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> **Value in healthcare is defined as outcome over cost**

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Q1 Looking back across your career, what motivated your move into roles that sit at the intersection of medicine, clinical leadership, and procurement?

I was going through the classic clinical leadership route, doing a lot of work regionally and some advisory work internationally. And I think that exposed me to being more interested in not just patient-facing clinical leadership, but more broadly in the appropriate use of resources. That naturally brings you into funding, and how can clinicians better understand the cost and the value of what they do, not just in terms of money, but in terms of outcomes and benefits. I think that inevitably leads to the more commercial side of healthcare delivery.

I'm lucky to have a portfolio career. I work for the London Procurement Partnership, UK, as their Chief Medical Officer (CMO). I'm also interim CMO of a Health and Care Partnership, UK, a strategic delivery arm, and I'm the Medical Director for the National Council of the Healthcare Supply Association (HCSA), a UK-wide association. These roles give me a real insight into the commercial, financial, funding, and resource-allocation perspective.

Very fortunately, this year, I've been working with UCL Global Business School for Health, UK, and collaborating with the Department of Health on value-based procurement, because we're moving toward more value-based healthcare, and value-based procurement sits right underneath that. You can't get away from that. So, I guess that's how I found myself here, more organically than through a clear trajectory.

Q2 Have you always kind of had an interest in finance, or has that only really developed since medical school?

No, I don't think I ever had an interest in finance. Actually, it came from when I was becoming more senior in clinical leadership roles, and I was starting to have financial responsibility, and I recognised that this was not my forte, so I did a financial management course at LSE, and I realised that it wasn't as foreign or scary as it can appear to be. So that was more reassuring. It enabled me to at least speak the right language and understand what accountants and financiers mean when they talk to clinicians like me, who didn't really understand economics early in our careers. I think doctors are not very aware of just, literally, what things cost in a hospital. I'll open a sterile pack to get a piece of equipment that I want, and if I realise it's the wrong piece of equipment, I'll put it on one side and open another one. And I have no idea whether that just cost 10 GBP or 1,000 GBP. We are just not that exposed to what the cost of different things is; although we do know that hospitals have different prices for the same thing. That became very visible during COVID-19, when newspapers published what different hospitals were paying for masks or other personal protective equipment. I think the public often assumes the NHS is a single body with uniform market leverage, but that simply isn't the case.

Q3 These days, is economics and procurement something that many medical students are aware of? Has it been introduced in the curriculum?

To my knowledge? No. But I do believe it will be, because as a healthcare economy, we are definitely moving towards value-based healthcare. Clinicians understand this intuitively. For example, no one is going to choose a cheaper hip prosthesis if it only lasts 10 years and then needs replacing, because that adds not only the cost of a second surgery, but also the patient's discomfort and the risks associated with another operation. Most people instinctively understand that it's better for the whole patient pathway to invest a little more upfront. It's the same kind of decision we make in our everyday lives: do you buy a cheap kettle and replace it next year, or spend a bit more and hope it lasts longer? It's not rocket science.

The challenge is that our health system is built around a 1-year financial cycle and is siloed in terms of funding. So, as a commissioner, if I see an innovation, a new product, service, or implementation, that over a patient's lifetime may save money, time, pain, or future care costs, but costs more upfront, what is my incentive to spend that extra money when the benefit might not be realised for several years? With value-based healthcare, most people quote a 5- to 7-year return on investment for a change in practice or product.

To make this work, the system has to be braver. One organisation may spend more money because it's the right thing for the patient, even if the immediate cost is higher. And sometimes the benefit doesn't accrue to that same organisation; it might be realised elsewhere in the system. For example, an acute trust could invest in an innovation that reduces community care needs. If we're only protecting siloed budgets, where's the incentive to invest? We need to be smarter about allocating funds and measuring outcomes, because measuring outcomes within a single financial year is meaningless. Doctors and patients don't view healthcare from April to April; it's irrelevant.

Would I expect this to come into medical school? Yes, absolutely. Medical students today are more tech-savvy and exposed to things we weren't, like resident doctor strikes and broader system issues. I would be very surprised if financial literacy and value-based thinking don't become part of the curriculum.

Q4 During the session 'Clinical Engagement in NHS Procurement' you discussed the vital role that clinicians play in procurement of innovations. What are the most common barriers that prevent clinicians from being meaningfully involved in procurement decisions, and how can systems address these?

I think that question kind of assumes that clinicians aren't involved, and I would disagree with that presumption, because I think there are lots of innovations happening all over. What is disappointing is that I don't think we're very good yet at pooling and sharing that kind of knowledge. Clinicians will say that one of their most precious assets is time, and anything that takes a lot of time doesn't progress; it gets frustrating, and as a result, doesn't get pursued.

We are quite cautious about adopting innovation or trying new things, and that's understandable, up to a point. But if we had a more joined-up approach to sharing knowledge, in terms of what's already been tried in one system, we don't need to repeat those efforts. We're strong in terms of orthodox research, but in terms of practical innovation, we're not quite there yet.

We clearly have enthusiastic clinicians. We have clinicians who, as we said earlier, are much more tech-savvy than my generation would have been at that stage. We just need to be better at pooling that energy. But also at the same time, we have people who are sceptical about technology; they just want the day-to-day things to work. For example, we've had bleeps and pagers. I had a bleep when I was a house officer. I now carry around a smartphone with me all the time, and it is not rocket science to be able to communicate with me via my phone instead of the bleeper. Another example is, why should I need to log in to a pathology system to see if some results are back, and then log in again later if they're not? That's wasted time. Why not just get alerted when results are ready?

There is definitely scepticism around why we are concentrating time, money, and effort on shiny, new, exciting things, when we can't get the mundane, frustrating, background processes right.

Q5 Based on the panel discussion and audience questions and answers, what concerns or priorities from clinicians stood out to you most strongly?

I didn't actually note how many clinicians were in the audience for my panel session. I'm not sure how large the audience was. I'm not very good at gauging, but I think there were only a very small number of clinicians, just in single digits, certainly. But interestingly, after the session, quite a lot of conversations happened after we left the stage, which was great, and a few people came out as clinicians then, but were less happy to stand up and be counted in the audience, which I thought was fascinating.

The overall theme from those conversations is that clinicians are uniquely placed to see where problems are, because that's what they're doing in their day-to-day. They do this repetitive task, and therefore they think 'I can make it better', or 'I can do something here', or 'I can improve it', or 'make it faster', or 'more efficient'. That's the pool of knowledge and insight that we need to somehow gather. But then we need to figure out how to scale or spread that information, or market it, or otherwise make it accessible.

Between the great idea or innovation and getting it to the patient lies the somewhat frustrating bureaucracy of the NHS and other regulatory bodies. And, of course, regulatory bodies are vital; they play a crucial role, but we do need to streamline processes to support innovation rather than make it unnecessarily difficult. Oftentimes, innovations are just small tweaks. They're small improvements. They're not huge, radical changes in practice. We need to oil the wheels so that instead of delaying and obstructing innovations from becoming patient-facing, we just need to make things easier and quicker. That is the kind of ongoing narrative that I hear a lot.

Q6 Over the next 5–10 years, how do you expect the role of clinicians in NHS procurement to change?

I think NHS procurement is going to move very much toward value-based procurement. We've talked about this already, but that underpins value-based healthcare. Value in healthcare is defined as outcome over cost. Cost is reasonably easy to quantify, but outcome is wholly sort of reliant on the patient and clinician deciding what a good outcome is, and that is much more complicated. How do you define and categorise outcomes?

I think the patient voice will help a lot. At the moment, we don't have a good patient voice in procurement, for a whole host of reasons. And, we don't have a strong clinician voice either. Both of these things will fundamentally change as we drive towards value-based healthcare, particularly as we develop our understanding of population health management.

We understand that prevention is better than cure. We are adopting the NHS 10-year plan, shifting care into the community and pre-hospital settings wherever possible.

To do this effectively, we absolutely need to understand where to allocate resources and how to optimise them for patient outcomes. That understanding relies almost entirely on information from patients, but also from clinicians.