

**VALUE BASED COMMISSIONING MASTERCLASS**

**29 November 2019 - Summary**

**Purpose:**

Value Based Healthcare is an important component but it needs to be embedded throughout organisations plans, whether strategic or operational, together with outcomes, and patient experience etc.

Value Based Healthcare will have achieved its objective when clinicians change what they do and how services are delivered, based on the information we are now able to collect and use.

**Nicola Prygodzicz**

**Director of Planning, Aneurin Bevan University Health Board**

The presentation reinforced the need to put patients and their families at the centre of healthcare activity and ensure that services are planned and delivered to support the individual’s health and wellbeing.

The presentation emphasised the need to capture the essence of Value Care Healthcare to ensure services are more bespoke, thus more effective for that individual, whilst at the same time being more efficient in the use of limited resources.

**Dr Sally Lewis**

**Director, Value Based Healthcare Programme**

The presentation depicted:

* Whole system approach and the need for integrated systems
* The use of data to inform decision making – moving data into intelligence
* The ability to harness patient power.

Dr Lewis reinforced the mantra that changing behaviour is ‘everybody's business’ and explored the consequences of not knowing the outcomes that matter.

COPD is a useful example, the majority of money is spent on inhaler therapy which is shown to have the least impact, whereas money would be better spent more on pulmonary rehabilitation which would give improved value.

**Dr Tom Kelley**

**Independent Consultant, Supporting Value Based Healthcare in Wales**

**Dr Kelley presented the Martini Klink case study:** it provided areflection on the similarities and differences between the German and Welsh systems. Some of the conclusions from the presentation included:

* The case study is applicable to Wales – Cancer centre in Swansea
* Wales is different because it is not based on private healthcare, funding and the ability to reinvestment has been a better driver in Germany to improve the outcomes
* Wales is not profit driven, so will not aim to drive up outcomes to drive up market share
* Martini has achieved high outcomes but with very substantial costs
* Important to see that although this German klink is private they are part of the university and have been able to move into something that is now integrated with the wider Hamburg healthcare system – there is more Multi-disciplinary team working now than at the start.
* Equity is difficult - how do we move from this one clinic to an all Wales model with equal access.
* Wales is trying to do more in terms of patient wellbeing

The discussion identified the similarities and differences between two systems:

Most services operate a ‘Non-integrated system’ with the patient going around the system rather than system around the patient. There are some good examples in wales but how do we scale it?

The Martini example is linked to profit but that’s not the model in Wales – while volume and market share motivation was there at the start, Martini now operates a more holistic approach and have moved from being a silo group of clinicians to a model more integrated with wider Hamburg hospital and full pathway – so it can be done.

Wales has opportunity to embed virtual integration across whole system not just physical integration in a building. Improvements in outcomes has been significant in the Martini exemplar but in Wales, equity is important so we need to consider how would we ensure equity and access while building the model of care.

It is important to use data to drive improvement and to use information across the whole pathway, to decide what can be changed and put that plan into action to address it. Wales is interested in wellbeing outcomes, not just clinical outcomes.

The presentation concluded that there were benefits from embracing the learning at Martini whereby senior clinicians can learn from juniors etc. thereby building a centre of excellence over time - cultures and behaviours.

Technical aspects must be right to support the aspects of VBHC but on its own not enough as there is a need to change clinical culture. Learning from colleagues and letting go of traditional roles is an important part of the transformation needed.

Data plays a key role in supporting Value Based Healthcare. It critical to have up to date information and constantly feeding back – an action learning cycle.

There are principles from Martini case study could be taken into the NHS planning process.

To really embrace and plan from the patient's perspective is difficult and takes time. We must be pragmatic as we move to achieve this vision. This change would have implications for planning process in Wales and it needs to be considered in the round.

We need to consider how to link individual patient measurements to the whole system level but at same time support more individualised personal treatments and tailored medication.

One of the major barriers is the time it takes to get the information out of the system and present it back to clinicians - we must make this available more quickly and linked to real time to see effectiveness of what we are doing.

**Other cases studies discussed:**

* Italy/ Netherlands examples
* North American and Canada examples
* Australia - similar approach to what has been happening with clinical audits in Wales -e.g. lung cancer

Value Based Healthcare can be embedded into Wales but we must have culture that enables and supports the change we want. We need to listen to people and create a data driven service. Primary care is important to improving health and wellbeing of the individual and to achieving better outcomes so this needs to be built into a strong action plan.

From a planning perspective ‘outcomes and process data’ can help guide prioritisation. Wales needs to invest in these areas. We need to decide what to measure and how to monitor it to see if it makes a difference. Planners can then decide what outcomes we need to capture and use technology to ensure patient’s outcomes are captured quickly and accurately and used effectively.

**Gareth John**

**NHS Wales Informatics Service (NWIS)**

**IMPLICATIONS FOR PLANNING -** National Lung Cancer Dashboard demonstration

Dr John presented the National lung Cancer dashboard explaining that the initial view was from clinical perspective. Through this lens it is possible to compare by health board but the viewer is still able to drill down to patient level data depending on permissions etc.

The Dashboard is in its infancy and more ‘proms data’ is needed. Value based decisions need to be based on outcomes data, activity data and costing data, we need to start looking at comparison data between LHBS so we can see the differences and start asking the right questions.

**Helen Thomas**

**Interim Chief Executive, NWIS**

Ms Thomas presented an overview of the importance of data and its use in improving services and care outcomes.

Not having the right data and therefore not being able to learn from it, is the main barrier to ‘Prudent Healthcare’. *A Healthier Wales* has 7 out of 40 actions relating to data and digital –the important is collecting the right data is critical to transforming the health care in Wales.

The NHS is awash with data but how intelligent is it and how do we use it? We need to improve our skills to interpret and use the data we have. Developments are underway:

* **A National Information Strategy** for Wales is being developed and a national data resource, SNOWMED CT to capture the data and build capacity in the workforce to use it. This is being developed jointly with Social Care Wales to develop an integrated health and social care approach.
* Core Principles and 4 Priorities in the Information Statement of Intent

<https://gov.wales/sites/default/files/publications/2019-05/statement-of-intent.pdf>

* **National Data Resource programme** has six components. Professor John Peters is the Senior Responsible Officer (SRO) for the project and phase 1 will be completed by Dec 2020. The lung cancer dashboard is the first of many such repositories to be made available. The aim is to have joined up data driving clinical care and organisation decision making. Health and social care have been slow to embrace digital revolution and it is key to embedding VBHC effectively.
* Other global data could be added for comparison. However, caution is needed to stop people drawing wrong conclusions – need more bespoke analysis. Wales is investing in integrated planning system which is about responding to need and getting best outcomes.

**The session breakout sessions - Feedback**

1. **Lung Cancer**

Three groups reviewed the lung cancer case study to determine the reasons for late presentation stage 4 diagnosis. The discussion resulted in observations that more data could be used to instigate new services that would better support patients i.e. more wellbeing services.

The available data showed variation, but this could be caused by various factors: lifestyle, Industry, rural v urban landscape, cultural – multi factorial =- so greater depth analysis would be useful to help understand the issues and be able to plan services which would have greater impact.

The available data showed differences between male and females, this may reflects different attitudes to seeking help - cultural and lifestyle issues – further in-depth analysis would help to address these.

The data showed a shortage of GPs or difficulties accessing GP services – this highlighted the need to re consider location for services, should services go where the patients are i.e. supermarkets with nurse support would be better than not being able to access healthcare advice.

The discussion groups acknowledged the need to understand the intelligence and information behind data and the implications this had for planning.

1. **Heart Failure**

Three groups reviewed the heart failure case study. The available data indicated that the Cardiff site appeared to be implanting more devices than Swansea. However, there was no outcome data available and that is important for planning purposes. We must plan for better outcomes not just productivity.

Many attendees had trouble interpreting and understanding data so it illustrated the need for more analytical training and support for clinicians and professionals, to be able to interpret data for their own services.

It was acknowledged that there was a need for a more longitudinal view in the data in order to track outcomes over the longer term. The data also highlighted the need to consider more investment in psychological services alongside physical support. Mental health triggers for many people with chronic conditions but this side of an individual’s condition is often side lined but looking at an individual’s wellbeing outcome it become more important.

There were insufficient data points to make a judgement on the mortality data examined. There appeared to be significant death rates - need to understand more about the patients e.g. were they towards end of life and should not have been admitted or were there any alternatives or was it patient choice to go to hospital for end of life

The discussions identified the need to link data sources to get patient perspective and pathway perspective. There is a need to ensure there are appropriate services within the community to avoid unnecessary readmissions.

1. **Knee replacements**

Two groups reviewed the knee replacement case study.

Within the case study a number of prosthetics were adopted. Prosthetic no 4 was regarded as the outlier from the available data. There could be good reasons why that had to be used but there was a need for more in-depth analysis to determine if this was the case.

The discussions identified variation in the costs of the procedures. This raised questions on the accuracy of the coding, the need to understand catchments and cohorts of the provider organisations - some tertiary providers might have more complex cases.

It was acknowledged that significantly better outcomes may cost more. More outcome data relating directly to the patient would be helpful, it would be but useful to know how patients are/what they feel about their treatment and future.

The group acknowledged the danger in looking at snapshot data but recognised that it provides a catalyst to asking questions.

**Discussion Summary:**

These exercises universally recognised the need to have the right data for right conversation with right people for right outcomes; they created a good starting point for conversations and agreed everyone needs to do this within their own services.

There was collective agreement that this approach could help move to commissioning rather than provider plans. It was agreed that the language used in the health service was important, the more consistent the VBHC language the more likely it was to support this change.

Greater emphasis on VBHC within key publications such as the NHS Planning Framework would be helpful to start to change attitudes and behaviours towards better planning, creating the right culture for services to deliver better outcomes.

There is a need for more focus on commissioning, it should be front and centre in the planning framework but health boards would have the freedom to respond differently. The ideal commissioning cycle would use data to identify need, experiment with solutions and test out and then refine.

The ‘Must do’ is to start with getting data better in our organisations.

However, ensuring the service can collect and interpret its own data correctly is important. Having the right skills to really look at data and use it is critical. NHS wales needs to provide more training for individuals in analysing data before change can happen.

The discussions identified the need to question whether services are making a difference for those who use them. Current performance targets are about pushing large volumes of certain types of treatments RTT through system at expense of others e.g. chronic conditions, we need greater balance.

The value based ethos needs to be better joined up and work as a whole system, health, social care and education. Need to use it as part of conversations with people and communities to elicit ‘what matters’ to people.

**Samia Saeed-Edmonds**

**Planning Programme Director, Welsh Government**

Ms Saeed –Edmonds summarised the day stating that people and outcomes should be the approach taken by planning - what matters to individuals is crucial.

Planning should be about relationships not process and about trying and testing out new things – it was a challenge for planners to be brave.

The Planning Framework is constantly being modified and in the next planning round it may go further with more focus on commissioning and the commissioning cycle:

* Requirement for data,
* Need to plan,
* Need for testing
* Evaluate it
* Modify the design on the basis of data
* Re-introduce and repeat.

The next steps are to move beyond conversations and shape Welsh Government policy and organisational behaviour to turn data into intelligence and to address what the data shows co-productively to improve services and care.

Welsh Government do want ‘pace and scale’ accept the need to be pragmatic. The challenge is to start somewhere not be overwhelmed by scale of challenge. Build capacity and capability to take forward and build momentum in organisations.

**Nicola Prygodzicz – Summary**

Ms Prygiodzicz implored the audience to ‘make a change’ that makes a difference – start small and maintain the change – be the catalyst.

Delegates acknowledged the need to work with groups and stakeholders to explore and analysis data and make changes that put the individual front and centre in our planning process.