

## Embedding Value Based Health and Care

<b>Organisation</b>	<b>CTMUHB</b>	<b>Date of Mid-Year Report</b>	<b>28/9/22</b>
		<b>Date of End of Year Report</b>	<b>31/3/23</b>

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](mailto:hss.performance@gov.wales)


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

	<b>Area Of Focus</b>	<b>Key Actions Taken During the Reporting Period</b>	<b>Outcome/What Was Achieved?</b>	<b>Comments/Context</b>
1.	Demonstrate improvements in the <b>reduction of adverse clinical outcomes</b> (as captured in clinical audit) in chronic conditions.	<b>Optimising Heart Failure Diagnosis – NT Pro BNP</b> 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. The pathways are to be compared to standing activity data from PAS in

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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><b>24/7 Alcohol Liaison Service</b></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>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. 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>The indicative current pathways have been finalised with associated costs, a workshop with clinical teams was held in December 2022.</p> <p>Workshops with Service Users were held in February 2023, where feedback on current service provision and improvement they would like to experience in the service.</p> <p>The Service Users Group are also reviewing patient information for collating alcohol intake for patients attending A&amp;E.</p> <p>A community creative also attended the session and is creating a song representing the experiences of our service users and their hopes for the future, this is currently being finalised in the studio and is titled – “Bridging the Gap”.</p> <p>CTMUHB hosted an All-Wales workshop to develop consistent patient information communications for Alcohol Liaison Teams across Wales, which can be localised, and will be developed in co-production with service users.</p>	<p>support of the Value Based Procurement aspect of this exercise.</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>Indicative pathway schematics have been developed with strong support from clinicians from all three teams.</p> <p>Planning has commenced to identify common currency &amp; 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>

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		<p><b>Mobile Respiratory Unit Project with Hywel Dda &amp; Respiratory Innovation Wales</b></p> <ul style="list-style-type: none"> <li>• Spirometry Mobile Respiratory Unit PROM data is a 9 month pilot project, in partnership with Hywel Dda UHB &amp; RIW, which finished at the end of December 2022.</li> </ul>	<p>The ALS project is the CTMUHB Person-Centred Care project with the Welsh Value in Health Team and Sprink. Key project leaders are undertaking the PCVBHC training.</p> <p>775 CTM patient attended appointments on the Mobile Respiratory Unit, (MRU), across 8 community cluster locations within the CTM Health Board Landscape. CTM patients were seen between May 2022 and Mid November 2022. who were offered appointments on the MRU, but were unable to attend, have been offered appointments with the clinical team in CTM clinics.</p> <p>The MRU locations within each of the 8 CTM clusters, took place in easy accessible locations, including supermarkets, shopping locations, leisure centres, a fire station and rugby club, are outlined below:</p> <p>Tesco Aberdare CF44 8DL  Pontrydd Rugby Club CF37 1HA  Abercynon Sports Centre CF45 4UY  Pencoed Halo Centre CF35 5PB  Maesteg Free Carpark CF34 9DT  Porth Morrison's CF39 9BA  Merthyr College CF48 1AR  Porthcawl Fire Station CF36 5TS  Tesco Extra Gelli Hirion Pontypridd CF37 5SN</p>	<p>The Task &amp; Finish Group is evolving into a Steering Group and VBHC programme plans and recruitment will shortly take place.</p> <p>Won highly commended in the Mediawales Awards 2022</p>

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			<p>MacArthur Glen Designer Outlet Bridgend CF32 9SU</p> <p>The Chronic Respiratory Questionnaire-Self Reported (CRQ-SR) is a disease specific questionnaire, PROM, that has been developed as part of this project by CTM and HDUHB, and its development and use was supported by the National Respiratory Health Implementation Group. It is used as a measure of quality of life for people with chronic lung disease. The CRQ-SR is designed to be completed by the patient, with assistance given by an administrator only as necessary. It consists of 20 items across four dimensions: dyspnoea, fatigue, emotional function and mastery. A minimally clinically important difference is deemed 0.25 per dimension (1,2). The first 5 questions are used to identify respiratory health, and the remaining score reviews wellbeing.</p> <p>The first PROM is completed by the patient prior to the first appointment to establish a baseline of their respiratory health and well-being. 634 PROMs were assigned to appointed patients. 122 were not sent due to appropriate contact details, (email and mobile telephone number), not being held on clinical systems. In total 514 were sent to patients prior to their appointments. A total of 211 were completed by patients, (41.8% completion rate), prior to their appointment at the MRU. Early data has been pulled, but not fully analysed as the review period is not complete, to date 26 PROMs were completed 3 months post appointment, and 63 completed 6 months post appointment.</p>	 <p>CTMUHB_CRQ_PROM EnglishWelsh 2</p>  <p>PROM Response data Jan 2023.xlsx</p>

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		<p><b>Welsh Wound Innovation Centre – Pressure Ulcer Project</b></p>	<p>An in-depth review of PROMs completed up to end of October 2022 (initial agreed end of the project) was undertaken on each of the questions within the CRQ –SRA. This has been attached for information. As the project was extended by a couple of weeks, and the clinical team are currently undertaking additional sessions back in CTM, to see patients who needed to defer during the project.</p> <p>CTM is working with the Welsh Wound Innovation Centre to deliver a programme of work that aligns with WWICs and CTMs aims and supports the health board with work it currently doesn't have the capability or capacity to deliver.</p> <p>More specifically WWIC will;</p> <ul style="list-style-type: none"> <li>• Completing a baseline assessment (to include a skin assessment of patients to inform the improvement effort)</li> <li>• Developing a robust and reliable data strategy and measurement platform to incorporate value-based measures including the patient reported experience (PREMs)</li> <li>• Provide targeted training to frontline teams</li> <li>• Provide expert advice and support to the CTM CAPU collaborative</li> </ul>	 <p>RIW_PROM_summar y.xlsx</p>

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		<p><b>MyMobility T&amp;O App in partnership with Zimmerbiomet</b></p>	<p>Improved patient condition prior to surgery by providing customised bespoke physiotherapy advice to ensure patients are optimized for surgery.</p> <p>Provides pre-habilitation to ensure patients get the best post-operative care to ensure enhanced recovery times and a reduction in follow up appointments and physiotherapy.</p> <p>Improved patient confidence in the NHS system as they are not “forgotten” about and allows information sharing between the patient and clinicians to ensure patients are receiving the care they need.</p> <p>Connectivity between the patient and the medical team for all levels of advice both clinical and non-clinical.</p> <p>Enhanced Physiotherapy to provide a more time critical physiotherapy input.</p> <p>Allows the capture of PROMS and PREMS data to ensure that patient experiences are captured to improve the service moving forwards.</p>	<p>Won the NHS and Working with Industry Award at the MediWales Awards 2022</p> <p>Supports the reduction of vital face to face appointments by allowing patients to communicate and receive support without appointments.</p>
2.	<p><b>Delivery programme of PROM collection and sharing PROM data nationally to inform value-</b></p>	<p><b>PROMs – total 2877</b></p> <ul style="list-style-type: none"> <li>• 777 Heart failure PROMs completed</li> <li>• 1221 Lymphoedema PROMs completed</li> <li>• 284 RIW PROMs completed</li> </ul>	<ul style="list-style-type: none"> <li>• CTMUHB have worked with SBUHB regarding repatriation and access to former patient records of Bridgend</li> <li>• CTMUHB has successfully transferred all HF PROM data from DrDoctor and is now being held in CTMUHB warehouse</li> </ul>	<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</p>

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	<p>based decision making and direct clinical care.</p>	<ul style="list-style-type: none"> <li>• Palliative Care PROM- set up on DrDoctor but not live- awaiting agreement/ authorisation from the National Palliative Care Group.</li> <li>• 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</li> <li>• Discussion took place with DHCW on reporting of the heart failure PROM data to share nationally.</li> </ul> <p><b>Heart Failure CROM</b> 213 collected since January 2023</p> <p><b>PREMs</b></p> <ul style="list-style-type: none"> <li>• Heart Failure – 290</li> <li>• MRU project - 239</li> <li>• Frailty Nurse – 40</li> <li>• Heart Failure Cardiac Rehab – 23</li> <li>• Pelvic Health Urogynae Clinic - 11</li> </ul>	<ul style="list-style-type: none"> <li>• 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</li> <li>• 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</li> <li>• 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.</li> </ul>	<p>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 booking support, and patient and clinical team support with awareness and understanding of PROMs, to support integration and improved uptake completion rates. These roles commenced in Oct 22 and have significantly increased the uptake and completion rates of Heart Failure VBHC measures.</p> <p>Aligned to PROMs, we have taken the strategic decision to implement PREMs (Patient Reported Experience Measures) and WREMs (Workforce</p>

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				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.
3.	Progress with <b>allocating resources to secondary prevention activities</b> 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><b>National:</b></p> <ul style="list-style-type: none"> <li>• <b>Lymphoedema Phase 1 &amp; 2</b></li> <li>• <b>Cellulitis</b> – funded band 7 AHP in National Team</li> </ul> <p><b>CTMUHB:</b></p> <ul style="list-style-type: none"> <li>• <b>Heart Failure Pathway</b> 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 HF Improving HF Palliative Care</li> <li>• <b>Diabetes</b> Pre-Diabetes Project Diabetes ante-natal project &amp; pilot GD-M App Weight Management Diabetic Retinopathy</li> <li>• <b>24/7 Alcohol Liaison Service (ALS) – Task &amp; Finish Group - mapping</b></li> <li>• <b>AF &amp; Hypertension – Task &amp; Finish Group - mapping</b></li> <li>• <b>UroGynae Physiotherapy</b></li> </ul>	<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 &amp; 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>The CTMUHB VBHC portfolio is supporting a number of digital apps to enable proof of concept trial and review.</p>	<p>Business cases, programme plans and highlight reports on the commenced projects are available on request.</p> <p>In addition, CTMUHB bid and were successfully allocated funding from the National VBHC pot for a 24/7 Alcohol Liaison Service and as a partner in a Regional AF &amp; Hypertension Project with SBUHB and &amp; HDUHB.</p>

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		<ul style="list-style-type: none"> <li>• <b>Mobile Respiratory Unit – Spirometry with HDUHB &amp; RIW</b></li> <li>• <b>MyMobility T&amp;O Digital App</b></li> </ul> <p>Further projects have been allocated funding as agreed beginning of September 2022, including:</p> <p><b>Diabetes Podiatry</b>  <b>UroGynae Physiotherapy</b>  <b>Medicines Management Digital App</b>  <b>Programme Support for ILD Lung Project Review</b>  <b>Programme Support for Frailty Project Review</b></p>	<p>Programme Management workshops and recruitment undertaken in these projects to enable project commencement.</p>	
4.	<p><b>Reduction in unwarranted variation and activity of limited value, and standardisation of best practice pathways which support delivering improved outcomes.</b></p>	<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 Digipharm 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 results, outcomes being monitored by the Digipharm platform</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>Lack of organisational access to data sources has delayed the transfer of data to Digipharm, and subsequent monitoring of agreed Outcome Measures.</p>

## Supporting Information



Microsoft  
PowerPoint Macro-E

Attached is our end of year VBHC @ CTM presentation:

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.