Value-based procurement essay series
Putting patients first

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To reduce avoidable harm in healthcare we need a transformation in our approach to patient safety. Patient safety should not be treated as one of several strategic priorities, but instead as a core purpose of health and social care. This requires us not just to respond to, and mitigate the risk of, harm, but also to design healthcare to be safe for patients and the staff who work within it. As patients, we must feel certain that in all our interactions with the NHS, that every product we use is not only safe, but undergoes rigorous checks and reviews across its period of use which can remove products from circulation as needed. The UK is considered one of the safest health systems in the world, with dedicated teams of healthcare professionals delivering high standards of care. But with healthcare rates of avoidable harm stubbornly not reducing at the rate we all want, for the benefit of patients we need to strive to achieve more.[1] This extends to how we source, supply, and monitor the use of healthcare equipment and products. Procurement and supply chains can be complex and may involve many organisations, with patient safety concerns manifesting themselves in a range of diverse ways. Using value-based procurement (VBP) is one way we can achieve safer care.

The barriers to overcome

The NHS has already identified VBP as an essential component of its strategy to drive patient outcomes. By focusing on reducing the total costs across the patient pathway, rather than just the unit cost of a product, we can reduce the risk of patient harm, increase operational productivity, and in turn reduce system costs.[2] However, despite its clear benefits, both financial constraints and low awareness means VBP has not been universally adopted. Patients can help drive this change.

Funding constraints are a common barrier to system reforms, but they are far from the only one. For example, patients are often unaware of the mechanisms that allow them to report directly to regulatory bodies the incidents of unsafe care, such as to the National Reporting and Learning System[3] or the Yellow Card[4] reporting to MHRA regarding medicines and medical devices. However, professionals also need to report such incidents and concerns, something highlighted in detail by the Independent Medicines and Medical Devices Safety (IMMDS) review.[5] There could also be benefit from the creation of forums and registers so healthcare professionals and patients can learn from past incidents and share information on how to address them. For this to happen, there needs to be a greater commitment to communication and patient engagement, with updated digital platforms made more accessible for users.

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Institutions as drivers for change

On a system basis, Patient Safety Learning welcomes the opportunity for safety to be designed across the patient pathway with the introduction of Integrated Care Systems (ICS). Putting the patient at the centre of design and delivery should lead to more effective and safer care. We hope they will focus on safety and can serve as a vehicle to introduce new national models and schemes to encourage the safe adoption of innovation, new devices and best practice techniques.

However, there is still more to do. For example, the creation of safety procurement boards and nominated leads in NHS organisations could serve as a forum for discussions on safety with clinicians; ensuring that procurement decisions are made on a measurable benefit across the patient pathway. For instance, there are products that provide a measurable benefit in the reduction of surgical site infections. This is clearly better for patients and will also reduce the length of stay of patients in hospital beds and reduce medication costs too. We need to have open discussions with trusted partners across the health system to ensure that VBP is an important part of decision making.

Alongside this, it is crucial that patient engagement is a central tenet of the NHS - something that can be aided by new digital tools to make record keeping and communication simpler and more effective. The Professional Record Standards Body (PRSB)[6] has just issued standards on information for shared decision making, a valuable contribution to this safety infrastructure. All these initiatives should be promoted and publicised, so patients know they have channels to raise concerns and that these concerns are analysed, heard, and inform improvements.

Industry: a key partner in patient safety

For healthcare to be an effective safety system, we need to include all aspects of the system, including service providers, regulators, academics, policy makers, patients and product suppliers. Industry should be a key partner in the delivery of safe care and the decision-making process for quality and safety. We are starting to see further innovative approaches from collaboration between industry, clinicians and patients which go beyond making sure a product is safe. These go beyond making sure a product is safe but centres on patient outcomes at the core of innovation. This approach is to be welcomed, ensuring feedback on products, shifting from a passive to a proactive approach to safety design, using the expertise of human factors experts is much more beneficial.

It is vital that there is a constructive relationship between regulatory bodies, patient groups, clinicians, and industry, which has not always been the case in the past. There are some examples of a recent change of attitude, but patient groups must be a core part of shared decision making and be confident that safety concerns are recognised and are swiftly addressed. Hopefully, these new developments mark the beginning of a new era where VBP models are given the importance they deserve - where strong patient voices are actively invited and engaged to ensure the safety, accountability, and effectiveness of health care.

1. Patient Safety Learning, Mind the implementation gap: The persistence of avoidable harm in the NHS, 7 April 2022. https://s3-eu-west-1.amazonaws.com/ddme-psl/Mindtheimplementationgap_ThepersistenceofavoidableharmintheNHS_2022-04-07-121554_vhao.pdf
2. Mangan, B. NHS Supply Chain Value Based Procurement Project Report and Findings. NHS Supply Change. 2021. https://azuksappnpdsa01.blob.core.windows.net/datashare/NHS-Supply-Chain-VBP-Report-February-2021.pdf
3. National Reporting and Learning System. Webpage. https://report.nrls.nhs.uk/nrlsreporting/
4. Yellow Card reporting site. Medicines and Healthcare Products Regulatory Agency. Webpage. https://yellowcard.mhra.gov.uk/
5. The Independent Medicines and Medical Devices Safety Review, First Do No Harm, 8 July 2020. https://www.immdsreview.org.uk/downloads/IMMDSReview_Web.pdf
6. The PRSB information standard on shared decision making provides a framework for clinicians to record the decision-making process between themselves and their patients. The standard also allows the shared decision information to be shared between professionals and their different record systems. PRSB, Shared Decision Making Standard, 8 June 2022. https://theprsb.org/standards/shareddecisionmakingstandard/

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