve the value and overall cost of our NHS. Procurement needs to be the change. Innovative, focused on value and cost efficiencies, removal of wasteful activities, that will ensure sustainable commercial outcomes

This report aims to outline the journey towards VBP rather than the destination, with the proposed framework a vehicle that can be used in full or part by healthcare providers and industry alike.

2.0 The need for change

2.1 Introduction

The publication in 2015 of *"Value based procurement in the NHS (NW)"* a joint research study by NHS North West Procurement Development (NWPD) and the University of Liverpool (UoL), concluded that there are considerable limitations in the price based procurement practices prevalent within the NHS. Change is required in order to deliver increased savings opportunities, wider operational efficiencies and improving patient care. The study proposes that application of the principles and practices of 'Value Based Procurement' (VBP) would enable these objectives to be met.

Value based healthcare is gaining interest internationally through studies from the likes of Michael Porter (Harvard Business School) and also in the English NHS through the likes of NHS RightCare. The RightCare report (2017) has the aim of;

"increasing value, reducing unwarranted variation and delivering better population healthcare"

The authors assert that procurement is a key enabler of the delivery of these objectives.

From a procurement perspective, recognition of the potential opportunity to use VBP as a lever for generating cash releasing savings has been acknowledged nationally with the introduction of the DH Future Operating Model who have stated that Category Tower Service Providers (CTSPs) will be;

"incentivised to procure product that demonstrably improves patient outcomes, or reduces total cost of ownership, or results in a total system cost reduction where such improvements are evidenced" (source; ABHI Procurement conference March 2018).

Medtech Europe is promoting VBP across Europe, through the use of the MEAT Framework (Most Economically Advantageous Tender). Countries such as Norway, Sweden, Portugal, Wales and Canada are working to adopt the principles of VBP as their health systems transition to value-based health care.

Based upon the experience of the authors in promoting the benefits of VBP, contributions from the International Consortium for Health Outcomes Measurement (ICHOM) and Hill Dickinson LLP, this report seeks to offer a framework of adoption for VBP for healthcare and industry professionals; aims to dispel the notion that the pursuit of value increases cost and suggests a vision for the future of healthcare procurement practices.

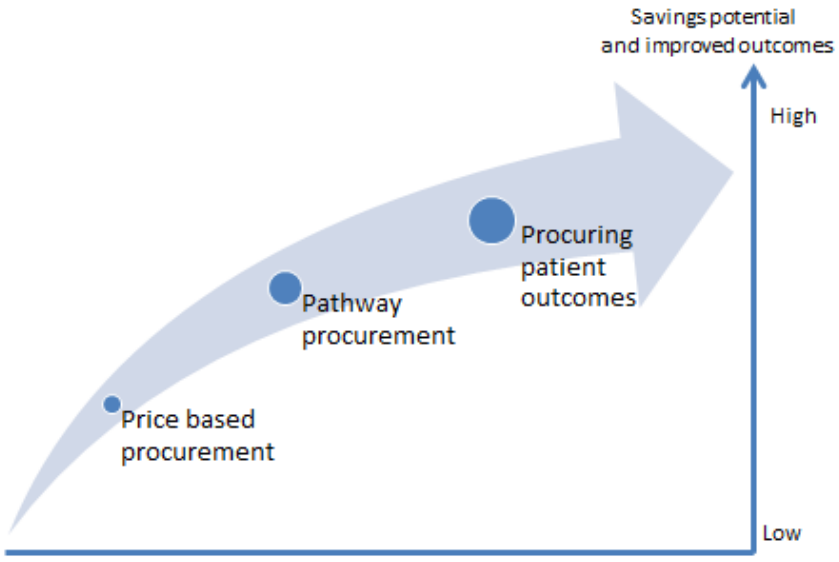
2.2 Value based procurement theory

VBP enables the incorporation of the Value-Based Health Care (VBHC) theory into procurement practice. Instead of focussing simply on the lowest price, VBP states that the focus should be on the products providing the greatest value – that is the best outcomes that matter to people at the lowest cost, across the full cycle of care. Value should be assessed at the time of the tender, reviewing studies that have been performed on specific products, but value should also be assessed with real-time data during the life of the contract. Those companies providing products that enhance value should then be rewarded.

The International Consortium for Health Outcomes Measurement (ICHOM – www.ichom.org) is working to develop standardised sets of outcomes for different medical conditions and population segments. These datasets aim to reflect the core outcomes that really matter to people and are being used by health systems across the world. They offer the opportunity to focus health systems (patients, providers, payers, suppliers, governments) on delivering a core set of standardized outcomes and additionally enable comparisons within and between countries to figure out which parts of health systems are achieving the best outcomes. Such datasets can be useful for including in procurement frameworks.

It is only by focussing on value across our health systems that we will achieve high quality, sustainable health systems. Health systems can then focus on value-enhancing cost reduction rather than simply cutting costs without knowing the effect it will have on the wider outcomes for patients. Procurement must embrace VBHC to ensure that suppliers of products and services are aligned with the rest of the health system in working towards achieving the best outcomes that matter to people at the lowest possible cost.

By focusing on pathways, VBP (or 'Procurement for Pathways') delivers far higher financial savings than traditional procurement approaches:



VBP approaches use the procurement process to drive market innovation to deliver life cycle value across patient services, improving patient outcomes, reducing cost, and evidencing impact. These approaches also attempt to strategically align suppliers' resources, products and services to outcomes based goals.

2.3 Rationale for change

In 2015, NWPD and University of Liverpool (UOL) conducted a research study to explore the feasibility of VBP in the NHS and to assess its efficacy against existing and historical approaches. A summary report and an academic peer-reviewed paper were published that detail the research results, copies available on request. Based on this work, subsequent analysis and engagement across the healthcare sector, some of the key findings suggest that:

- NHS procurement is predominantly focused on product price and current processes do not give sufficient attention to total acquisition and related pathway costs.
- Current procurement cycles are restricted to short term cost reduction and these can compromise long term opportunities that could deliver greater levels of savings.
- The pressure to deliver annual savings targets in procurement departments drives the adoption of a short-term focus on small margin reductions rather than a medium to long-term strategic focus on all elements of cost and value. In one Trust in the North West of England, this approach resulted in a workplan that contained 150 projects to deliver £500k savings.
- Relationships with many suppliers lack sufficient collaboration required to create and capture value.
- Best practice supplier relationship management should see engagement with suppliers as a key to the solution, rather than a cause of the problem.
- To further the strategic vision of VBP and to capture operational benefits, both NHS procurement and NHS suppliers must embrace behavioural change.

From a national perspective, the rationale for change is driven by:

- "Next steps on the NHS five year forward view" (NHS England, 2017) which set out a clear goal that; *"the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care."* This has led to a wider system-based approach to commissioning and provision in the NHS and a greater focus on developing outcomes and capitated models for populations.

- NHS RightCare is a national NHS England programme which looks to deliver the best care to patients, making the NHS's money go as far as possible and improving patient outcomes. The RightCare approach is rooted in optimal system design as the platform for implementation, an approach which is in line with VBHC, as well as looking at how you may implement the new system through procurement and contracting.
- The Carter review in 2015 which concludes that aggregation of demand is necessary to increase efficiency, reduce prices and price variation; allow rationalisation of suppliers; and the opportunity to adopt strategic procurement practices such as SRM (Supplier Relationship Management).
- The new structure to replace NHS Supply Chain (Future Operating Model - FOM) across the NHS. With the introduction of National Category Towers for key category spend areas and an increase in number of products included in the national contracted products programme will inevitably have an impact on the role of procurement at a local trust level. DoH have stated that Category Tower Service Providers (CTSPs) will be incentivised to improve patient outcomes and work to reduce total cost of ownership, rather than simply price.
- The introduction of the national "Scan4safety" programme, requiring organisations to adopt GS1 standards by 2020. A co-ordinated approach to procuring via pathways would potentially lead to Trusts benefiting from lower systems cost, greater interoperability between organisations and significant cost saving opportunities. As a result, the contribution and profile of supply chain management will be heightened significantly.

3.0 Framework for delivering change

The issues discussed above can be addressed through the adoption of a holistic procurement model for VBP:

1. Financial targets are based on total pathway and efficiency targets across a medium-long term time frame.
2. Value is maximised within existing contracts through supplier relationship management.
3. Pre-tendering activity requires early engagement with stakeholders to develop specifications that identify potential areas of value across patient pathways.
4. Tenders are designed to and assessed to reflect short, medium and long-term value dimensions..
5. Supplier engagement is developed throughout the contract delivery to ensure value is captured and to support the co-creation of additional value.

3.1 Targets

As referenced in section 2.3 above, a key driver of buyer and supplier behaviour is the pursuit of annual savings plans, which to date have restricted the ability to apply whole life costing to procurement activity a prerequisite for the adoption of VBP. However recently the Prime Minister has acknowledged the need for a longer-term focus for financial management in the NHS. Speaking in front of MPs on the House of Commons Liaison Committee on 28 March 2018, Ms May said:

"We need to get away from this annual approach we see to the NHS budget…recognise that for the NHS to plan and manage effectively we need to get away from those annual top ups of the budget that we see and we do need to have a sustainable long-term plan…and that, I think, should build on the work of the five-year forward view, but look beyond it and a plan which allows the NHS to realise greater productivity, to realise efficiency gains."

This stance from the UK government is yet another positive signal for the introduction and integration of VBP practices. That said, at a Hospital level, close collaboration between Trust Finance and Procurement leads is also an essential element to the adoption of VBP and there are some initial challenges that must be overcome.

In respect of the construction of the savings target it is proposed that elements included are initially centred on desired efficiency gains in areas where data is easily accessible, for example theatre time, length of stay, 18 week targets etc, with the vision to ultimately capture data relating to long term patient outcomes. The move to a new VBP based approach will also include entering into a contract which reflects a VBHC approach which the Trusts will need to understand and which will have a key element dealing with changes to the finance model. The move away from a price-based model to value presents the finance team at Trusts with a new dynamic and one which initially at least may appear less certain than simply measuring activity and units of a product.

To this end it is important that the Trust is very clear over the indicative value or range of values for what is on offer / how much may be moved to outcomes as well as the limitations or boundaries that may be put around the scope of the procurement.

This will be important as well in scoping the procurement for the Trust as well as by giving providers confidence that the risks which they are being asked to take in the move to value by the Trust are clearer and more manageable by them.

Trust finance teams must have robust costing systems that enable the identification and monitoring of key value elements across the patient pathway, the NHS GS1 adoption programme "Scan4safety" is an excellent example of a key enabler for VBP.

Research undertaken to date, suggests that the NHS Procurement community have limited knowledge and visibility of how pathway costs are constructed, other than the price of the product purchased for a procedure. Therefore organisations wishing to apply VBP should be encouraged to offer training and support to non-finance staff in this area.

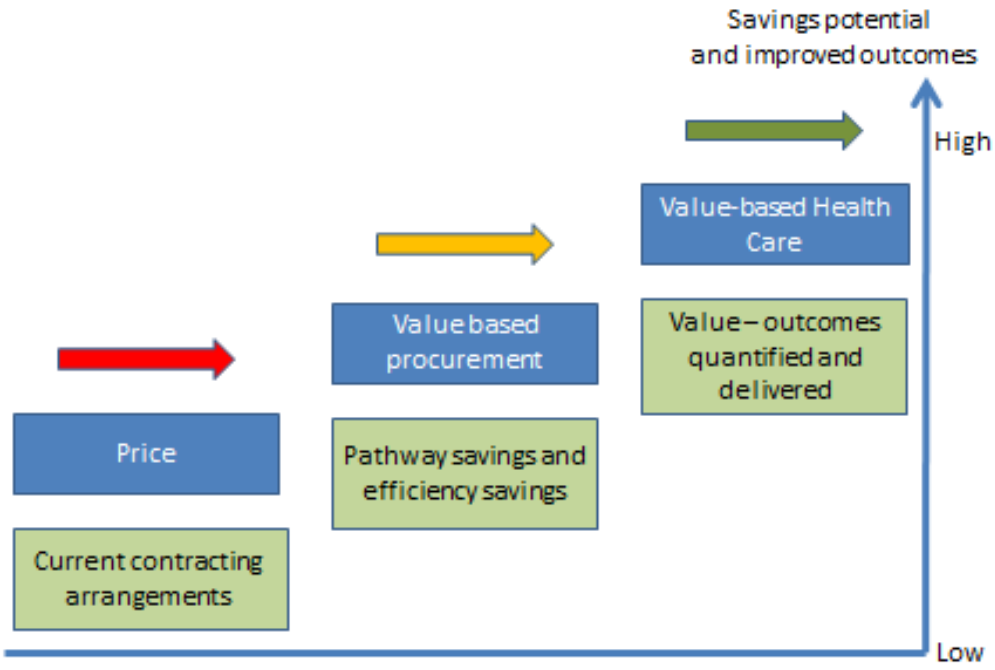


Fig: The move from Price to a Value-based healthcare approach

3.2 Supplier relationship management

Supplier relationship management (SRM), presents considerable opportunities for VBP. Developing supplier relationships through effective contract management facilitates the collection of market intelligence and ensures savings actually reach the bottom line.

When Trusts are already under contract with a supplier, or at least have a compliant route to market readily available, they can engage in value based activities without necessarily having a need for a new, full tender process. An example service blueprint taken from a SRM project is included as appendix A.

Framework for value-based supplier relationship management
As part of UOL's continued engagement with NWPD, a framework for working with suppliers in a value based way has been devised which incorporates.:

- Data analysis to produce supplier reports. These are SRM and category handbooks to give a summary of the current market position and to highlight critical areas of spend per Trust, per product category.
- Initial meeting with supplier at the appropriate level, i.e. a contact with the relevant authority to act at a regional level on behalf of the supplier.
- SRM project proposals (agreed with the supplier via the initial meeting and subsequent engagement):
  - Aims & objectives e.g.:
    - Behavioural change in NHS and supplier – emphasis on trust and shared benefits
    - 'Different conversations' between buyer and supplier – emphasis on value
    - Increased price consistency
    - Value Based Procurement
  - Mini SWOT analysis
  - Desired outcomes e.g.:
    - Improved quality of goods and services purchased across the region.
    - Increased levels of clinical and stakeholder engagement within the procurement process.
    - Long term cost reduction throughout the supply chain.
  - Measures and KPIs
  - Identify Trust(s) for pilot project
  - Project plan (an example is provided in Appendix B)
- One day workshop with relevant stakeholders from the pilot Trust (or wider place, or STP/Integrated Care System if feasible) to work through three strands, i.e. commercial (e.g. price consistency), clinical (e.g. opportunity for VBP) and supply chain (e.g. more efficient ordering and invoicing methods).

- Each strand will form sub-groups to complete their tasks agreed at the workshop. The project manager will facilitate the coordination of these strands and provide project management support.
- Outcomes need to be tangible benefits (often based on behavioural change).
- Roll-out to the wider region (or nationally) is via workshop(s) in which each strand from the pilot project demonstrate their benefits and how these were achieved.
- Project manager facilitates the roll-out and maintains the high level relationship with the supplier.

By undertaking SRM in this structured way, long term benefits are more likely to be achieved. Furthermore, by rolling-out findings, there is a high level of organisational learning achieved by sharing best practice and value based opportunities. This approach allows the NHS to operate at scale and pace.

Example data from 2018 project work with a supplier of Pneumothorax treatment devices shows how a change in the use of a product within the patient pathway can lead to a significant reduction in the amount of hospital admissions:

Based on patient with 'Primary Spontaneous Pneumothorax'

Benefit Summary	
Saving of inpatient management costs after HRG income	£1,097.08
Income from outpatient management after HRG income (in surplus)	£531.02
Total Benefit	**£1,628.10**

Based on patient with 'Iatrogenic(Post Biopsy) Pneumothorax'

Benefit Summary	
Saving of inpatient Management costs after HRG Income	£951.00
Income from outpatient management after HRG Income (in surplus)	£677.10
Total Benefit	**£1,628.10**

[More detailed breakdown in appendix C]

3.3 Pre-tendering activity

Procurement engages with internal stakeholders and suppliers to develop specifications that identify areas of value. Pre-market engagement with suppliers is encouraged within the EU Procurement Directives (2014) and yet is often overlooked within NHS procurement activity.

Background

Traditionally, buyers and suppliers have entered into an adversarial relationship based on diametrically opposed primary objectives - procurement's primary objective of reducing product price and the supplier's dual objectives of maximising profits and increasing market share. Over the past five years, the Department of Health in the UK has driven towards increased transparency, which coupled with the objective to remove non-disclosure agreements in contracts has unearthed evidence of suppliers' pricing approaches. A historical approach was to offer discrete pricing, with in some cases little correlation between price and volume.

Much of industry has reacted positively to the transparency agenda by developing clearly defined pricing structures and the days in the UK of "you're my special customer" are on the wane. Also, many Medtech organisations are now at the forefront of the development of VBHC approaches internationally, seeing this as a positive from the supplier side in rewarding innovation which delivers better patient outcomes and more value for the cost.

More recently, the DH have made clear that suppliers to the FOM category towers will be able to proposition their products/services over the value they deliver to the NHS and patients. CTSPs will therefore actively seek innovation from suppliers that can reduce total cost in the system. (Source; ABHI Procurement Conference March 2018).

Research findings

It is recognised that some parts of the Medtech industry are highly supportive of the promotion and adoption of VBP within healthcare sectors across the globe. However experience gained over the past three years by NHS NW Procurement Development and the University of Liverpool has identified that within the procurement community (in the UK and abroad) that there is a degree of scepticism, with the view that industry are merely trying to keep prices artificially high and maximise their profit margins.

The assertion of the NWPD/UoL research team is that VBP can only thrive where there is; perceived equality of power; suppliers can provide transparent and evidence based data to substantiate value based claims; and where proposed benefits can be under-written in the form of an agreement that apportions equitable responsibility for both parties.

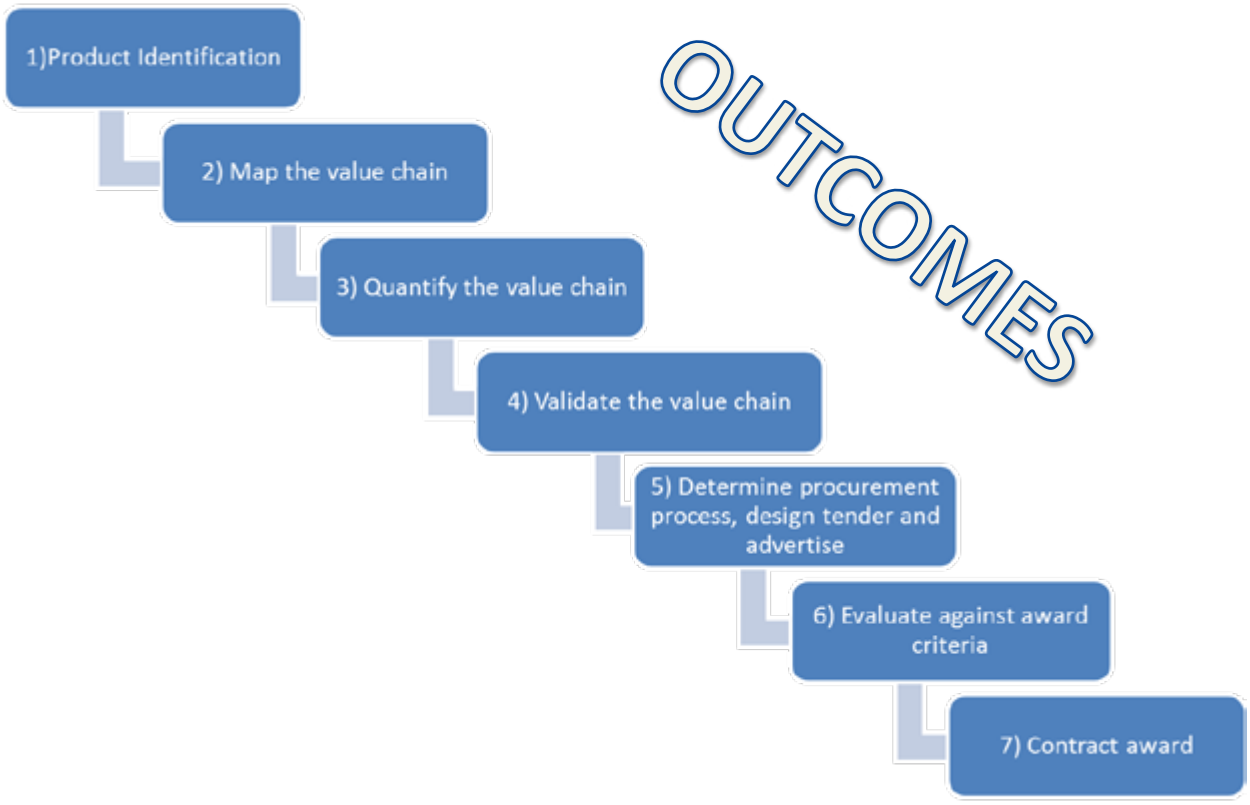
Recommendations for suppliers to engage in VBP

- Review organisational objectives and incentive schemes so that they are aligned to the principles of transparency, partnership working and demonstrate to the healthcare community how these are embedded within the suppliers organisational culture.
- Ensure that roles, responsibilities and financial opportunities are clearly articulated, that data is accessible, quantifiable and accurate.
- Ensure that value based claims are evidence-based and applicable to the territory in which the efficiencies will be delivered.
- Ensure that you are willing to except and underwrite claims made within a tender.
- Consider open-book trading with healthcare partners.

3.4 Tender activity

VBP principles should be built into tenders and assessed against these strategic measures.

Framework for value-based tender processes



Stage 1 – Product identification
Appendix D depicts an example of a decision making process with regards to the use of VBP.

Typical products may include the likes of, hearing aids, ICDs/pacemakers, infusion pumps, anaesthetic products, ophthalmology, orthopaedic prostheses, radiology equipment, spine surgery, stents/balloons and wound care.

VBP is not limited to purely medical areas however. You could consider a product like pressure care mattresses:

A project to deliver a total bed management contract at a North West NHS Trust used value-based thinking to mark a step change in procuring pressure care mattresses and all associated products and services. The outcome reduced costs and more importantly reduced incidents of pressure ulcers for patients.

Stage 2 – Engagement with clinical stakeholders to map the value chain
Clinical stakeholder engagement is essential in order to map the value chain, identify desired patient outcomes and inform the approach of the procurement and finance teams. For a controlled approach, project style governance is suggested to:

- Create steering group and inform all clinical stakeholders

This stage aims to gain buy-in from all sides and educate on the process mapping where necessary to ensure a smooth roll-out.

- Produce a draft patient pathway

Observe and accurately record each step in the current pathway. Produce a clear map of the exact pathway for all to see and review. This is often called a 'brown paper' exercise – a rough and ready, visual tool for the draft pathway.

- Series of workshops

All clinical stakeholders to view and analyse the draft, 'brown paper', to ensure accuracy. New pathway alternatives are identified, detailed and analysed.

- Produce new 'white paper' and present to steering group.

This could be in the form of 'service blueprints'. Service blueprints are relatively simple and their graphical representations are easy for all stakeholders involved to learn and use for a particular innovation's requirements (Bitner et al, 2008).

[Appendix A for example service blueprint for an audiology project]

Stage 3 – Engagement with finance stakeholders to quantify the value chain
Engagement is now required from the finance team in order to quantify the steps in the value chain. Again, this could be in the form of service blueprints. At this stage the systems need to ensure that the various steps can be quantified, measured and reviewed. Typically this may boil down to:

- Process time
- Staff – numbers and grades
- Products – numbers and value
- Patient recovery time as well as other patient related outcomes
- Any income generated – eg via tariffs

A key area to be considered here and one where VBP process and VBHC contracts should differ from current practice is setting in the duration of the contract itself. The new approach should look towards longer contract terms, enabling all parties to take a longer-term view around investment and innovation (as well as risk) in outcomes and greater value. This is important as some of the key patient outcomes which the Trust will want to shift could take a number of years before the impact of the new way of working is seen and therefore the contract should support this investment by the suppliers.

This is not to suggest that the new contract under VBP cannot accommodate break clauses and benchmarking provisions to ensure that the services remain at the appropriate level, or that the suppliers cannot be performance managed on quality. Early termination can also be tied into compensation for a supplier (where appropriate to reflect their front end investment into the contract if this is not covered elsewhere) or the Trust.

Stage 4 – Supplier engagement to validate the value chain, agree the outcomes that the suppliers will be working to improve and establish risk sharing and value commitment mechanism

When value claims are made against future pathways, there needs to be a commitment from supplier and the NHS organisation that these claims will be achieved.

At this stage, discussions with potential suppliers should reveal how this commitment can be made – what the roles of the supplier and the Trust are and how the risk of non-achievement can be shared.

For example, in an anaesthetics project, the impact on average length of stay and bed days were used as the basis of a target for process improvement towards more day-case procedures. This method allowed the financial impact of achieving day-case targets to be quantified and measured.

Stage 5 – Determine the procurement process, design tender and advertise

When, where and how value is created and captured should involve the whole supply chain. From a procurement perspective, how value opportunities are expressed needs careful consideration to take account of the full spectrum of procurement mechanisms, including pre-market engagement, tender notices, contract terms, service level agreements, supplier evaluations, and other supplier engagement events.

Value is often ill defined in tenders and contracts. Failure to understand and define value can result in sub-optimisation of outcomes, opportunism by suppliers or Trusts, inability to measure good practice and additional costs.

At tender design stage, consideration should be made as to the scale of the tender exercise and the capacity required to deliver it. For example, it may be more beneficial to work with other Trusts and go to market as a collaborative of several organisations. This is the type of approach which would fit in well with the current drive to operate on a wider "Sustainability and Transformation Partnership" (STP) or Integrated Care System footprint in the NHS.

Whilst the 'Competitive dialogue' or 'Competitive procedure with negotiation' options from the Public Contract Regulations 2015 could be used for VBP, these methods are often less well known to internal NHS procurement teams and can result in associated high consultancy-support costs.

Where the pre-tender work and supplier engagement has been carried out and there is a clearer scope and envelope for tenderers to bid against then the 'Restricted procedure' could still be an adequate mechanism. The regulations make clear that award criteria should focus on whole life costs and not merely acquisition price – fitting nicely with VBP principles. Bid scoring and weighting models should follow the principle of measuring all aspects of value. Sub-categories and weightings should be adjusted to reflect the specific objectives of each tendering exercise. An example of a bid scoring and weighting model for VBP is included as Appendix E, with the extension to VBHC then depicted in appendix F.

In a similar way, mini-competitions from existing EU compliant frameworks can also be tailored to suit VBP award criteria. In these circumstances, the awarding body should liaise with the framework provider to discuss allowable criteria based on the original contract award criteria. For the national FOM frameworks, CTSPs are being incentivised to include *"intangible cost savings"* in their award criteria:

For example, a score of 5/5 (Excellent) would be given for; *"considerable reduction in total system costs across a number of areas".* (Source; ABHI Procurement conference March 2018).

The supplier's engagement with the VBP process and the desired changes will be very important. Where a contract is introduced via a procurement exercise, the buy-in of the supplier to this approach can be tested but where this is not the case the position can be more complex.

Many suppliers will perceive the shift in contracting away from fee for service/goods or more traditional models to be a high risk for them as an organisation. This can be very disruptive and has resulted in legal challenges or referrals to national regulators from suppliers.

Therefore, the Trust should consider detailing a clear process for engaging and working with the relevant suppliers both in management and clinical areas (engagement with clinicians to agree a new way of working and outcomes can be a very powerful way to develop wider engagement from organisations) - this model may also need to be refined for the procurement process.

There is also a need for Trusts, their commissioners and regulators to also change their way of working with suppliers in:

1. Moving away from a tightly managed, highly specified input contract into what should be a looser outputs/outcomes driven environment - this would be a move from 'micro-commissioning' where the payers define the services/product and the exact nature and location of delivery (which effectively builds in the existing system and a level of inflexibility to the contract) to prescribing the outputs and core metrics, which need to be met/measured and allowing flexibility as to how these are achieved (obviously within legal parameters), and;

2. Considering the internal implications of this approach-for example the procurement team at the Trust may be tasked with delivering immediate cost savings from the contract award to meet internal targets. This would not really fit with the wider aims of system working which starts to look at how to share risks and deliver wider value for patients across the population rather than extracting short term process savings at the expense of wider quality of provision and patient outcomes.

The form of supplier organisation to take on these innovative VBP processes and contracts is not pre-set and could be a combination of forms or suppliers in different areas depending upon factors such as the local healthcare system, the pathway and scope of the desired health outcomes and the appetite for risk from both the Trust and suppliers.

Appendix G provides a worked example of the potential difference in cost approaches between a traditional, price-based approach to tendering; and a pathway, value-based approach. By including pathway measures such as length of patient stay, theatre time and reduction in instrumentation trays, the total cost of acquisition is calculated. The example depicts a tender whereby the unit price is 16% higher for bid 3 than bid 1. However, once the TCA is calculated, bid 3 becomes 58% lower than bid 1 across the whole pathway.

Stage 6 and 7 – Evaluate against criteria and award contract
At this stage, the commitment and risk sharing agreement for future value should be finalised and signed off.

In England NHS is starting to adopt greater use of outcomes and risk and gain share into its contracts. It is also initiating interesting discussions between health suppliers and Trusts around where the risk lies in the wider pathway.

Considering the risk share gives the Trust (and potentially their commissioners) the chance to work more collaboratively with the budget by using a mechanism where the Trust and suppliers can share in efficiency gains to incentivise better operation and all parties are incentivised to jointly remodel care delivery to mutual benefit across organisations.

This can be implemented in practice in a number of ways and some examples include the agreement between the parties of a capped risk and/or agreement to share efficiencies between the parties in defined proportions (i.e. the provider is responsible for cost overruns to a defined level with the Trust taking the risk beyond this level or both parties taking a share in the initial risk of overspend/gain on underspend to a defined level).

Risk share is though just one factor which new VBHC contract models will need to address if they want to avoid simply reverting from fee for service back to a 'block' single payment contractual approach, which would (1) not incentivise greater engagement between the parties and (2) could facilitate centralisation under one large supplier under a pathway with removal of wider smaller suppliers whose value is not recognised under a more basic model.

As with any tender, feedback should be offered to unsuccessful bidders to help those suppliers to improve for future bids across the NHS.

3.5 Post contract work with suppliers

Post contract work with suppliers should be prioritised to manage the contract appropriately and to deliver the value identified in the VBP. Downstream contract management requires management of the supplier at an organisation level (as opposed to a service level) covering overall performance, value initiatives, cost improvement targets, risk profiles, financial viability, administrative efficiency, and corporate responsibility.

Contract management provides the platform for robust auditing of supplier promises and opportunities, innovation, sustainability etc. identified at the selection stage to ensure tracking of promised savings achieved.

The contracting environment needs to encourage suppliers and internal Trust stakeholders to engage in the co-development and implementation of value-based, cost-effective solutions.

However, the complexity in changing the operational mode of the contract and the collaborative behaviours of suppliers should not be underestimated and much work will be required to define the outcomes, metrics and performance standards and link these to the payment mechanism in the procurement. Areas such as the change mechanism in the Contract will be key to ensuring that the longer-term arrangements are able to evolve over time with the system relationships and outcomes to meet the demands of the Trust and the local healthcare system.

4.0 Vision for the future

We envisage all stakeholders in health systems across the world working together towards the achievement of value – that is achieving the outcomes that matter to people at the lowest possible cost. Procurement is a central part of this – the suppliers of products and services will need to demonstrate how their products and services improve value. Additionally, they will need to support health systems in capturing data in real time to eventually demonstrate how they are contributing to the achievement of value, such that we develop mechanisms of accountability where reimbursement of suppliers is linked to the value that is achieved in real-time.

Change is never easy. Even when the benefits and principles are not disputed, the actual transition to something new can be difficult, emotionally challenging, and complex. In the NHS with such demanding financial pressures, resource constraints, and the sheer criticality of the service, the fear of failure is palpable. These fears and demands to make savings are acknowledged, but the current approach where short term reductions to profit margins are not sustainable. VBP that puts the long-term viability of the NHS, patient outcomes, and efficiency at the very core of procurement is a change that must be adopted. VBP demands a collaborative effort between procurement, clinicians, suppliers and other health care professionals. As buying professionals, we get the markets we buy from.

In conclusion, this report aims to outline the journey towards VBP rather than the destination, with the proposed framework a vehicle that can be used in full or part by healthcare providers and industry alike.

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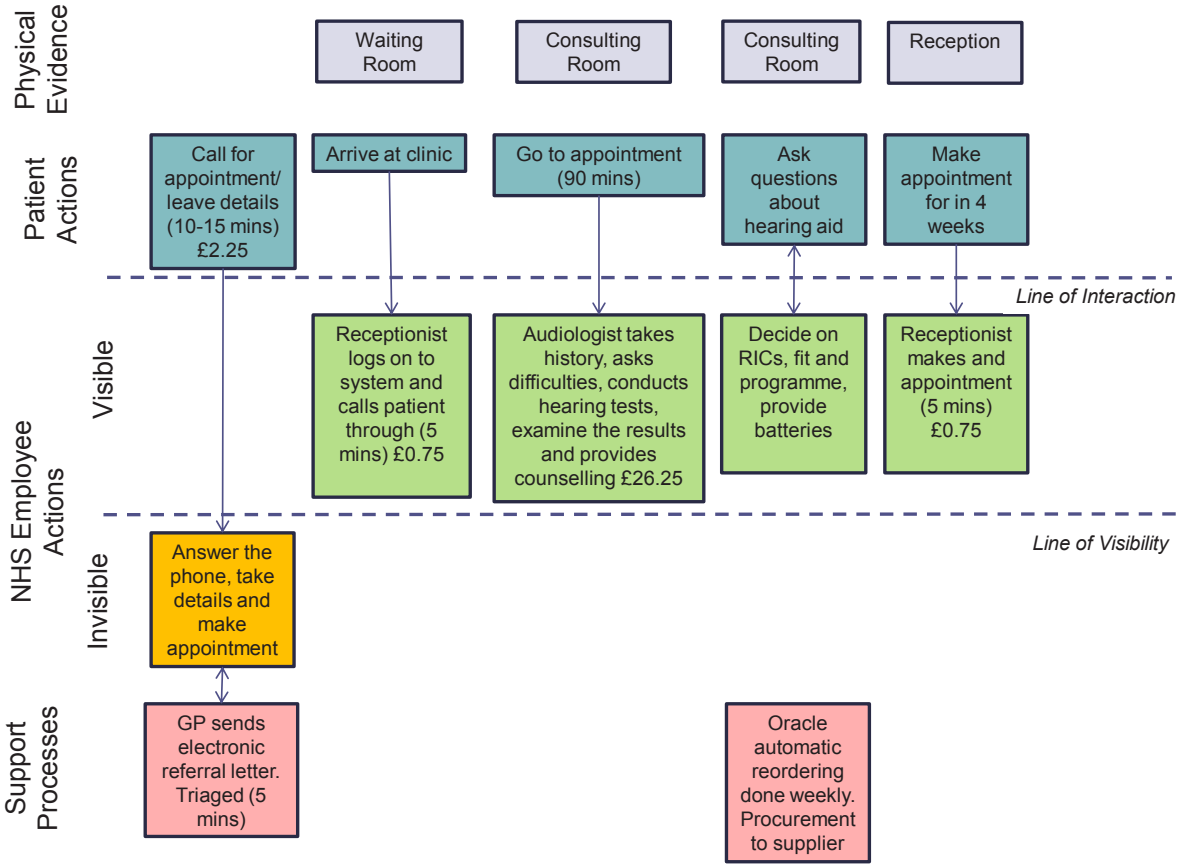
Appendices

Appendix A – example service blueprint



Appendix B – example project plan for SRM

Draft NWPD SRM Project - workplan

Work to be done | Work overdue
Work Completed

Stage	Task	Owner	Year / Month	Year Month 1	Year Month 2	Year Month 3	Year Month 4	Year Month 5	Year Month 6
1	**Project scope**								
1.1	Initial review of data	PM							
1.2	Initial meeting with supplier	PM							
1.3	Summary report	PM							
1.4	Identify areas for savings & benefits	Supplier							
1.5	Engage with relevant Trust(s) and identify pilot	PM							
1.6	Agree scope for mini-project	Board							
2	**Stakeholder engagement**								
2.1	Workshop for all key stakeholders	All							
2.2	Agree aims and measures for commercial	Finance lead							
2.3	Agree aims and measures for clinical	Medical lead							
2.4	Agree aims and measures for 'supply chain'	Procurement lead							
3	**Pilot actions**								
3.1	Commercial	Finance lead							
3.2	Clinical	Medical lead							
3.3	Supply chain	Procurement lead							
4	**Produce 'framework' for regional SRM**								
4.1	Lessons learnt & project report	Board							
5	**General support for project**								
5.1	Ongoing feedback and support	Board							

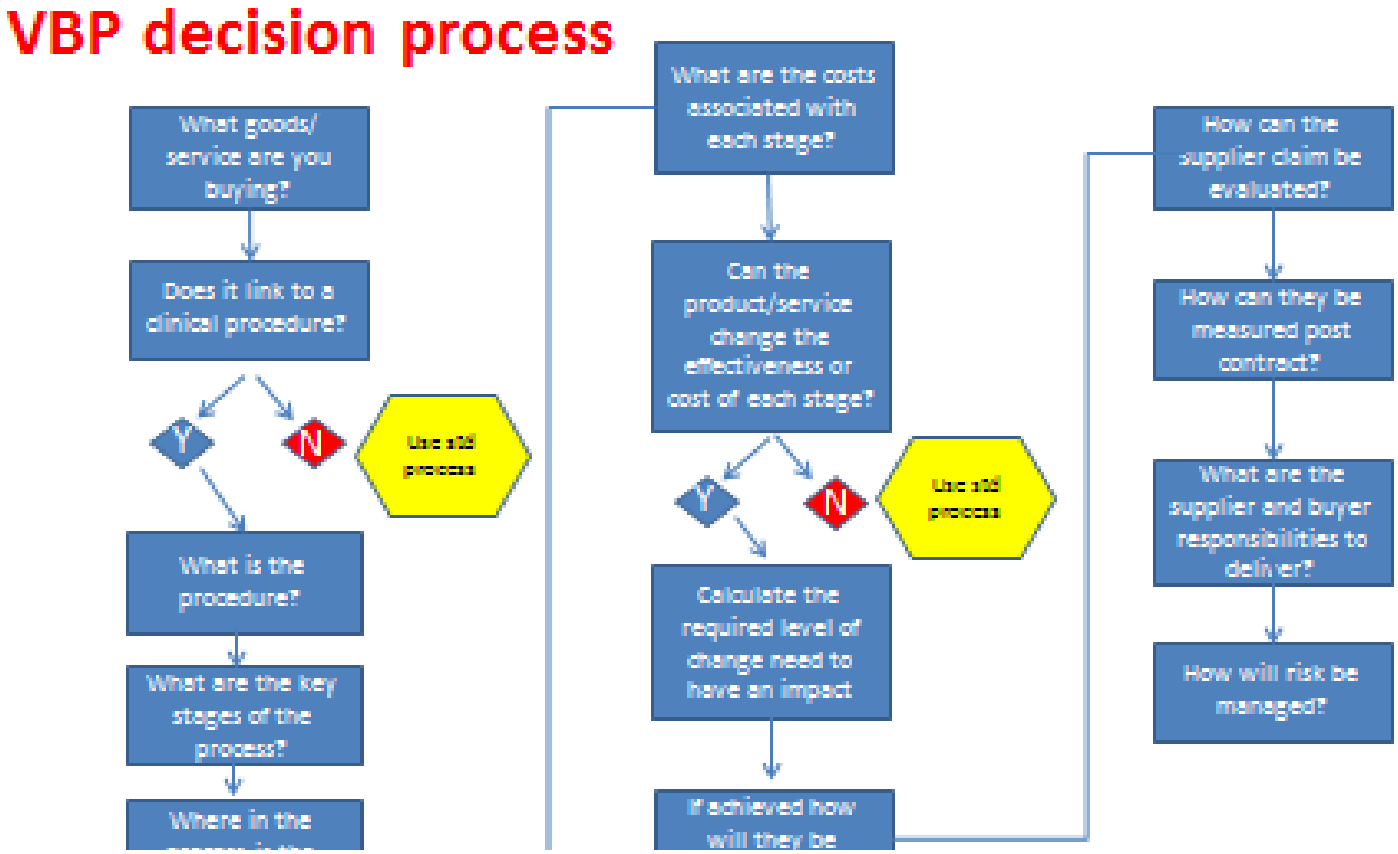
Appendix C – cost v benefits analysis for pneumothorax treatment

Value Proposition- Move to Ambulatory Care for Pneumothorax Patients:		
All figures are from published NHS Data and Clinical References- full details are available		
These models illustrate the cost for 1 patient		
This is for illustration only and needs to be validated by the Trust		
Costs for Admission of patient with Primary Spontaneous Pneumothorax:		
		Source
Cost of A&E Admission	£146.08	(NHS Reference Cost)
Cost of Chest Drain System	£92.00	(NHSSC)
Mean Admission Days	4	(Marquette et al, 2006)
Cost per day admitted	£400.00	(NHS Reference Cost)
Total Cost	£1,838.08	
HRG Income	£741.00	
Overall Cost Position	-£1,097.08	
Cost of Outpatient Management for Primary Sponteneous Pneumothorax:		
Cost of A&E Admission	£146.08	(NHS Reference Cost)
Cost of Chest Drain System	£99.20	Drain and Valve
Cost of Outpatient Visit	£163.70	(NHS Reference Cost)
Total Cost	£408.98	
HRG Income	£940.00	
Surplus (HRG Income - Total Outpatient Cost)	£531.02	
Benefit Summary		
Saving of inpatient Management costs after HRG Income	£1,097.08	
Income from outpatient management after HRG Income (in surplus)	£531.02	
Total Benefit	**£1,628.10**	

Appendix C (cont.)

Costs for Admission of patient with Iatrogenic(Post Biopsy) Pneumothorax:		
		Source
Cost of Chest Drain System	£92.00	(NHSSC)
Mean Admission Days	4	(Marquette et al, 2006)
Cost per day admitted	£400.00	(NHS Reference Cost)
Total Cost	£1,692.00	
HRG Income	£741.00	
Overall Cost Position	-£951.00	
Cost of Outpatient Management for Iatrogenic (Post Biopsy) Pneumothorax:		
Cost of Chest Drain System	£99.20	Drain and Valve
Cost of Outpatient Visit	£163.70	(NHS Reference Cost)
Total Cost	£262.90	
HRG Income	£940.00	
Surplus (HRG Income - Total Cost)	£677.10	
Benefit Summary		
Saving of inpatient Management costs after HRG Income	£951.00	
Income from outpatient management after HRG Income (in surplus)	£677.10	
Total Benefit	**£1,628.10**	

VBP decision process



Appendix E – example draft bid scoring and weighting model for Value Based Procurement

NHS NWPD - DRAFT Bid scoring and weighting model for Value Based Procurement

Name of procurement exercise:			
Category	**Weighting**	**Sub category**	**Weighting**
Cost	%	**Acquisition price (product price)**	%
		Anciliary costs - are there any ongoing additional costs associated with the product?	
		Pathway costs - as appropriate, for example; theatre time, length of stay, instrumentation	%
Quality	%	**Fit for purpose** - compared to specification; consider if this is pass/fail or a qualitative score	% or pass/fail
		System/process innovation - as appropriate, are there potential areas of innovation over and above the specfification that will add value and that can be substantiated?	%
	%	**Medical patient outcomes** - substantiated improvements to patients' medical outcomes as a result of this procurement. For example; reduced revision rates, reduced infection rates, improved PROMS score.	%
		Patients' secondary benefits as appropriate, are there secondary benefits to patients such as reduced number of outpatients appointments?	%
		Project specific - state any project specific outcomes that could vary between providers and therefore require measurement	%
Service - ongoing performance & contract management	%	**Customer service -** to include delivery, after sales, techincal support, training	%
		Management systems - to include KPI reporting mechanisms, measurement systems, ordering systems (e.g. use of and development of e-catalogues)	%
		Contract terms - to include risk sharing mechanisms and guarantees	%
Sustainability	%	**Environmental** - proportionate to the contract, are there opportunites for environmental benefits such as reduced carbon emissions, reduced packaging waste, reduced energy usage?	%
		Socio-cultural - proportionate to the contract, are there opportunites for socio-cultural benefits such as increasing the use of disadvantaged labour?	%
Totals	100%		100%

Appendix F - example draft bid scoring and weighting model for Value Based Health Care

NHS NWPD - DRAFT Bid scoring and weighting model for Value Based Health Care			
Name of procurement exercise:			
Category	**Weighting**	**Sub category**	**Weighting**
Cost	%	**Acquisition price (product price)**	%
		Anciliary costs - are there any ongoing additional costs associated with the product?	
		Pathway costs - as appropriate, for example; theatre time, length of stay, instrumentation	%
	%	**Fit for purpose** - compared to specification; consider if this is pass/fail or a qualitative score	% or pass/fail
		System/process innovation - as appropriate, are there potential areas of innovation over and above the specfification that will add value and that can be substantiated?	%
	%	**Medical patient outcomes** - substantiated improvements to patients' medical outcomes as a result of this procurement. For example; reduced revision rates, reduced infection rates, improved PROMS score.	%
		Patients' secondary benefits as appropriate, are there secondary benefits to patients such as reduced number of outpatients appointments?	%
		Project specific - state any project specific outcomes that could vary between providers and therefore require measurement	%
Service - ongoing performance & contract management	%	**Customer service -** to include delivery, after sales, techincal support, training	%
		Management systems - to include KPI reporting mechanisms, measurement systems, ordering systems (e.g. use of and development of e-catalogues)	%
		Contract terms - to include risk sharing mechanisms and guarantees	%
Sustainability	%	**Environmental** - proportionate to the contract, are there opportunites for environmental benefits such as reduced carbon emissions, reduced packaging waste, reduced energy usage?	%
		Socio-cultural - proportionate to the contract, are there opportunites for socio-cultural benefits such as increasing the use of disadvantaged labour?	%
Totals	100%		100%

Total knee replacement (TKR)

1000 knees implanted during contract length

Probability that value based proposals will apply to 75% of procedures

Pre market engagement to determine value drivers and confidence levels

	Unit price	total VBP reduction	LOS < 1 day = £400	Theatre time < 1hr = £1000	Instrumentation trays < 1 tray £25
Bid 1	£950	£25	0	0	1
Bid 2	£1,000	£425	1	0	1
Bid 3	£1,100	£950	1	0.5	2

	Std procedures *250	VBP procedures * 750	TCA	TCA = Total cost of acquisition
Bid 1	£237,500	£693,750	£931,250	
Bid 2	£250,000	£431,250	£681,250	
Bid 3	£275,000	£112,500	£387,500	