Embedding Value Based Health and Care

Organisation	Hywel Dda University Health Board

Date of Mid-Year Report	14/09/2022
Date of End of Year Report	14/03/2023

Mid-Year Report Prepared By	Simon Mansfield
End of Year Report Prepared By	Simon Mansfield

Value based health and care (VBHC) is the equitable and sustainable use of available resources to achieve better outcomes and experiences for every person.

The NHS Wales Planning Framework 2022/25 recognises our overarching system focus must be on safety, equality of access and improving outcomes, with VBHC as the basis on which services should be planned and delivered.

Four areas of focus are listed below, against which organisations should be able to demonstrate progress in adopting a VBHC approach in their strategic decision-making, planning and allocation of resources. Organisations are welcome to submit their Value Based Health and Care Plan as additional supporting material.

Reporting Schedule: Progress is to be reported bi-annually. This form is to be submitted on:

- 14 September 2022 (covering the period 1 April 2022 to 31 August 2022)
- 14 April 2023 (covering the period 1 September 2022 to 31 March 2023)

Completed form to be returned to: hss.performance@gov.wales

Update on the actions implemented during the current operational year to support the embedding of Value Based Health and Care

	Area Of Focus	Key Actions Taken During the Reporting Period	Outcome/What Was Achieved?	Comments/Context
1.	Demonstrate improvements in the **reduction of adverse clinical outcomes** (as captured in clinical audit) in chronic conditions.	Heart Failure – implementation of actions from Service Review including appointment of Lead Nurse, Development of a Pharmacy led One-Stop Diagnostic Clinic	Reduction in Heart Failure admissions of 50% Reduction in Heart Failure readmissions by 51%	In line with the work of the Cardiovascular Atlas of Variation, work has been undertaken in Heart Failure, Acute Coronary Syndrome and in Atrial Fibrillation to improve

	Area Of Focus	Key Actions Taken During the Reporting Period	Outcome/What Was Achieved?	Comments/Context
			Reduction in time from referral to up-titration of medication of 92% Reduction in avoidable mortality through quicker diagnosis and treatment for Heart Failure Patients. Reduction in time for Acute Coronary Syndrome patients to be transferred to tertiary centre by 28%	all of these services through the lens of Value. Measurable outcomes have exceeded targeted expectations and have been sustained over a 5-month period.
		Lessons learned from PROM capture across a range of chronic conditions	Identification of a common theme of psychological distress in chronic conditions, suggesting that a broader, health coaching model may be suitable instead of support for each pathway areas	Work being scoped to population level rather than pathway level interventions that will positively affect a range of conditions through modifiable lifestyle factors.
		Support of RIW Mobile Spirometry Unit	Development and deployment of PROM/PREM capture for patients using the mobile spirometry unit, used to	PROM and PREM data indicates that patients are unwilling to travel to appointments at hospitals despite an awareness

	Area Of Focus	Key Actions Taken During the Reporting Period	Outcome/What Was Achieved?	Comments/Context
			provide enhanced diagnostic capacity following the pandemic.	of the health benefits they would gain. Mobile units that provide services in the community may be applicable in other service areas.
		Provision of a face to face and electronic Pain Management Programme and evaluation of PROM and PREM responses	Provision of effective alternative for patients suffering with chronic/persistent pain. Evaluation of PROM and PREM data has been undertaken as well as formal review through the TriTech Institute. In conjunction, a review of prescribing practices and education of primary care prescribers has been undertaken to significantly drive down the rates of opioid prescribing across the Health Board.	The Pain Management Programme has received excellent PREM feedback, but needs to be considered earlier in the pathway for chronic pain patients and ideally before they are referred to secondary care pain services.
2.	**Delivery programme of PROM collection and**	Development of a strategic document 'Our Approach to	Strategic document has been produced and shared, aligning	

	Area Of Focus	Key Actions Taken During the Reporting Period	Outcome/What Was Achieved?	Comments/Context
	sharing PROM data nationally to inform value-based decision making and direct clinical care.	Value Based Health Care 2022-2025' Live PROM and PREM collection areas and supporting activity Planned PROM and PREM collection areas	with organisational Planning Objectives for Value Based Health Care. PROM collection has been undertaken in 30 service areas and has been supported by the development of visualisation dashboards in 3 service areas and the completion of 11 PROM data analytic reports. Furthermore, the consumption of resources has been described in 8 service areas. Combining all of the above data, Service Reviews have been undertaken through the lens of Value in 8 service areas and have resulted in 61 discrete projects to be prioritised and implemented. For the coming year a further 25 PROM collections are	

	Area Of Focus	Key Actions Taken During the Reporting Period	Outcome/What Was Achieved?	Comments/Context
		Sharing PROM data nationally	planned with a further 6 Service Reviews to be undertaken. The Health Board is progressing with sharing the PROM data sets with DHCW and will complete this by the end of May 2023.	
3.	Progress with **allocating resources to secondary prevention activities** in high volume clinical areas that have a significant influence on patient outcomes and utilisation of resources.	• Heart Failure one-stop diagnostic clinics • Re-instigation of treat and repatriate programme • Atrial Fibrillation screening • Evaluation of SDEC	• Improved speed of diagnosis, reduction in admissions and improved PROM responses • Reduced waits for ACS patients to be transferred to tertiary cardiology centre • Improved screening and anticoagulation for AF patients	

	Area Of Focus	Key Actions Taken During the Reporting Period	Outcome/What Was Achieved?	Comments/Context
		• Implementation of ERAS • Mobile Spirometry • Development of Chest Pain Clinics	• Evaluation of Same Day Emergency Care in avoiding unnecessary admissions and providing patients with swift access to diagnostic • Reducing clinical variation between sites and lowering length of stay for T&O patients • Provision of critical diagnostic testing at a range of sites close to patient's homes. • Provision of Chest Pain Clinics to rapidly diagnose and refer patients to the most appropriate part of the cardiology pathway.	

	Area Of Focus	Key Actions Taken During the Reporting Period	Outcome/What Was Achieved?	Comments/Context
		• Development and evaluation of Community Falls Programme • Development of new models of monitoring IBD patients	• Reduced conveyance by WAST and lowered admission for falls patients through managing falls in the community • Provision of tailored care that allows OP capacity to be maximised for those patients in greatest need of review and provides digital/virtual follow up for routine patients.	
4.	**Reduction in unwarranted variation and activity of limited value**, and standardisation of best practice pathways, which support delivering, improved outcomes.	Heart Failure Clinical Nurse Specialists.	Through the Cardiology Transformation Programme, a Lead Heart Failure Nurse has been appointed to provide services that are more coherent across the three counties. This, along with the provision of a bespoke PROM dashboard is enabling	

	Area Of Focus	Key Actions Taken During the Reporting Period	Outcome/What Was Achieved?	Comments/Context
			the Heart Failure Service to operate with less variation between sites.	
		Heart Failure – one-stop diagnostic clinic.	Improved diagnostic pathway, which provides a quicker and more compliant route to diagnosis for patients and reduces the low value echocardiography activity that is not clinically warranted.	
		Chronic Pain – Pain Management Programme and Medicines Prescribing education.	Through the Pain Management Programme and engagement with primary care prescribers, patients have been supported to de-escalate opioid use. Together with more prudent prescribing practices, this has reduced the rates of opioid prescribing significantly.	

Supporting Information

A VBHC approach requires consideration of the whole pathway of care, so that we make informed decisions regarding optimal utilisation of resources to achieve the best outcomes.

In order to do this, a data-driven health and care system is needed, where decision makers at every level have readily accessible information on patient outcomes, to support decisions on planning the allocation of resources and service design that meets true need across the whole pathway of care.

We achieve value for our population through the sum of all interventions across the pathway:

There are many ways to improve outcomes and sustainability of our healthcare system. In this planning cycle, we are focussing on **interventions that are likely to improve outcomes and optimise resource utilisation in the short to medium term, whilst organisations build their systems for longer-term value.** These are:

- reducing **unwarranted variation** in care pathway delivery, to release capacity; and
- investment in **secondary prevention** approaches to improve outcomes, minimise harm and reduce acute health care utilisation. Secondary prevention refers to activities which reduce the impact of conditions already diagnosed, with shorter-term favourable impact on outcomes.

We are also asking organisations to invest in their **collection and use of data on both clinical and patent-reported outcomes** to inform value-based decision making and direct clinical care. Measuring cost and outcome data will provide an evidence-base from which to demonstrate improvements in **the reduction of adverse clinical outcomes in priority condition areas**.

These vital foundation steps in embedding a VBHC approach are set out as **four areas of focus in the template above**. Providing information on progress against these four areas will allow for a consistent picture nationally of VBHC delivery, within an approach that recognises local priorities and population need.

The Welsh Value in Health Centre can provide support to organisations as they look to embed a VBHC approach, including advice on data collection and analysis, access to information tools, and examples of high-value interventions across a range of condition areas.