

**PWYLLGOR STRATEGAETH A CHYNLLUNIO
STRATEGY AND PLANNING COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	28 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Value Based Health Care Update Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mark Henwood – Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Simon Mansfield – Head of Value Based Health Care

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

The purpose of the report is to provide assurance to the Strategy and Planning Committee (SPC) on the work of the Value Based Health Care (VBHC) Programme and the refresh of the Strategic approach to Value Based Health Care within Hywel Dda University Board (HDdUHB).

Cefndir / Background

The 2022-25 VBHC Programme Plan has been developed in response to both national drivers and local needs and supports the delivery of the HDdUHB Strategic Approach to VBHC, included as Appendix A.

The Welsh Government Value and Sustainability Board has identified four high-value, high-impact areas for Health Boards to prioritise:

1. Diabetes
2. Orthopaedics – Hips and Knees
3. Cardiology – Heart Failure
4. Bone Health

In addition to these services, respiratory disease has been identified as a local priority area.

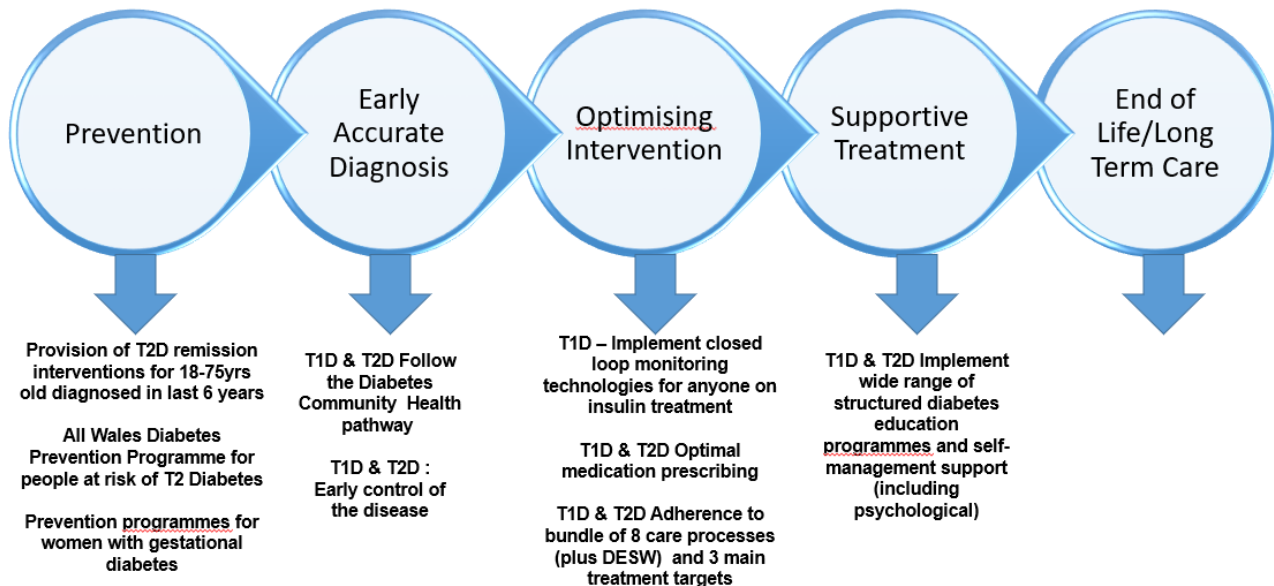
Together, these national and local priorities form the foundation of the 2025/2026 VBHC Programme Plan.

The following section provides an overview of the priority areas and highlights the specific projects currently being undertaken by the VBHC Team.

Diabetes

High Value High Impact Interventions

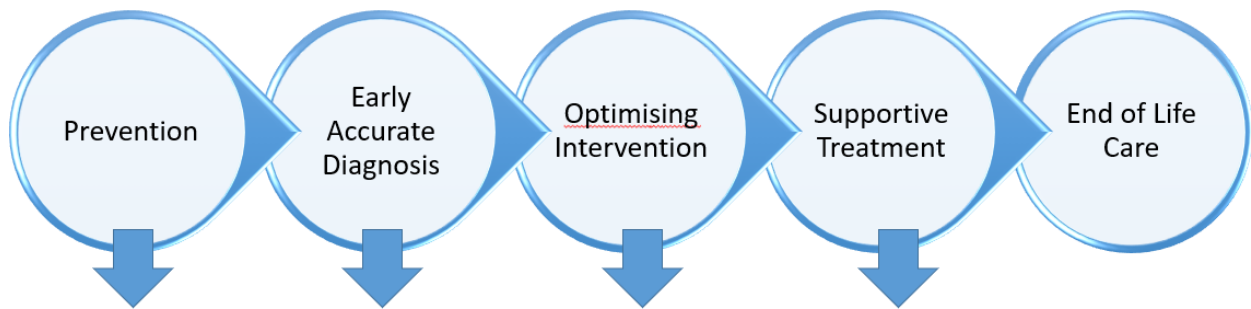
Diabetes Optimal Pathway: Short term High Value Interventions



- Developing a business case for VBHC Delivery Funding to support a Remission Service.
- Supporting a VBHC approach to the introduction of a Pump Service, enhancing access to effective diabetes technology across both paediatric and adult services, with integrated dietetic and psychological support.
- Supporting the introduction of a One-Stop Pre-Consultant Clinic to improve compliance with the eight care processes for people living with Type 1 diabetes (T1d).
- Collaborating with Primary Care to improve compliance with the eight care processes for people living with Type 2 diabetes (T2d).
- Reviewing the efficiency and value of Diabetes Education Programmes offered in HDdUHB.
- Reviewing Patient-Reported Outcome Measures (PROMs) responses with diabetes psychological services.
- Analysing PROMs data for patients treated with Glucagon-like peptide-1 (GLP-1) receptor agonists.
- Exploring health inequalities through PROMs data analysis.

Orthopaedics

High Value High Impact intervention Arthroplasty (Hip and Knee): **OPTIMUM PATHWAY**



Public Health Awareness

Understanding of OA
Lifestyle – weight management/ Activity/
Alcohol/ Smoking
Recovery following injury
Early symptoms (joint stiffness /
straightening knee)

Risk Factors (family history/ abnormal
alignment and tailoring exercise)

Education and advice through referral management programmes/PC services

Community/primary Care services set up
across Wales and can refer to dietetics and
physio. E.g CMAT/ Primary Care first contact
practitioner /OAK set up in AB /SB Exercise
Lifestyle Programme

Ensure right time, right place for timely diagnosis and shared decision making

Pathway Guidance (Canterbury)

Primary Care MSK Services (for early opinion
and intervention)

Expert radiographers (for disease staging the
intervention)

Prehabilitation

Muscle strengthening
Optimised health and medical condition
Education clinic/Joint school

Surgical Intervention

Understanding good practice (GIRFT)
Reducing unwarranted variation
Reducing low value interventions
Reducing risk factors, complications and re-
admissions
PROM collection

Support and optimisation pre-surgical intervention

PROMs to capture symptoms/self-management
capabilities

Prehabilitation

Optimising post-surgical care

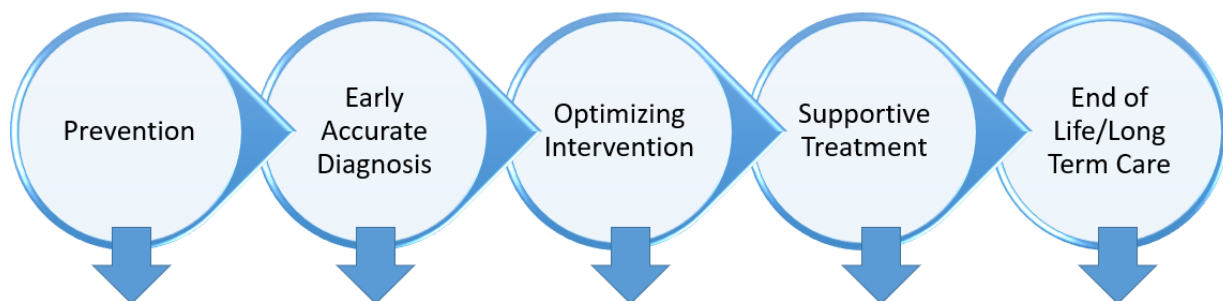
Optimise physio/OT support and immediate advice
include PIFU advice. (important for day case
arthroplasty)

Follow-ups managed via remote monitoring using PROMs

- Produced 'Our Outcomes' Power BI dashboards showing longitudinal changes in PROM scores for patients who have undergone hip or knee arthroplasty in HDdUHB.
- Measuring Shared Decision-Making using validated Patient Reported Experience Measured (PREMs) and analysing variation between clinicians as well as patients' perceived involvement in their care and subsequent treatment decisions.
- Collaborating as part of an international consortium to test the feasibility of capturing and measuring patients' goals.
- Working towards alignment with the National PROMs Pathway for hip and knee arthroplasty.

Cardiology – Heart Failure

High Value High Impact intervention Heart Failure



Risk Factors:

- Healthy lifestyle/Public Health Awareness

- Existing disease

ACS

Access to ProBNP testing for anyone with HF symptoms in primary and secondary care

Access to timely ECHO:

- BNP >400 <2000 within 6 weeks

- BNP >2000 within 2 weeks

Specialist review within 2 weeks of confirmed diagnosis for high risk (BNP >400 <2000 within 6 weeks; BNP >2000 within 2 weeks)

Achieving recommended whole time equivalent HF specialist nurses

Optimised 4 pillars therapy within 4 months of referral

HF MDT

Fully funded HF rehabilitation programme

PROM embedded in clinical practice

Consider devices therapy

Supportive Treatment

Develop a self care plan and share with primary care

Discharge to primary care for 6 monthly reviews (SOS/ PIFU model of care)

Access to:

- Pts and families support groups

- Counselling

- Phase 4 rehabilitation

End of Life/Long Term Care

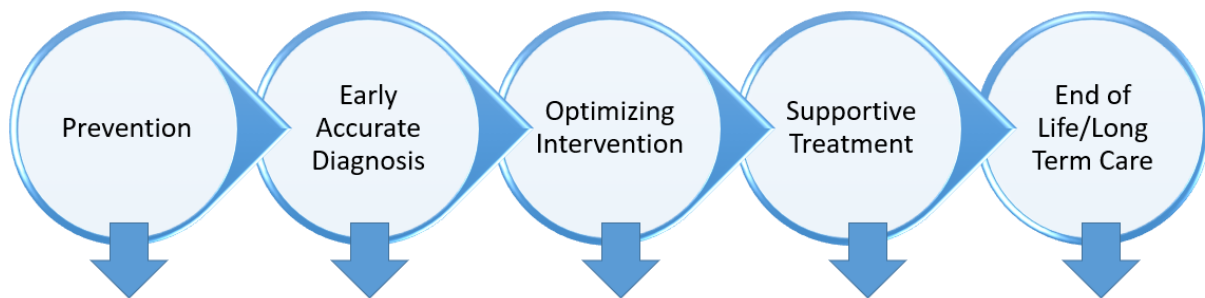
Identify patients approaching end of life

HF Palliative care pathway in place

Bone Health

High Value High Impact intervention Bone Health: Optimum Pathway

The Optimum Pathway – Independent and pain free



Risk Factors

Age, Menopause, Family History (Osteoporosis), Medical conditions including mental health e.g. Coeliac disease, Endocrine (e.g. diabetes), Eating disorders

Medications e.g. steroids

Education (public)

Self care plan Pregnancy/Toddler/School children education on exercise/weight/diet

Healthy lifestyle/Public Health Awareness

Education/Alcohol/Nutrition/Weight/ Smoking

Falls Risk awareness

WAST/Third Sector/Primary Care

Fracture Liaison Service

Systematic identification of fragility # >50 years through integration with all front door services / T&O/Spines/Radiology

Initiation of falls and bone health care plan / Early falls risk assessment (hospital and Community)

Equity for hip and non hip # and those deemed high falls risk

Compliance to Audit input (FLS-DB)

KPI 2-5

FLS partnership and vital integration with:

Ortho-geriatricians/Rheumatology/ Clinical Leads

Optimise Care Plan with:

Community Pharmacy/CRT. Primary Care for long term follow up

Compliance to standards

NOGG/ROS Standard to treat 50%/monitor 80% (KPI 6-10)

Optimum follow up to check adherence (16 weeks)

Support

Falls care plan and muscle strengthening and balance training in community

Education on exercise/diet/support for friends and family/self-care plan

Increase self administration of injectable

Good mental wellbeing without fear of falling

Residence of choice

Compliance to standards

NOGG/ROS standard to monitor 80% (? KPI 11)

Optimum follow-up to check adherence at 52 weeks

Long Term Care

Partnership with PC and Frailty /community (CRT)/Palliative Teams

Annual review to ensure drugs continued

Specific referrals

Re-referral pathways as appropriate in case of re-fracture/treatment failure

- Expanding PROM collection to include follow-up at 16 and 52 weeks.
- Comparing HDdUHB PROMs responses with those from Aneurin Bevan University Health Board (ABUHB).
- Completed PROMs analysis and identified areas for improvement.
- Exploring the feasibility of automatically referring patients to lifestyle optimisation interventions (e.g. smoking cessation) based on PROM responses.
- Hip fracture rates have been projected using historical data from the National Hip Fracture Database, and the impact of the Fracture Liaison Service is now being tracked against these projections.

Respiratory Disease

- Supporting the introduction of remote monitoring for patients on Continuous Positive Airway Pressure (CPAP), enabling Respiratory Physiologists to monitor and manage patients remotely, identify those not using their machines (allowing devices to be reallocated to patients in need), and transition to a virtual follow-up model.
- Evaluating the Chronic Obstructive Pulmonary Disease (COPD) Optimisation ProjEct (COPE) template, designed to guide consultations with COPD patients in Primary Care. The COPE template aims to ensure accurate diagnosis and optimise both non-pharmacological and pharmacological management.
- Introducing the Asthma Control Test (ACT) and COPD Assessment Tool (CAT) in community respiratory services.
- Introducing PROMs in Pulmonary Rehabilitation.

Additional Projects

In addition to the highlighted project areas, the HDdUHB VBHC Team is also working on the following projects:

- Opportunistic screening for Atrial Fibrillation (AF) in Podiatry Clinics.

- Transforming Vascular Services in HDdUHB by enabling Podiatrists to see patients who were previously waiting to see Vascular Surgeons — improving patient outcomes while reducing the cost of achieving them.
- Introducing PROM capture and analysis in Musculoskeletal (MSK) Podiatry Clinics.
- Collaborating with Aberystwyth University to undertake health economic evaluations of projects including the Children’s Epilepsy Specialist Nurse service, Lung Cancer Services, and Local Procurement.
- Ongoing implementation and integration of Promptly, the digital PROM collection platform.

Strategic Approach

The current Strategic Approach to VBHC expires at the end of 2025, consequently work is now underway to develop a refreshed Strategic Approach to VBHC for the 2026-2029 period. The national and local priorities and context will be developed in conjunction with stakeholders to help develop a coherent vision. This vision will guide the strategic objectives before being crystallised into annual VBHC delivery plans. The refreshed Strategic Approach to VBHC will be presented to the February 2026 Strategy and Planning Committee for ratification.

Argymhelliad / Recommendation

The Committee is asked to:

- **RECEIVE ASSURANCE** from the VBHC Programme activity
- **NOTE** the proposed re-development of the VBHC Strategic Approach for ratification in February 2026.

Amcanion: (rhaid cwblhau)	
Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.9. Seek assurance on the delivery of Value Based Healthcare strategic plans and programmes.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks to Programme delivery are managed via the Value Leadership Group.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable

Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:

Ar sail tystiolaeth: Evidence Base:	Annual Report of the Chief Medical Officer 2018/19
Rhestr Termau: Glossary of Terms:	Contained within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Strategaeth a Chynllunio Parties / Committees consulted prior to Strategy and Planning Committee:	Value and Sustainability Group VBHC Leadership Group National Value in Health Community of Practice

Effaith: (rhaid cwblhau) Impact: (must be completed)

Ariannol / Gwerth am Arian: Financial / Service:	WG funding has been provided to substantiate the VBHC Programme, including the resources required to deliver the programme, as well as creating a Value Delivery Fund, to be used for supporting the development of high value and sustainable health care.
Ansawdd / Gofal Claf: Quality / Patient Care:	VBHC is designed to improve outcomes and the use of resources in delivering them. It is also driven by Prudent Healthcare principles driving the delivery of equitable services across the Health Board.
Gweithlu: Workforce:	The delivery of the VBHC Programme Plan requires resources from within the VBHC Team as well as resources from the Value Finance Team, Informatics Teams and from Service areas as appropriate.
Risg: Risk:	VBHC Programme risk assessment has been completed and is managed through the DATIX risk management system, however individual project areas are subject to their own project structures with risk assessment being an integral component.

Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Privacy Impact Assessment has been completed for PROM and PREM capture as part of the VBHC Programme.
Cydraddoldeb: Equality:	Equality Impact Assessment completed.