

Embedding Value Based Health and Care

Organisation	CTMUHB	Date of Report	28/9/22	Report Prepared By	Head of Value Based Healthcare
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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.	Optimising Heart Failure Diagnosis – NT Pro BNP In support of the work to produce a standardised pathway across CTM for the diagnosis of heart failure via Primary Care, the current reality pathways across the three former ILG areas have been mapped in partnership with clinicians and costed.	The initial TDABC costs have been prepared for each step in the current pathways using the agreed Welsh approach and toolkit. There is strong clinical engagement supporting the process. Data is currently being collated from a range of sources to review effective and appropriate	This project is part of a whole systems pathway approach in Heart Failure, including projects in optimising medication, rehabilitation and palliative care. This will enable the service to understand the impact at each stage within the pathway and the cumulative effect for patients.

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		<p>Further work to review the current utilisation levels of NT ProBNP and potential impact on inappropriate use of ECG is being undertaken. A costing review will also be undertaken.</p> <p>Evaluation of Remote Monitoring of Heart Failure Patients App, (HUMA)</p> <p>To support the evaluation of a proof of concept patient digital remote monitoring system in the heart failure medication titration process. Patients are reviewed and if appropriate registered to use the digital app, supported by the Heart Failure nurse. The cost of new and historic treatment routes was identified and reviewed, as well as any change in intervention method and patient outcomes.</p>	<p>diagnostic opportunities and to reduce inequity across CTM.</p> <p>This data will further be used to test a VBHC procurement contracting system which can utilise patient clinical outcomes aligned with contract agreements.</p> <p>Given the typical nature of condition-specific specialist nursing, bottom-up costing was not viable and as such a fully-apportioned approach was used. Core costs per cohort were identified and an analysis of available activity data was undertaken.</p> <p>It was identified that although there was not a significant difference in the Heart Failure nurse costs for intervention, 6/8 appointments were undertaken virtually rather than face to face, and took place following changes identified in symptoms and clinical measurements related to medication titration – enabling a shorter time to optimise. Usual practice of face to face titration usually takes 8 months, titration supported by the digital app is demonstrated in Table 1.</p> <p>Table 1</p> <table><tr><th>Days to Optimise</th><th>Frequency</th><th>%</th></tr></table>	Days to Optimise	Frequency	%	<p>The next step is to finalise the indicative current pathways and associated costs, a workshop with clinical teams has been planned for Nov 22.</p> <p>The pathways are to be compared to standing activity data from PAS in support of the Value Based Procurement aspect of this exercise.</p> <p>A trial run of data through the Digipharm platform is being planned following required training from McKesson to access and use the data.</p> <p>VBHC allocated funds were used to extend the original project to enable evaluation work to take place. CTM are currently undertaking wider work to review a strategic approach to the use of digital applications as an organisation.</p> <p>Further details of the pilot are available on request</p>
Days to Optimise	Frequency	%					

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		<p>24/7 Alcohol Liaison Service</p> <p>To facilitate the opportunity and benefits of a 24/7 alcohol liaison service across CTM, based on the VBHC best practice approach of ABUHB, current service pathway mapping, resource (staffing, partners and costing) mapping and identification of activity have been undertaken.</p> <p>This is being led by service and planning colleagues with support from the VBHC team to progress this work.</p> <p>Interventions Not Normally Undertaken (INNU)</p> <p>Action came from the workstream from the Chief Executive to review INNU activity and potential related savings.</p>	<table><tr><td>8-66</td><td>37</td><td>56%</td></tr><tr><td>66-125</td><td>19</td><td>29%</td></tr><tr><td>125-183</td><td>6</td><td>11%</td></tr><tr><td>183-242</td><td>1</td><td>0.02%</td></tr><tr><td>242-300</td><td>1</td><td>0.02%</td></tr><tr><td>>300 (407, 418)</td><td>2</td><td>0.03%</td></tr></table>	8-66	37	56%	66-125	19	29%	125-183	6	11%	183-242	1	0.02%	242-300	1	0.02%	>300 (407, 418)	2	0.03%	<p>Indicative pathway schematics have been developed with strong support from clinicians from all three teams.</p> <p>Planning has commenced to identify common currency & language to describe the activities the three teams undertake. This is important for numerous reasons including the ability to ensure any changes made improve the efficiency of the service and outcomes for patients.</p> <p>The resource mapping and activity identification are underway.</p> <p>Given the current INNU activity levels, the review was shifted to analysis of INNUs entered onto the waiting list to ensure that elective capacity is maintained for high value activity with ongoing engagement with the services.</p> <p>The waiting list data has been extracted and is undergoing validation checks.</p> <p>An updated list of INNUs to cover the entire health board is being prepared to reflect latest guidance on INNUs and the amalgamation of</p>	<p>This project sits within the VBHC portfolio and was recently successful in mid-year VBHC funding allocation received from WG/FDU for additional VBHC projects.</p> <p>The Task & Finish Group is evolving into a Steering Group and VBHC programme plans and recruitment will shortly take place.</p> <p>Next steps: Publish updated INNU guidance within HB whilst awaiting full INNU review by WG and Public Health colleagues. Include INNU information in external validation of waiting lists i.e. asking patients if they have experienced tonsillitis in last 12 months if on a waiting list for a tonsillectomy.</p>
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			Princess of Wales with Royal Glamorgan and Prince Charles Hospitals.	
2.	Delivery programme of PROM collection and sharing PROM data nationally to inform value-based decision making and direct clinical care.	<ul style="list-style-type: none"> • 257 Heart failure PROMs completed • 215 Lymphoedema PROMs completed • 106 RIW PROMs completed • Palliative Care PROM- set up on DrDoctor but not live-awaiting agreement/authorisation from the project team. • Training has been provided to the relevant clinical staff to enable them to access and review the patient PROM data that has been completed by patients on the digital PROM platform. Staff can review the data and action where needed within the relevant clinical care teams • Discussion took place with DHCW on reporting of the heart failure PROM data to share nationally. 	<ul style="list-style-type: none"> • CTMUHB have worked with SBUHB regarding repatriation and access to former patient records of Bridgend • CTMUHB has successfully transferred all HF PROM data from DrDoctor and is now being held in CTMUHB warehouse • CTMUHB have now made the HF PROM data available to DHCW for reporting who have confirmed that the raw data being transferred to them is good and covers a lot in the DCCQ-12 DSCN. Therefore the testing of the reporting raw data is now complete • CTMUHB currently in talks with DrDoctor to automate the heart failure PROM data from their system to CTMUHB and then automate out from CTMUHB to DHCW. This is currently a manual process which will need to be rectified in the near future • Digital Lymphoedema PROMs within CTMUHB went live June 2022. This data is currently not being reported to the national lymphoedema network team however discussions are being undertaken to make this happen in the near future. • Spirometry Mobile Respiratory Unit PROM data is a 6 month pilot project, in partnership with Hywel Dda UHB & RIW, which will finish at the end of Oct 2022. A clinical respiratory PROM was developed and agreed with RHIG, PROM data is currently not being reported on 	<p>CTMUHB are supporting the National VIH Team and Shared Services in the development of a National PROMs provider procurement framework, and are keen to then utilise this to undertake a local procurement exercise to procure a PROMs provider which meets the newly published PSOM National standards and guidelines.</p> <p>This will ensure that key data interoperability, sharing, analysis etc within CTMUHB and Nationally will be achievable. Other founding aspects of this work include the requirement for ease of visualisation of the data by clinical teams, which is not possible with our current limited provision.</p> <p>A number of delays have been experienced in the development of the National PROMs procurement framework, which have directly impacted on our ability to progress this area. However, CTMUHB have used the opportunity to introduce the concept and processes of PROMs collection, analysis, and integration to service delivery, however, we have restricted the roll-out across the VBHC portfolio, awaiting the framework, to reduce the impact of implementing and then withdrawing.</p> <p>We have developed hybrid clerical support roles, which provide clinical</p>

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			nationally, however a report will be published on the data in the future once the project is complete.	<p>booking support, and patient and clinical team support with awareness and understanding of PROMs, to support integration and improved uptake completion rates. These roles commence in Oct 22.</p> <p>Aligned to PROMs, we have taken the strategic decision to implement PREMs (Patient Reported Experience Measures) and WREMs (Workforce Reported Experience Measures) concurrently, to provide a wider breadth of information to support the whole of the patient outcome and experience in health intervention, and to identify if interventions and approaches do enhance relationships and improve shared decision making.</p>
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.	<p>CTMUHB VBHC funding allocated across our VBHC portfolio and to key CTMUHB and National priority areas and programmes including:</p> <p>National:</p> <ul style="list-style-type: none"> • Lymphoedema Phase 1 & 2 • Cellulitis – funded band 7 AHP in National Team <p>CTMUHB:</p> <ul style="list-style-type: none"> • Heart Failure Pathway NT Pro BNP – Optimising HF Diagnosis HF Optimising Medications – Recruitment of 4 x HF Nurses and hybrid VBHC clerical support HUMA Digital Remote App HF Optimising HF Rehabilitation 	<p>A systematic performance and assurance framework has been developed and implemented across the VBHC portfolio, ensuring consistency. A VBHC programme management suite has been developed and utilised with support to the established programme groups.</p> <p>Highlight reporting templates are completed by each programme, shared at specialist Steering Group level and then form regular composite reporting to the VBHC Steering Group.</p> <p>Task and Finish Groups were established in new areas including AF & Hypertension, 24/7 ALS and Spirometry MRU.</p> <p>Baseline reality resource and activity mapping has been undertaken and is being aligned with costing profiles, to support identification of optimising interventions.</p> <p>Recruitment for projects has been on-going, with a number of posts being filled in this timeframe.</p>	<p>Business cases, programme plans and highlight reports on the commenced projects are available on request.</p> <p>Further projects have been allocated funding as agreed at beginning of September 2022, including:</p> <p>Diabetes Podiatry UroGynae Physiotherapy Medicines Management Digital App Programme Support for ILD Lung Project Review Programme Support for Frailty Project Review</p> <p>In addition, CTMUHB bid and were successfully allocated funding from the National VBHC pot for a 24/7 Alcohol</p>

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		<p>HF Improving HF Palliative Care</p> <ul style="list-style-type: none"> • Diabetes Pre-Diabetes Project Diabetes ante-natal project & pilot GD-M App Weight Management Diabetic Retinopathy • 24/7 Alcohol Liaison Service (ALS) – Task & Finish Group - mapping • AF & Hypertension – Task & Finish Group - mapping • UroGynae Physiotherapy • Mobile Respiratory Unit – Spirometry with HDUHB & RIW • MyMobility T&O Digital App 	The CTMUHB VBHC portfolio is supporting a number of digital apps to enable proof of concept trial and review.	Liaison Service and as a partner in a Regional AF & Hypertension Project with SBUHB and & HDUHB.
4.	Reduction in unwarranted variation and activity of limited value, and standardisation of best practice pathways which support delivering improved outcomes.	<p>Building on the Heart Failure work carried out in Swansea Bay and CTM Bridgend ILG, the VBHC Team initiated a project to investigate the unwarranted variation in the diagnostic phase of the Heart Failure pathway.</p> <p>A JWA (Joint Working Agreement) has been put in place between CTM, Roche Diagnostics and Digipharma with the intention of:</p> <p>a) Improving outcomes for patients in the diagnostics phase, increasing the use of NT-proBNP within CTMUHB primary care</p> <p>Utilising a Value Based Procurement approach to contracting on outcome improvements and payments on</p>	<p>Several Joint workshops have been held involving CTM Clinical Staff, Procurement, Finance, Programme Management, Industry Partners, Welsh Value in Health Team, Life Sciences Hub</p> <p>In consultation with clinical staff, 3 Heart Failure pathways (per CTM ILG) have been mapped and costed.</p> <p>An MDT Workshop is being planned for mid-Nov 22 with the intention of reviewing the pathways and identifying unwarranted (and warranted) variation, and standardising wherever possible for CTM</p>	Lack of organisational access to data sources has delayed the transfer of data to Digipharma, and subsequent monitoring of agreed Outcome Measures.

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		results, outcomes being monitored by the Digipharma platform		

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 patient-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.