PRUDENT HEALTHCARE:

A RADICAL AND COMPREHENSIVE REDESIGN OF HEALTHCARE IN WALES?

A study supported by the Health Foundation

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June 2017

University of South Wales
Prifysgol De Cymru

wihsc
1995-2015
YEARS

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FOREWORD

Prudent Healthcare (PHC) was launched in early 2014 by the then Minister for Health and Social Services in Wales, Professor Mark Drakeford AM, as an attempt to galvanise fundamental change in the way healthcare is delivered across Wales. The vision, captured in four Principles, was of a healthcare system which no longer indulged in tests and treatments of little added value, where staff could operate at the top of their licence to practice, where harmful variation was eradicated, and above all, where patients, the public and professionals worked in partnership to improve health and wellbeing.

This report summarises the findings of a year-long study, supported by the Health Foundation. It charts the origins and implementation of the policy, and considers how it has impacted over the past three years on services generally, including in key areas such as long term conditions, mental health and frailty provision, as well as on the healthcare workforce and on partnership working ('co-production'). The prospects for the future are explored, and a provisional assessment made of what Prudent Healthcare may have achieved so far.

We are immensely grateful to all those who worked with us on this research. More than 100 healthcare professionals from across Wales contributed to a series of interviews and workshops for Phase 1 of the work, which focused on the possible future impact of Prudent Healthcare on four specific service areas: mental health, long term care, frailty and end of life care, and early years and prevention. This work is summarised in Chapter 2 of this report, and it informed the models of future financial impact on healthcare in Wales reported elsewhere[1].

Phase 2, which began in August 2016, forms the remainder of this report, and looks at the system-wide impact of the four Prudent Principles. 45 people were interviewed in depth for Phase 2, including Mark Drakeford AM and senior civil servants in Welsh Government, many NHS Chief Executives and Executive Directors, senior clinical leaders and managers, and external stakeholders. Others took part in three workshops, and provided the team with extensive documentary evidence on the impact of Prudent Healthcare. This work would have been impossible with their enthusiastic and generous contributions.

We are also immensely grateful to Brigid Bowen who was a key part of the research team in Phase 1. Adam Roberts and Toby Watt of the Health Foundation have offered their unstinting support and, together with their colleague Anita Charlesworth, and Michael Trickey of Wales Public Services 2025 were great colleagues during the work on Phase 1.

The report is presented as follows:

- Chapter 1 identifies the antecedents of Prudent Healthcare, and describes our approach to the study

[1] http://www.health.org.uk/publication/path-sustainability

- Chapter 2 summarises the findings from the first Phase of work, looking particularly at four service areas
- Chapter 3 explores how Prudent Healthcare was originally conceived, how it has developed, and how it is now understood in practice
- Chapter 4 explores how the policy has been implemented, and what can be learnt from that experience
- Chapters 5 and 6 look respectively at the impact of PHC on the Workforce and on Co-production, two areas which have proved to be pivotal
- Chapter 7 looks at the evidence of impact so far, and includes several case studies which highlight what PHC is starting to mean in practice; further information on the case studies is in Appendix 2
- Chapter 8 draws some conclusions.

EXECUTIVE SUMMARY

BACKGROUND

Prudent Healthcare (PHC) is a major policy initiative designed to stimulate fundamental change throughout the health system in Wales. Launched early in 2014 by the then Minister for Health and Social Services, Professor Mark Drakeford AM, it has now been adopted by the new Cabinet Secretary, Vaughan Gething AM, and is likely to remain as one of the defining elements of Welsh health policy throughout the current Assembly term. At its heart are four Principles:

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production;
- Care for those with the greatest health need first, making the most effective use of all skills and resources;
- Do only what is needed, no more, no less; and do no harm.
- Reduce inappropriate variation using evidence based practices consistently and transparently.

The policy was designed to improve the way in which health services are delivered in Wales, promoting sustainability and providing a service that '*fits the needs and circumstance of patients and actively avoids wasteful care that is not of benefit to the patient*'[2]. Prudent Healthcare sets a precedent for bringing together a number of concepts that have been central to the debate on driving improved patient safety, quality, effectiveness and sustainability of care, in one national policy.

In February 2016, an attempt was made to set some national priorities for implementation. '*Prudent Healthcare Securing Health and Wellbeing for Future Generations*' was issued to the service as a Circular from Government, setting out three areas for 'collective national action':

- Reducing unnecessary and inappropriate tests, treatments and prescriptions, and ensuring people are able to make informed decisions about the care they receive;
- Radically changing the outpatient model, making it easier to get specialist advice in primary care settings;
- Developing strong public service partnerships and integration to provide the right care, in the right place, at the right time.

This report primarily presents the findings of the second phase of a year-long project funded by the Health Foundation, undertaken by the Welsh Institute for Health and Social Care (WIHSC), University of South Wales, on Prudent Healthcare (PHC) in Wales. This phase of the study was an in-depth, mainly qualitative exploration of how Prudent Healthcare is being implemented across Wales. It combines a grey literature review, interviews with a structured

[2] Prudent Healthcare – The Underlying Principles. The Bevan Commission, 2014.

sample of 45 key informants from national and local contexts, and three workshops. It aims to address two key questions:

- How has Prudent Healthcare been implemented?
- How can its implementation in the future be optimised?

The results from the first phase of the study are summarised in Chapter 2.

What is Prudent Healthcare?

As the research has revealed, this is not an entirely straightforward question, and it certainly does not have a single answer. At one level, it was clearly a Ministerial policy initiative, which has subsequently been adopted by his successor as Cabinet Secretary, and which would now appear to have currency at least until the end of the present National Assembly term. In practice, PHC has appeared to be all of the following: a rallying call for change; a framework of analysis; a Driver of Change; and a Plan. Chapter 3 explores how Prudent Healthcare policy is perceived by the key stakeholders in Wales. It summarises the key perspectives on Prudent Healthcare policy as a whole and on each of its four Principles.

The policy has provided a useful vision and coherent philosophy. It has been subject to wide interpretation and application across Wales – this is seen as both a strength and weakness. The principles are widely seen as being 'sensible' and have helped to shape thinking on current and future innovation. Of the four Principles, the first and second were identified as those with the most potential to make a difference overall, but the first – relating to co-production – was seen as the one that would be hardest to achieve, over the longest time scale.

How has it been implemented?

Chapter 4 explores what has helped and hindered the implementation of Prudent Healthcare since its launch in 2014. It has set out a philosophy and set of Principles which have appealed to people's professionalism and values, and in places has encouraged the development of a critical mass of like-minded enthusiasts. It has offered a framework for thinking about how services should develop, and a set of prompts for those charged with improvement and reform. Most parts of the NHS in Wales have decided that Prudent Healthcare should infiltrate the breadth of their work, rather than become a silo of its own. There are many examples here of the policy being appropriated and colonised in ways which managers and practitioners feel is consistent with the Principles but has greater practical value for them as a tool for change.

What impact has it had on the workforce?

There is a widespread recognition that significant changes are needed to the workforce if Prudent Healthcare is to become a reality, requiring changes to workforce configuration, individual jobs and roles, and even to the ways in which staff carry out their roles. Chapter 5

considers what those changes might be, and upon what they would depend. It then explores what progress has been made to date, and how such changes might be expedited in the future.

Progress is clearly being made in the prudent remodelling of the workforce. Progress is often greatest where staff see the benefit of change, where patients are involved, and where changes have already been explored for some time. Prudent Healthcare provides what many regard as a useful lens through which to examine the workforce, and the slogan 'only do what only you can do', and the desire to work 'at the top of one's licence' appear to find greater resonance than some of the other Principles of Prudent Healthcare. For those who have always been champions of change, Prudent Healthcare, in workforce as in other areas, provides useful support.

What impact has it had on co-production?

Chapter 6 shows that interpretations and definitions of co-production are wide-ranging across the NHS in Wales, as is the extent to which it influences local practice. We found no examples of a radically new way of doing co-production since the launch of Prudent Healthcare policy. There is a widespread appreciation of the magnitude of change in attitudes of staff and patients if a truly co-productive approach is to be embedded, involving a major shift in the power balance between the public and professionals, and a more effective sharing of responsibility between the two. Co-production requires a particular frame of mind as well as a set of skills.

What has happened as a result of Prudent Healthcare?

The problem of attribution is clearly a difficult challenge in answering this question, and understanding what would have happened *without* PHC is largely a matter of (informed) conjecture. As Chapter 7 explores, the Prudent Principles have commanded overwhelming support, as being in accordance with most people's values, and as addressing important issues for the quality and sustainability of care. It has been helpful that they have been discussed and endorsed across the whole of Wales, thereby enabling cross-Board discussions and comparisons. It has also been helpful that they have been so enthusiastically and authentically endorsed by Ministers, and have sufficient longevity to counteract the cynicism which often accompanies transitory policy enthusiasms.

So far, the response of the NHS has been overwhelmingly pragmatic. There are many examples quoted in the earlier chapters of local stakeholders adopting those Principles which they regard as being helpful to address the issues affecting them, and in the process, capitalising on the strengths outlined in the paragraph above. There is also some evidence of people using PHC as an analytical framework to set their own agendas, and of using the principles as a 'check list' when developing or appraising local plans and business cases. This can be used to address relatively simple questions, such as 'what is the most prudent

configuration of the workforce in a particular service?' as well as more complex questions such as 'which approach to service delivery would add most value?'

How successful has Prudent Healthcare been?

It is difficult to be precise, and Chapter 8 explores this in more depth. Some reasons for this are not surprising, the most obvious being the difficulty of attribution and isolating the confounding variables, which has been mentioned above. Any policy initiative introduced into the dynamic complexity of the NHS is unlikely to have a simple and easily identified cause and effect relationship. But PHC presents a set of challenges of its own in this respect, which stem from the fact that there has been little explicit statement of its intended outcomes and timescale. It is not even clear, in fact, how such impact should be measured – there are no clear metrics of success.

This is not by mistake. Prudent Healthcare was conceived from the outset as more of a rallying call, leading to a 'social movement', rather than the more prescriptive approach which might normally be seen in a Welsh Government health policy initiative. So it deliberately has no specified end-point or milestones, there is no implementation plan (*pace* the three national foci introduced in 2016) or allocated responsibilities. It is therefore unclear what it should have achieved by now, and whether it is broadly on track or not. Most interviewees and participants expressed their own views on these questions, but they are just that: their own.

Most would argue that progress against the four Principles could broadly be characterised as follows:

Principle *(in order of progress to date)*	Progress to date
Principle 4. Reduce inappropriate variation using evidence based practices consistently and transparently	Rank 1st: Most progress. This is a long-established priority for the NHS so has professional acceptance and is gradually being fuelled by better evidence on outcomes and efficiency.
Principle 2. Care for those with the greatest health need first, making the most effective use of all skills and resources	Rank 2nd: Key staff shortages and emerging new roles have helped, and also sometimes benefits from a link to cash-releasing savings.
Principle 3. Do only what is needed, no more, no less; and do no harm	Rank 3rd: Emerging evidence is starting to support this, but progress to date has been limited by the availability of good evidence and the association with 'cost containment'
Principle 1. Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production	Rank 4th: Least progress. Still requires considerable public and professional understanding and engagement, service redesign, professional training and transfer of power from professional to patient

But these are essentially unverifiable and for discussion.

What has determined its success?

It is possible to discern various factors which have helped and which have hindered progress towards greater prudence, and these are also set out in Chapter 8. Supportive factors have included professional engagement with the Principles, pre-existing familiarity with some elements, alignment of managerial and clinical interests and enthusiasm, universal adoption of the Principles across NHS Wales, and (light touch) accountability for progress.

Several rate-limiting factors have also emerged. Perhaps the three which have generally been regarded as most significant are: Services having too many other priorities, the rigidity of current service patterns and behaviours, and a lack of resources. A fourth factor was also much quoted – the perceived lack of engagement and understanding among patients and the wider public with Prudent Healthcare. This may not yet amount to much of a rate limiting factor, but it would become so if more progress were to be made in tackling the other factors.

Where does Prudent Healthcare go now?

Prudent Healthcare remains a priority for Welsh Government and the Welsh NHS, and this longevity is a key strength. Change on this scale requires many years, and PHC has that lifespan. Much of the organic adoption of the PHC Principles – local actors using them in the ways described above – will continue, and will continue to achieve progress. PHC continues to be supported by those hungry for change, who view PHC as a useful part of their armamentarium. Work is needed to engage patients and the public more effectively in the PHC agenda[3]. We found many local examples, in every Health Board and Trust, where this was being achieved with patients, but they remain relatively isolated examples.

If the analysis is correct, progress could be further enhanced by addressing the rate-limiting factors described above, and those discussed in Chapters 3 to 7. There is still a live debate in Wales about whether PHC would now best be advanced by continuing with a more nationally-led approach, with more explicit and uniform objectives, clearer metrics and accountability, or whether the organic, largely opportunistic approach is more likely to be successful. Views on this often reflect people's views on the best relationship more generally between the national and local in Welsh health policy. The nationally-prescribed priorities of 2016 have not gained much traction in the NHS, with many regarding them as being an unhelpful distraction, often fitting rather poorly with local priorities and not necessarily achieving much. In addition, in the case of PHC, a shift towards a more 'top-down' approach would effectively redefine PHC itself, away from the original conception of a social movement which was designed to effect change in a new sort of way.

[3] Since the fieldwork for this research was completed, the Welsh NHS Confederation agreed to produce for Welsh Government 'a comprehensive strategic communication and engagement plan, which will drive a compelling and persuasive prudent healthcare "offer" to the Welsh public' (Welsh NHS Confederation (March 2017) *A Public Engagement and Communications Strategy for Prudent Healthcare* Cardiff: Welsh NHS Confederation)

Many of the people we interviewed, or who took part in workshops, regarded progress on Prudent Healthcare as being less than ideal. They were conscious of how much more still needed to be achieved in relation to all four Principles, of the harm caused by further delay (in terms of perpetuating suboptimal care), and of the need to effect radical change more quickly before the demographic and other pressures further undermined healthcare sustainability.

So, increased pace was a widespread aspiration; but how was it to be achieved? If organic change was inevitably slow, and if nationally-led priorities gain little traction, was there an alternative? This is a simple and long-standing question, with a complex and elusive answer. Until it is resolved, there is a host of small changes, described in this report, which may be expected to enhance progress towards more Prudent Healthcare, and towards more prudent public services more generally.

In the meantime, considerable encouragement can be derived from that fact that Prudent Healthcare has so effectively and comprehensively won the hearts and minds of all concerned, and it still has many enthusiastic supporters.

CHAPTER 1 - THE ORIGINS OF PRUDENT HEALTHCARE AND OUR APPROACH TO THE STUDY

This chapter explores the history of Prudent Healthcare in Wales and describes the approach taken in Phase 2 of the research.

BACKGROUND

Prudent Healthcare is a major policy initiative designed to stimulate fundamental change throughout the health system in Wales. Launched early in 2014 by the then Minister for Health and Social Services, Mark Drakeford AM, it has also been adopted by the current Cabinet Secretary, and is likely to remain as one of the defining elements of Welsh health policy throughout the current Assembly term. The policy was designed to improve the way in which health services are delivered in Wales, promoting sustainability and providing a service that '*fits the needs and circumstance of patients and actively avoids wasteful care that is not of benefit to the patient*'[4].

The origins of Prudent Healthcare

A number of UK and Global initiatives that aim to address key issues in relation to sustainability, patient safety and quality in health systems are firmly established, and can be seen as antecedents of Prudent Healthcare.

Over-diagnosis, defined as '*when people without symptoms are diagnosed with a disease that ultimately will not cause them symptoms or early death*' [5] has been at the centre of a number of international and UK-based initiatives that have grown considerably in profile over the past five years. In the UK the BMJ group – Too Much Medicine - and the over-diagnosis standing group of the Royal College of General Practitioners – Better Medicine: Shared decisions - are major advocates and a resource for the medical profession in addressing over–diagnosis. Internationally, the prevention of over-diagnosis scientific conference is now in its fourth year.

Similarly the concept of co-production, defined by The New Economics Foundation and Nesta as *'delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours'*[6] is well established in its own right. As a concept, it was coined by a US academic team in the late 1970s (led by Elinor Ostrom) and then later shaped by Edgar Cahn, who developed the Time Banking concept[7]. Edgar Cahn defines co-production as '*restoring balance — balance between the two economies, market*

[4] Prudent Healthcare – The Underlying Principles. The Bevan Commission, 2014.
[5] *Welch G, Schwartz L, Woloshin S. Overdiagnosed: making people sick in pursuit of health. Beacon Press, 2011*
[6] The challenge of co-production: How equal partnerships between professionals and public are crucial to improving public services. Nesta. 2009.
[7] A Timebank is a tool used to organise people or organisations in a system of exchange, whereby they are able to trade skills, resources and expertise through time. People Can. Timebanking UK 2011

and nonmarket; balance between the two sides of our nature, competitive and co-operative' and goes on to describe time banking as a *'medium of exchange to restore that balance.'* The definitions given here are two of many – and there is no agreed universal term for co-production[8].

Co-production as a concept is gaining momentum in the UK. It has been included in statutory guidance associated with *The Care Act 2014*, where it was recommended co-production should be a key part of implementing the Act.[9] In Scotland the NHS has its own co-production network[10] and in Wales, 'All in this Together, the Co-production Network for Wales'[11] is a member-led network of citizens and professionals working for '*a Wales where everyone is valued as a* contributor'. In England 'Think Local, Act Personal' is a national partnership that aims to *'transform health and care through personalisation and community based support*' and one if its four work stream areas is to 'Model Co-production in Action'.

There have also have been a number of social movements and more recently, programme responses, in the US and Europe that have drawn on a combination of these elements. The most established of these is 'Slow Medicine', which originated in Italy and was described by an Italian cardiologist in 'An invitation to Slow Medicine'[12] as a reflective, slower approach to a traditionally 'Fast Medicine' culture where more is better. Since 2011 the Slow Medicine movement in Italy has developed into a national network of health professionals, patients and citizens[13] - and promotes a Measured, Respectful, and Equitable Medicine – based on dialogue, listening and decision sharing with the patient[14]. The Netherlands and Brazil have similar national professional networks. In the US the Choosing Wisely campaign, launched in 2012 by the American Internal Board of Medicine, and now established in the UK and Italy, is based on promoting conversations between providers and patients with the goal of avoiding wasteful or unnecessary medical tests, treatments and procedures.

More broadly, the American College of Physicians in 2012 issued ethical guidelines recommending clinicians should aspire towards delivering *'Parsimonious care that utilizes the most efficient means to effectively diagnose a condition and treat a patient respects the need to use resources wisely and to help ensure that resources are equitably available.'* Champions for parsimonious medicine have highlighted the substantial proportion (20%) of routine medical practices in the US that do not add value to health care but continue to be performed[15]. Like Choosing Wisely and Slow Medicine, the central concept of avoiding unnecessary and wasteful care is fundamental to the principle of parsimony. It has been argued that '*parsimonious medicine rests squarely on the principles of doing no harm and*

[8] Needham, C. and Carr, S. (2009) SCIE Research Briefing 31: Co-production: An emerging evidence base for adult social care transformation, London: Social Care Institute for Excellence.
[9] Care and Support Statutory Guidance, Department of Health. 2011
[10] http://www.coproductionscotland.org.uk/
[11] https://allinthistogetherwales.wordpress.com/
[12] Dolara A. Invitation to "slow medicine" Ital Heart J Suppl. 2002;3(1):100–101
[13] http://www.slowmedicine.it/pdf/The%20project%20English%20version.pdf
[14] Recenti Prog Med. 2015 Feb; 106(2):85-91. doi: 10.1701/1790.19492.[Italy's Slow Medicine: a new paradigm in medicine].
[15] Berwick DM, Hackbarth AD. Eliminating waste in US health care. *JAMA*. 2012; 307(14):1513-1516.

attending to the good of patients in need' in response to the idea that parsimony is really about rationing – making the clear distinction that parsimony is not based on principles of distributive justice, rather that '*it is an essential attribute of professionalism.'*[16]

Realistic Medicine, developed by the Chief Medical Officer in Scotland, was published in January 2016 [17], and acknowledges Prudent Healthcare as one of its own antecedents. The report sets out challenges facing healthcare and aims to stimulate dialogue with clinicians about how these challenges might be tackled. Realistic medicine is described as a 'philosophy and movement' and centres around change in six key areas - change style to shared decision making; building a personalised approach to care; reducing harm and waste; reducing unnecessary variation in practice and outcomes; managing risk better; and becoming improvers and innovators.

Prudent Healthcare policy – history and developments

The Bevan Commission published its first paper on Prudent Healthcare in 2013[18]. This was followed by Mark Drakeford AM, the Minister for Health and Social Services outlining the vision for Prudent Healthcare at the Welsh NHS Confederation conference in January 2014, which included a draft set of Principles. The draft Principles were then tested in four Health Boards and further refined. In January 2015 the final set of four Principles was launched:

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production;
- Care for those with the greatest health need first, making the most effective use of all skills and resources;
- Do only what is needed, no more, no less; and do no harm;
- Reduce inappropriate variation using evidence based practices consistently and transparently.

Later that year, Health Boards were invited to attend a Team Wales Event in December 2015 to discuss their Prudent Healthcare plans individually with the Minister. Each organisation was also requested to submit a paper summarising key aspects of any plans, including practical actions and measurable impacts linked to implementation of Prudent Healthcare. Welsh Government requested that Health Boards receive a Prudent Healthcare report, demonstrating local actions, in a public board meeting before the end of February 2016. In February 2016 '*Prudent Healthcare Securing Health and Wellbeing for Future Generations'* was published, which set out three areas for 'collective national action':

- Reducing unnecessary and inappropriate tests, treatments and prescriptions, and ensuring people are able to make informed decisions about the care they receive;
- Radically changing the outpatient model, making it easier to get specialist advice in primary care settings;

[16] JAMA, February 27, 2013—Vol 309, No. 8 773 Corrected on April 4, 2013
[17] Chief Medical Officer for Scotland. Annual report 2014-15. Realistic medicine. 2016. http://www.gov.scot/Resource/0049/00492520.pdf
[18] Simply Prudent Healthcare – achieving better care and value for money in Wales – discussion paper: Mansel Aylward, Ceri Phillips, Helen Howson. 2013

- Developing strong public service partnerships and integration to provide the right care, in the right place, at the right time.

This update was issued to Health Boards along with a Circular, outlining developments to date and recommendations to focus Health Board activity on these three priority areas. This is included as Appendix 1 of this report.

Intended model of change for Prudent Healthcare Policy

Our interviews with key national figures have revealed considerable discussion in the early days of Prudent Healthcare about how it was intended that the policy would achieve an impact – the intended 'model of change'.

There was a range of opinion on whether the implementation approach for Prudent Healthcare should be 'top down' or 'bottom up', with a number of policy makers agreeing that we should 'expect top down involvement' but that implementation of Prudent Healthcare should 'not be driven top down'. There was also agreement on the following. First that the intention was to foster 'organic' growth of Prudent Healthcare without rigid guidance or expectation about how it should be implemented, allowing Health Boards to adapt and implement Prudent Healthcare according to their own needs and interpretations. It was agreed however, that 'steer and leadership' were needed. Second, it was highlighted that whilst some assessment of Prudent Healthcare outcomes is a necessary part of measuring and determining the success of the policy, it is too soon (as of November 2016, when the relevant interviews were conducted) for any meaningful conclusions to be drawn. This takes into account that there were no national priorities or direction for the implementation of Prudent Healthcare until February 2016 – two years after the launch of the policy. It was also suggested that measurement of 'milestones' would be a key part of determining success going forward, although they have not been published.

There was also broad agreement that Prudent Healthcare needed to be a 'social movement' alongside any structured priorities or guidance. It was agreed that clinical buy-in and leadership would be a key factor in successful implementation. This was reflected in *'using experience from across the [health] system'* to develop and test the Principles after the initial draft Principles were developed.

Another intention was to share good practice and make progress visible through the website resource *'Making Prudent Healthcare Happen'* launched in October 2014. Other reflections included the importance of including Prudent Healthcare in three year Integrated medium term plans for Health Boards.

Finally, the *Wellbeing of Future Generations Act* was recognised as the 'right legislative framework' in terms of the requirement to work with other public sector organisations. There was also recognition that the principle of co-production between professionals and the public is implicit in the *Wellbeing of Future Generations Act* – under one of the 5 ways of working 'involvement' and this further supported broad adoption of a prudent approach.

These different understandings of the intended model of change, and how the differences were played out over time, are explored in more depth in chapter 4.

METHODS FOR PHASE 1

The methodological approach and a summary of the findings from Phase 1 of this study are described together in Chapter 2. These early findings were used to shape and focus the more detailed work carried out in Phase 2.

METHODS FOR PHASE 2

Literature review

A grey literature review (primarily reviewing papers from Health Boards and Welsh Government) was undertaken to determine what activity defined as 'Prudent Healthcare' has taken place over the past three years at Health Board level. A wider review of published and grey literature has considered what other work relating to the four Prudent Healthcare principles is taking place elsewhere (UK, globally).

Interviews

Participants were purposively sampled to include key informants from Health Boards, national organisations, professional bodies and non-health public service organisations to provide a range of perspectives on the implementation of Prudent Healthcare policy in Wales. In total 45 semi-structured interviews were completed. The majority of these were face to face (33) and the remainder (12) were telephone interviews. We interviewed 6 National Policy Leads, 6 Professional Leaders, 11 Senior Clinical Managers, 10 Local Senior Managers, and 12 Local Middle Managers. Senior Clinical Managers, Local Senior and Middle Managers were selected from across Wales. All interviews were recorded and transcribed. Interview transcripts were then coded and analysed inductively/ thematically.

Consensus workshops

Three national consensus workshops were held in Cardiff and included representation from National Policy Leads, Senior Clinical Leads and Senior Local Managers. Two of the workshops considered three topics that emerged as key themes from the interviews: workforce re-design, pathway re-design and co-production. The final workshop included national representation from palliative care clinical leaders and focussed on prudence in end of life care. Findings from the workshops contributed to contextualising overall findings (from phase one and thee one-to-one interviews from Phase 2).

Research activity	Timeline
Literature reviews	August 2016
In depth interviews	September 2016 – January 2017
Consensus workshops	January 2017
Analysis and contextualisation	December 2016– February 2017

CHAPTER 2 - THE FINDINGS FROM PHASE 1

BACKGROUND

Phase 1 of this study was a qualitative exploration of the potential impact of PHC in four clinical areas and across eleven activity generating components of care[19] in the NHS in Wales over the next 5 years. The four clinical areas were Mental Health, Long Term Conditions, Frailty and End of Life Care, and Early Years and Prevention, chosen to represent a diverse range of healthcare activity, different challenges and different types of potential for greater prudence. The estimates of financial impact which emerged from this were used by the Health Foundation to model the impact that adopting PHC might have on projected funding pressures[20].

In addition to exploring the financial impact that PHC might have, the study also explored, in more detail, wider views about how PHC might impact each service area, including, which areas would be most impacted by PHC and what a prudent service might mean for each clinical area (see Boxes 2, 3, 4 and 5 below).

The methods and key messages emerging from Phase 1 are summarised in this chapter. The qualitative findings helped shape Phase 2, which is the focus of the remaining chapters of this report

METHOD

Initially, 65 system leaders from across Wales were surveyed on line. Participants were asked to estimate the likely impact on current activity trends if PHC made good progress in the next 5 years.[21] Estimates of impact were expressed as percentage increases or decreases against current trends. These estimates were given for each activity-generating component of care, across the four clinical categories. Views on where the most impact would be seen were also sought and used to identify case studies in three local health board areas, for the next part of Phase 1.

The case studies were explored in greater depth in a series of workshops in Hywel Dda, Cardiff and Vale, and Aneurin Bevan Health Board areas for Mental Health, Long Term Conditions, and Frailty and End of Life Care respectively. Representatives from health, social care and the third and independent sectors participated – including frontline staff, managers, clinicians and policy makers.

In the final phase, experts from across Wales were brought together to triangulate data gathered to date. The focus of these national consensus meetings was to validate findings

[19] The 11 activity generating components of care: elective admissions, non- elective admissions, mental health and wellbeing, community contact, average length of stay (elective and non- elective), outpatient appointments, accident and emergency, GP appointments, prescriptions and social care.

[20] http://www.health.org.uk/publication/path-sustainability

[21] An approximate time horizon of five years was selected for pragmatic reasons, to allow people to think about future impact without become ensnared in too many imponderables.

from local work, extend the discussion into clinical areas that had not been considered and to amend conclusions as necessary. Delegates were also asked to provide estimates for the impact of PHC in their respective areas.

A slightly different approach was adopted for Early Years and Prevention. After the initial on-line survey, a single national workshop was convened to explore the potential for a more prudent approach, asking similar questions as for the other three clinical areas, but focusing in particular on the issues associated with provision for the first 1000 days of life, and for reducing Adverse Childhood Experiences (ACEs)[22] (an acknowledged key factor in shaping long-term needs for health and other support).

KEY MESSAGES

The following emerged as key messages from the local and national workshops taken as a whole.

Push towards prevention

- Prudent Healthcare will require the NHS in Wales to evolve to meet the needs of an ageing population, often with long-term health conditions and degenerative diseases. This will require a change in focus and different inputs.
- More resource needs to be invested early to enable a shift towards primary and community care.
- Move to a preventative agenda to change the culture of late intervention.
- Focus on well-being and prevention rather than disease and cure.
- Prudence means simple pathways and flexible, responsive services.
- Reach people before they become patients: health education is key.
- Doing more earlier will save money and create better outcomes for people.
- Resources will be needed to shift focus away from secondary care towards primary care, the community and third sector.
- Current health systems are not yet prudent. Significant organisational and behaviour change needs to happen first.
- NHS Wales leadership must embrace and endorse prudence, and start on a significant process of change.

Share responsibility

- Prudent Healthcare means everyone taking responsibility for their part in maintaining health.
- Put health literacy on the school curriculum.
- Grow people's resilience to reduce their reliance on health services.
- Move to assets based approach. Empower people to do more for themselves.
- Encourage people to take back ownership of their own health so they can drive

22 http://www2.nphs.wales.nhs.uk:8080/PRIDDocs.nsf/7c21215d6d0c613e80256f490030c05a/d488a3852491bc1d80257f370038919e/$FILE/ACE%20Report%20FINAL%20%28E%29.pdf

change. Co-production means staff and service users becoming agents of change.
- Unpaid carers must not bear the burden of delivering the shortfall in services.

Tell the story

- A public health campaign is needed to encourage people to take responsibility for their own health.
- Prudent Healthcare messaging must not be seen to be about cost or rationing. We need to put patients first, while making them aware of finite resources.
- Dementia and mental health awareness for all to encourage a more compassionate society.

Protect don't penalise

- Identify and mitigate Adverse Childhood Experiences (ACEs) to realise the biggest system wide cost savings and well-being gains.

Measure what matters

- New outcomes metrics are needed, and a body of evidence based on people's experiences about what helps them stay well.
- Social, economic and environmental factors are fundamental determinants of human health. The well-being of people in Wales will depend on more than just access to health and social care.
- Enable healthy risk taking, so only the worst cases end up in secondary care.
- Community, compassion and co-production are at the heart of prudent palliative care. Let's open up the conversation around death and dying and make our wishes known.

Work together

- Prudent Healthcare will have a significant impact on the third sector. It's vital that they have sustainable income.
- More working together between social and health care.
- Collaborative approach needed if co-production agenda is to happen.
- Local authorities, health services, the third sector and communities must work together to deliver prudence.
- Co-production is key to prudence and it won't happen without it. The Social Services and Well-being Act needs to change the way we work with partners.
- Prudent Healthcare is relational, and staff and patients need time to train so they can co-produce properly.

Change the script

- Give GPs confidence and training to provide more than just medicine.
- Social prescribing can boost well-being and help build greater capacity for health7.
- Prudence means identifying barriers and helping individuals and communities develop

skills and connect with resources.
- Put the patient at the centre, and help them to achieve goals they have identified for themselves.

Get connected

- Design services fit for the 21st Century.
- Smart technology and digital health solutions will be central to a Prudent Healthcare system.
- Digital health can improve efficiency for staff, patients and service users and its adoption is long overdue.

Be patient

- Change won't happen overnight. In order to embed prudent Principles, we need to adjust the training curriculums from a medical model to a bio psychosocial strengths and relationship based approach.

WHAT DOES A PRUDENT APPROACH MEAN WITHIN CLINICAL CONTEXTS?

The following summaries are taken from local and national workshops where examples from clinical areas identified as most likely to be impacted by PHC were explored. These summaries focus on what will be needed if services are genuinely to become more Prudent.

Mental health

The following key messages (Box 1) emerged from local workshops in the Hywel Dda Health Board area and subsequent national workshop, exploring Tier One primary care and secondary care in the community, Child and Adolescent Mental Health Services (CAMHS), adult inpatients and co-occurring problems.

Box 1: · What does a prudent approach mean in mental health? Summary of findings

Prudence means...

… moving beyond a medical model and from services focused on acute crisis to ones focused on prevention, recovery and co-production;

… keeping people in Tier One services and encouraging them to seek help in the communities where they live. Acute care only be for the most complex cases;

… helping kids grow resilience from an early age by teaching mental health literacy in primary schools;

… new ways of working across a wide range of agencies, including peer mentors. New community organisations are needed to take forward the co-production agenda;

… ending the silo mentality and creating a unified vision. Co-production is key, but staff must be given time out to train;

… encouraging positive risk taking and a culture of shared responsibility. Give GPs the confidence to refer to community organisations and the Third Sector;

… giving people more than just medicine. Grow social prescribing and ask people what works for them;

… normalising mental illness with powerful health promotion campaigns to make looking after our mental health an essential part of healthy living;
… not over pathologising the human condition. See people's strengths and help them to develop tools to cope with life, rather than focusing on "deficits" and illness;
… giving people the tools to manage their own lives and re-imagine their own futures, rather than being passive recipients of "care";
… seeing the whole person and getting care and treatment plans right from the start; and
… investing in the workforce and making sure all staff are trained in how to co-produce effectively.

Long term conditions

Case studies relating to circulatory conditions and musculoskeletal conditions were explored at local workshops in the Cardiff and Vale Health Board area. Type II diabetes, chronic obstructive pulmonary disease (COPD) and asthma case studies were explored at a subsequent national workshop. A summary of findings is given in Box 2.

Box 2: · What does a prudent approach mean in long term conditions? Summary of findings

Prudence means...

… doing more sooner. Prevention can save lives and improve outcomes for patients with chronic disease;
… more generalist posts on multidisciplinary teams to look after the whole person and any co-occurring conditions;
… talking about the tough stuff. Don't wait until someone is morbidly obese and chronically ill to mention their weight;
… reaching people before they are patients, and giving them the tools to manage their own health;
… giving people access to non-medical activities, like exercise and creative activities. Keeping fit can improve conditions like breathlessness and help people stay well for longer;
… simplifying the patient journey and helping people see surgery as a last resort;
… using digital health apps to help people manage their own health and live well with long-term conditions;
… compassionate care. Give staff the tools to cope with people in crisis;
… reducing variation by having agreed outcomes and standards;
… a whole systems approach and an end to working in silos;
… simple changes, like making foot checks as regular as blood pressure checks for diabetics;
… creating timely access for people when they need it, where they need it;
… partnership working across health, social care, the Third Sector and education;
… investing in innovative IT: responsive systems can help reduce harm and promote collaboration;
… de-medicalising back pain and giving people opportunities to manage their own health;
… changing the "Fix Me, I will Fix you" model to a co-productive approach; and
… investing in health campaigns in the community. Get advice about back pain into chemists, supermarkets and leisure centres, not just at the GPs.

Frailty and end of life care

Case studies relating to anticipatory care and dementia were explored at workshops in the Aneurin Bevan Health Board. Medicines management, falls prevention and palliative care and pain management were explored in a subsequent national event. A summary of findings is given in Box 3.

Box 3: · What does a prudent approach mean in frailty and end of life care? Summary of findings

Prudence means...

… understanding that many older people do not define themselves as frail, and can live well with frailty;
… advancing the co-production agenda and helping people collaborate in managing their health;
… doing more in the community, and keeping people living with frailty out of acute care where possible;
… seeing and understanding what matters to a person to help them achieve quality of life;
… taking positive risks to enable a person to be at home, for as long as home is where a person wants to be;
… empowering people living with frailty to do as much as possible for themselves;
… managing health not illness;
… reducing waste and inefficiency by not duplicating tests or pushing people into hospital;
… making dementia everyone's business. Take advantage of free training like Alzheimer's Society Dementia Friends;
… making all communities dementia friendly. It's never too soon to raise awareness of dementia. Have dementia awareness sessions in primary schools;
… talking about death and dying while people are still well and can make their wishes known;
… listening to people with dementia to find out what gives their life meaning;
… making dementia a priority. Have social prescribing teams in communities so people can be given access to social and creative activities to help them stay well;
… encouraging people to engage in low cost activities like choirs and dementia cafes to boost wellbeing and help combat loneliness and social isolation;
… supporting unpaid carers and not expecting them to fill gaps in services;
… flexible, responsive services and promoting mechanisms that enable choice, like direct payments; and
… locating services in communities and supporting people to stay in places where they feel safe.

Early years and prevention

Recent research on the prevalence of ACEs (adverse childhood experiences) in the Welsh adult population and their impact on health and wellbeing across the lifecourse,[23] has generated much interest at a practice and policy level across Wales - and was the topic of discussion for the national workshop on early years and prevention. A summary of findings from this workshop is given in Box 4.

[23] http://www.cph.org.uk/wp-content/uploads/2016/01/ACE-Report-FINAL-E.pdf

Box 4: · What does a prudent approach mean in early years and prevention? Summary of findings

Prudence means...

… mitigating the risks of ACEs by helping people grow resilience early on;
… changing a system focused on picking up the pieces to one geared towards prevention;
… turning around the culture of late intervention and predicting and preventing problems in the first 1,000 days;
… training midwifes to ask women about ACEs, and to do more than just deliver a healthy baby;
… identifying those children and adults who have been exposed to adverse, and enabling them to build resilience and move towards recovery;
… raising awareness of how ACEs can be a barrier to health;
… helping adults who have been exposed to ACEs make better decisions for their own children;
… moving away from a punitive approach to promote safe and supportive public services for children;
… making early years and poverty grants more flexible;
… recruiting people with the right values to work in children's services; and
… Prudence means pump-priming – investing money to save later on.

CONCLUSION

The enthusiasm for PHC was very strong in each of these workshops, as people recognised the genuine opportunities it offered for improved quality and effectiveness of care, greater efficiency and a new sort of relationship between professional, patient and public. This enthusiasm was tempered by a recognition of the issues still to be tackled, which are summarised in this chapter.

The findings from Phase 1 helped to shape the areas for further exploration in Phase 2 of the study in the second half of 2016, the findings of which for the remainder of this report.

CHAPTER 3 - WHAT IS 'PRUDENT HEALTHCARE'?

This chapter explores how Prudent Healthcare policy is perceived in Wales. The first part describes how the policy as a whole is perceived; the second part looks in more detail at how the Principles were intended to work, and then explores the reality of each individually.

PERSPECTIVES ON PRUDENT HEALTHCARE POLICY

The following is an account of what a range of stakeholders in Wales understand Prudent Healthcare policy to be. We explored a number of key areas, asking interviewees for their perspectives and thoughts on the title 'Prudent Healthcare', what they understood by Prudent Healthcare as a concept, and the level of awareness of the policy. We also explored what traction it had in service development and improvement.

Perspectives

The policy was commonly described as a vision, a concept and a philosophy, however some interviewees were less sure of its value as a vehicle for change:

> *'You have to start somewhere and have a vision…and I think the vision is where PHC kicked in with us.'* (Professional Leader[24])

> *'As a concept it's unimpeachable – as a vehicle for change, it's too nebulous and ill-defined.'* (Professional Leader)

It was also described by a national policy lead as 'not an intervention' but an underlying approach that should run through all strands of health board work.

On the title, it was suggested by both health and wider public sector interviewees that 'Prudent Healthcare' might inappropriately suggest that prudent approaches were focused on clinical services. It was suggested a more inclusive term for public services as a whole would be 'Prudent Health'.

In summary, a policy maker gave this definition of Prudent Healthcare:

> *'I feel totally clear about what PHC is and I think it's best understood if you consider why we might be improved…what I say with our £7 billion for 3 million people, what we do is provide 20*

[24] To preserve the anonymity of interviewees, we describe them throughout the report according to one of the following five categories: **National Policy Lead** (including the Minister of the time, the most senior civil servants and leaders with a national i.e. all-Wales NHS role); **Local Senior Manager** (which includes Chief Executives and Executive Directors of Health Boards; some come from a healthcare professional background); **Local middle manager** (a varied group, typically of 3rd- and 4th-in line staff in Health Boards); **Senior Clinical Manager** (practicing clinicians who also hold substantial managerial responsibility locally); and **Professional Leader** (someone talking from a perspective other than that of an NHS employee, including health and non-health). Other sources of quotation (e.g. workshop participants) are identified individually.

million GP appointments…primary care appointments…we give people 26 prescriptions per head of population per year…we refer a million people…not a million people, but a million referrals to outpatients every year that's a third of the population equivalent ….despite that we have nearly half a million emergency admissions… so is that really high value expenditure? I think you have to ask that question. It doesn't feel like it when you look at public health outcomes, the NHS contributes maybe 10/20/25% to those only. So it feels like there is a huge amount of activity on an industrial scale that may not necessarily be delivering what people need. So I think PHC firstly starts with a recognition that maybe that's the case, then it essentially becomes a value-based health care conversation. Actually a lot of that stuff we do is probably inappropriate…either low value or actively harmful. The harm comes in the elements of prudent healthcare which is over complexity and over medicalisation.' (National Policy Lead)

Most of our interviewees, and those we worked with in the workshops, chose to highlight specific aspects of what they regarded as key to PHC, and these are discussed below. Some were perceived as strengths, others as potential weaknesses, but all merited consideration in their view. In their choice of aspect on which to focus, one can see how PHC is being defined in practice by those who are implementing it.

Offering less

'It's about engaging with citizens and the public - that's the bit that's missing…..people see prudent as being thrifty. It's about engaging with citizens about limited resources and communicating the idea that there is a limit to what medicine can do.' (Local Senior Manager)

Clinicians and managers felt that a common perception among NHS staff and the public was that Prudent Healthcare was seen as being 'thrifty'. It was commented that the word prudent was synonymous with saving money, and that some staff interpreted 'prudent' as the NHS 'offering less'. Although none of the staff interviewed expressed this view personally, it was widely commented that this was a common perception more broadly with staff.

It was agreed that better engagement with the public was needed to overcome perceptions of Prudent Healthcare being primarily about saving money. It was also suggested that a broader conversation about finite resources and the 'limits of medicine' would be a good way to engage citizens.

Parsimony

*'Prudent and that principle [parsimony] come together. So when I heard about it, it was like a light going on – that's absolutely as close to the right way to think about delivering the NHS as we can get.' (*Local Senior Manager)

Parallels were drawn between the concept of parsimony and Prudent Healthcare. Examples from End of Life and psychological therapies were given where interviewees felt a 'less is more' approach was more empowering for the patient, and to be mindful of the risk of overtreatment. This sort of approach was interpreted as being 'Prudent':

*'I've always worked under that notion - that to give too much is disabling and to stop the therapy short of a cure – which is a mythology in itself – is the right thing to do, so that you discharge people when you feel they are confident enough that they're strong enough to do it on their own.' (*Local Senior Manager)

'We should not admit people to hospital who are very elderly, we should accept that maybe they are near to end of life and a more social approach to their problems rather than list of diagnoses, tests and investigations would serve them.' (Senior Clinical Manager)

Stopping waste

A common view amongst clinicians and mangers was that Prudent Healthcare was about 'eradicating waste' in the health system. This was viewed as a common sense approach and something that is already aligned to NHS priorities.

Sustainability

A view that was shared between policy makers and mangers was that Prudent Healthcare had a part to play in the conversation about sustainability of the NHS. One manager commented:

*'The NHS doesn't have the resources to continue as it is – we need to look at a wider model. PHC challenges the status quo – away from the way things have been done in the past. [PHC has] given opportunity for the architects of the health service to create a more functional, multi professional, multi-agency - including service users - conversation about what health care is and what healthcare could be and what healthcare isn't.' (*Local Senior Manager)

Other conversations about the potential of Prudent Healthcare to impact on sustainability were centred around service re-design. There was agreement that Prudent Healthcare policy should play a significant role in re-designing services. (There was some debate on what constitutes a service and where a pathway should begin – see Chapter 7).

'At its heart PHC should be about redesigning health services and wellbeing services and people's use of them, in a way that is sustainable.' (Professional Leader)

Local interpretation

NHS managers agreed that there has been 'very broad application' of Prudent Healthcare policy, which has been dependent on 'personal interpretation and a willingness to be involved'. The policy was also described by some as 'amorphous', but this was viewed positively by many because it allowed wide interpretation and wasn't too 'prescriptive'. Many managers agreed that an approach that was too prescriptive would put people off as it might be viewed as too onerous and distracting from other priorities.

Some managers explained that they had adopted alternative approaches to 'being prudent'. Importance was placed on local acceptance and appropriateness. For example in one health board, the 'Value Based Healthcare' approach has been adopted:

> *'We're doing quite a lot of work on VBC and although it's not called PHC, it's the same thing, and our clinicians really like that approach.'* (Local Senior Manager)

It was also explained that the Health Board was committed to measuring some of their work through the ICHOM – International Consortium for Health Outcomes Measurement and this was also aligned to the Value-Based care approach so fit well their aspirations.

Policy makers also recognised that there was wide interpretation of the policy and that people had 'defined it for themselves'.

Alignment with organisational culture

Many interviewees described Prudent Healthcare as something that 'aligned' with what they were doing and with the values of their organisation. One interviewee commented:

> *'It's more about alignment than conscious choice…. it fits with what we were trying to achieve, the values of the organisation, which are about patient experience, patient outcomes, the value patients get from their contacts with clinical services. Also it fits with the University Health Board status, because what does that mean to an organisation that isn't teaching, using evidence, benchmarking, research development and innovation?' (*Local Senior Manager)

It was also described as having 'rationale' to it, and that it would be difficult not to sign up to. Conversely, this was also described as a potential problem:

> *'That's the problem with Prudent Healthcare – why wouldn't you do that anyway?'* **(**Professional Leader)

In response to the question 'what has Prudent Healthcare added?', since it was a common sense approach and not a new idea, many interviewees explained that Prudent Healthcare 'legitimised' some of the more innovative or pioneering approaches to work they were already taking. One clinician commented:

> *'It's added the recognition that all of those things are important – it's not fringe. And that we recognise that this is the basis for running a healthcare system.'* (Professional Leader)

Awareness of Prudent Healthcare policy

It was broadly agreed that awareness of Prudent Healthcare among senior staff was good, whilst further down the structure awareness was poorer. In many conversations, managers explained that although staff were working on projects that would be classed as 'prudent' they wouldn't necessarily know about the policy. This was also reflected in conversations

with operational staff we spoke to in connection with case examples of 'Prudent' work. There were mixed views on whether there was a need to raise awareness with staff. Some managers explained awareness raising had started with more senior staff as a priority, and more work was needed to improve awareness for others.
Most interviewees expressed the view that there was very little public awareness of Prudent Healthcare policy. Many felt that there was a role for Welsh Government in raising awareness of the policy. The observation was made that although one of the intentions of the policy was for there to be 'public awareness', the policy had not been.

> *'Properly launched into the public domain by Welsh Government.'* (Local Middle Manager)

A senior manager in one Health Board felt that 'Prudent Healthcare' as a concept was not easy to understand, and that one needed to be selective with its presentation. For example, concentrating on just one aspect of PHC that resonated with staff was a way of 'starting a conversation', rather than trying to raise awareness of all four Principles. In one health board there was a focus on the resource element of the second principle: 'only do what you can do' was used as a strapline to encourage staff to think about how to be more prudent in everyday practice.

PERSPECTIVES ON PRUDENT HEALTHCARE PRINCIPLES

In addition to exploring people's perspectives on the policy generally, we considered how the Principles were being understood and used.

Awareness of the Principles

Some managers and clinical staff who were involved with or leading 'prudent' projects commented that awareness of the Principles was less than their general understanding and familiarity with Prudent Healthcare policy as a whole:

> *'If you asked a number of my colleagues, what are the Principles, they probably wouldn't be able to tell you…in terms of each separate one… but they have an idea of what's going on and use the word prudent a lot more.'* (Senior Clinical Manager)

Do the Principles make sense?

Leading on from the initial conversation about clarity of the Principles, there was very broad agreement that their content was 'sensible'. There was no disputing the value of each of the Principles in the policy. It was also agreed that formulating the Principles into a policy was helpful:

> *'The thing about Prudent Healthcare is – the fundamental Principles are sound… when you read it you think , that makes sense, but it's useful to formulate into a policy because it directs what you do.'* (Senior Clinical Manager)

'All of the Principles are sound – and match up to the principle of parsimony.' (Local Senior Manager)

*'If people buy into those philosophies, and you can understand those Principles, they're overarching things… they are essentially common sense, but perhaps sometimes common sense is sometimes lost in the complex detail.' (*Senior Clinical Manager)

Clarity

Many of our interviewees had difficulty in recalling the Principles without prompting - this included clinicians, managers and policy makers. There was some confusion over what the final Principles were, with some interviewees recalling some of the draft principles, instead of the final four. For example, many interviewees referred to Principle two as 'only do what you can do' which was wording from the earlier draft principles. Clinicians and managers also commented that six distinct concepts (partnership; care for those with the greatest need first; most effective use of resources; only do what is needed; do no harm; reduce variation) had been fitted into the four principles, which made it difficult to remember them and use. It was generally agreed that the principles didn't 'trip off the tongue'.

There was a difference of opinion on whether the Prudent Principles should be re-worded to address some of these issues. Some felt that re-wording would confuse further, but that some further explanation on each of the Principles to clarify the intention of each one would help:

'I don't think we should think about them again, they have already changed twice… Keep them the same, but clarify why you are doing it.' (National Policy Lead)

The opposing view was that the Principles needed to be simpler to be commonly understood and recognised:

'The work should start now….we should look at making them even simpler. It's difficult to sometimes not get one Principle mixed with another.' (National Policy Lead)

How the Principles work in practice

'I think they have been useful in terms of describing current innovation and actually managing of thinking about further innovation – in a very structured simple way of looking at services'. (Senior Clinical Manager)

A common viewpoint among policy leads and senior clinicians was that the Principles were 'overarching' ideas and useful as a 'guide and an enabler' for thinking and planning ahead. From an operational perspective, the Principles were described as a useful way of 'packaging historic programmes' to demonstrate what has been achieved. There was very broad acknowledgment that a lot of what 'we have done would have happened anyway' but 'the

Principles help to tell a story'. Many interviewees also described the Principles as being helpful in thinking about future projects. They were also described as 'being open to local interpretation'.

Do the Principles work together?

From a policy perspective, there was broad agreement that the 'freshness' of Prudent Healthcare policy was in bringing together the Principles and showing how they could relate to each other. Most of the clinicians and managers interviewed felt that 'balancing' all four Principles in decision making was the 'ideal' approach. One manager commented *'I'd love to see an example of something just hitting just one Principle – can that happen?'* In practice, one manager commented that prudent projects were generally classed as those that *took into account* all four Principles.

Others argued that in practice most initiatives or specific plans tended to focus on only one or two of the Principles. This was not surprising – the focus of such initiatives was inevitably fairly narrow. However, all four Principles needed to be used, with approximately equal weighting, when considering changes to the health care system as a whole.

THE INDIVIDUAL PRINCIPLES

The following is an account of discussions on each individual principle. Some elements of this discussion are explored in more depth in the next four chapters.

Principle 1: Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production

Overall, taking a co-productive approach was viewed positively. In one example, where all the staff within an Audiology service had received co-production training, it was commented that 'nobody has been negative about the approach'.

There was general consensus among clinicians, managers and policy makers that the first Principle holds the most potential to transform the health system. One national policy lead commented: *I think co-production still remains the one that will probably transform the system if we really went for it*.

It was highlighted by a clinician, however, that the consequences on service provision of embedding co-production were largely unknown - we may 'end up with a remarkably similar system' if co-production was embedded. *The outcome of course is that they've [patients] had a part to play'*, and the presumption was that this would be a 'better' service.

There was also broad consensus that co-production would be the most challenging of the four Principles to embed meaningfully and where the least progress had been made to date.

Several managers explained they are not delivering at pace equally across all four Principles, with co-production being the slowest to gain momentum.

One of the explanations given for the slowest progress being made on co-production, was that it was a 'newer' concept and not already an integral part of NHS business. One manager commented:

> *'Co-production is a new thing to us to be honest – it's a new approach, talking to [clinical colleagues] from other areas, it's not something they've come across…'* (Senior Clinical Manager)

This was described as a contrast to the other Principles, which are aligned to explicit NHS priorities and were described as 'normal business'.

Another perspective on why co-production might be a challenge to embed was described by many clinicians and managers as the lack of citizen engagement, partly due to poor awareness raising of co-production with the public. One professional leader commented there has not been *any serious attempt to get citizen ownership [of their health]… all effort is put into health professionals.* It was also suggested that citizens have less awareness of resource pressures on the NHS than professionals and that they are unaware that they *should ask for less from their GP*.

Staff engagement with the Principle could also be a challenge:

> *'Co-production works – it's just getting the staff to take it on.'* (Senior Clinical Manager)

Policy makers and clinicians also recognised the challenge associated with fundamentally changing the way in which health professionals engaged with patients. The need to take on patient views meaningfully and the willingness to share power emerged as two challenges to embedding a co-productive approach. One National Policy Lead commented:

> *'I think because we find it hard…bringing patients into our process….our lives….you have to stand back and think differently about the system and need to trust the patients….it's another thing for clinicians to make their own step forward to accept that patients sometimes do it in a different way and they need to embrace it too. I think there is hesitation still about what it means to draw patients in.'*

Finally, there was also some agreement between clinicians and policy makers that co-production with patients and between professionals was a necessary element of embedding the other Principles. For example, it was agreed that the third Principle, summarised as '*only do what is necessary and do no harm'* could only be achieved if patients were involved co-productively in the decision making process around their treatment options.

Principle 2: Care for those with the greatest health need first, making the most effective use of all skills and resources

Discussion of the second Principle centered on prioritisation of health care and workforce development. On the prioritisation of care, some interviewees expressed the view that it sounded like 'rationing' and that it may cause difficulty:

> *'Treat people in priority order sounds a little bit like you are rationing… that's the one people will have the most difficulty with. But it is not wrong.'* (Senior Clinical Manager)

Prioritisation of care was largely talked about in the clinical context. There was also some recognition that this Principle linked to health needs on a population level, primarily by public health professionals but also by policy makers, managers and clinicians. It was also the aspect of the policy that aligned thinking about prevention and tackling health inequalities. One clinician commented:

> *'On caring for those with the greatest needs first] It's about tackling inequalities. So that's a question of health inequalities as a result of wider social inequalities. It's about the whole social structure and politics. So it's about looking to health to address inequalities in society. Not an easy solution… and it means tackling the most difficult people first.'* (Professional Leader)

One public health leader raised the question about how prioritisation of care might impact existing services that are provided not solely based on need.

The question of how and who determined need was also raised, with several clinicians raising the question about the patient's role in defining need. Several asked the question 'who defines need'? Another view was that a broader conversation about 'wants' would be a good way to get to the 'needs':

> *'If you don't address the wants, you won't get onto the needs – you won't convince the person of the needs.'* (Professional Leader)

Following on from this there was a broader debate about how to balance 'wants and needs'. One Professional Leader commented:

> *'I think there may be some areas of healthcare, where it is perfectly reasonable to say, no matter how much you want that… it is not available. And that is a decision for society at large to make… informed both by evidence, clinicians, managers, politicians, and public.'*

Many interviewees referred to the workforce element of the second Principle as 'only do what you can do', which was the original wording for the second principle. This was mostly viewed as a very positive approach to making the NHS more Prudent. One Senior Clinical Manager commented:

> *'I'm a strong believer in the only do what you can do element.'*

This lead to discussion about 'working to the top of your license' as a basis for workforce re-design. There was consensus that 'making the most effective use of all skills and resources' was prudent. The view was also expressed that it was likely to be a 'quick win' and 'likely to make the most difference' overall to making the health system more prudent (along with co-production). Clinicians and allied health professionals agreed that there was risk of introducing rigidity to the workforce through creation of artificial divides between roles within a team if 'only do what you can do' was applied as a rigid rule:

> '*It could easily re-establish a very hierarchical approach. And I don't think it's realistic. Because I think the boundaries about how we work are always blurred. So that there are sometimes things that can be done – quicker and cheaper – by somebody else, but the nature of your relationship with the patient or the system. It actually makes sense for you to do that as well.'* (Professional Leader)

It was agreed that 'only do what you can do' would be a good approach if taken as a guiding principle as opposed to a rigid rule.

There was also extensive discussion about potential changing workforce requirements if a more prudent approach was taken. Several managers and clinicians highlighted the potential expanding role of allied health professionals in primary care and how this might impact the role of the GP:

> *'Workforce is probably a quick win. There is a job to look at skill mix and workforce development. We're hearing from patients – I don't care who sees me. As long as the person is competent. Which is a shift from… I want to see the doctor because they know it all. Now they assume whoever they see is competent.'* (Professional Leader)

Principle 3: Only do what's needed: Do no more, no less, and do no harm

There was little debate about the value of this Principle and it was something NHS staff were very familiar with. However, it wasn't recognised as something that would be 'transformative' in the way that the first two Principles had the potential to be. It was also mentioned that there was potential for faster progress in this area, because it is familiar and people were 'signed up' to the concept already. There was broad recognition however that having a national policy stating this clearly made clinicians more 'comfortable' with managing patients in more flexible ways:

> *'Only do what's needed: Do no more no less, do no harm - Something that wraps around what we do – that makes us more comfortable… that we can manage patients more distantly.'* (Senior Clinical Manager)

It was also mentioned that this Principle challenged the culture of patient contact based on need as opposed to risk. It was explained that 'only do what is needed' should take into account the level of risk a patient is experiencing in addition to their need which would prevent overtreatment.

It was also acknowledged that there was some alignment with this aspect of the policy and the 'over diagnosis movement':

> *'Speaking for general practice – what has really taken off over the last few months is the over diagnosis movement… that comes from a feeling that we've over treated.'* (Professional Leader)

The further point was made that alignment with the over diagnosis movement may be a good way to respond to get traction on the Prudent Healthcare agenda:

> *'The over diagnosis movement is quite successful – it's a good handle. Probably more medical than other disciplines – how do we improve penetration and system responding to the Prudent Healthcare agenda? I think over diagnosis is one way of doing that. It seems to be catching on quite a lot. And it's disruptive – and I think quite a few of my colleagues would like that.'* (Professional Leader)

This Principle was also described as one where there was a 'good handle' on the evidence base that would help to measure progress. The NICE 'interventions not normally undertaken' list was mentioned as a potential outcome measure to check progress on this Principle.

Principle 4: Reduce inappropriate variation using evidence based practices consistently and transparently

The fourth principle was quoted as one that the NHS was much more 'familiar' with because it had been around longer. It was also quoted as having potential to make a difference and that it was very much part of NHS priorities already, so would be easier to do:

> *'This is much more familiar – because we have been at it for longer.'* (Professional Leader)

But there was also recognition that there was still much work to do to achieve this and that it was a valid focus for Prudent Healthcare work:

> *'We haven't bit the bullet on that one… in terms of trying to address variation. We haven't addressed it. We've just said.'* (Professional Leader)

One aspect of reducing variation that stimulated discussion, with both clinicians and policy makers, was the distinction between reducing variation in treatment approaches (whether that was medicines or therapies) and reducing variation in health outcomes. It was recognised that in order to provide a service that meets needs and is flexible enough to be prudent, there would inevitably be a need for variation, but the focus should be on reducing variation in outcomes. This was explained in terms of equity versus equality:

> *'What you don't want is inappropriate variation in the outcome or the quality of care. If you have to do something differently for a patient or group of patients – that's fine. As long as the outcome is the best they can achieve. When we look for equality and equity – they are very*

different things. As long as there is equity in the outcomes. How we actually achieve that is different in … different geographical areas.' (Senior Clinical Manager)

CONCLUSIONS

This chapter has given an account of key perspectives of Prudent Healthcare policy as a whole and on each of the Principles. Key issues include:

On the policy as a whole:

- Prudent Healthcare policy provides a useful and attractive vision and philosophy
- There has been quite wide interpretation of the policy across Wales – this is seen as both a strength and weakness
- There is need for an awareness raising campaign for staff and the public on Prudent Healthcare – potentially by Welsh Government

On the Principles:

- The Principles are 'sensible' and help to shape thinking on current and future innovation
- Of the four Principles, the first and second Principles were identified as those with the most potential to make a difference overall
- The first Principle – relating to co-production – was seen as the one that would be hardest to achieve, over the longest time scale

There are many examples here of the policy being appropriated and colonised in ways which managers and practitioners feel is consistent with the Principles but has greater practical value as a tool for change.

CHAPTER 4 - IMPLEMENTATION

This Chapter considers how Prudent Healthcare was introduced to NHS Wales, and how it has subsequently been propagated and embedded. The first part of the chapter considers the intended model of change underlying the policy; the second part explores other factors which appear to be governing the scale and pace of implementation.

THE INTENDED MODEL OF CHANGE

The introduction of Prudent Healthcare was, by any standards, a significant process of change, intended to affect the nature of millions of patient:clinician interactions, the structure and behaviours of the workforce, the 'culture' of services, and the interaction between those services and the public. In the introductory chapter five key facets of the intended approach to this change management exercise were summarised:

- a mixture of national leadership and strong local determination of the detail of the approach ('top down' and 'bottom up');
- a relatively long timescale;
- a broad engagement, sometimes likened to a 'social movement';
- a determined attempt to learn from each other and share good practice; and
- all set within the relatively new legislative framework of the Wellbeing of Future Generations Act and the Social Care and Wellbeing Act.

Each of these facets has attracted some discussion amongst the various stakeholders, with varying views about the effectiveness of the approach taken. These are discussed below.

Top down and bottom up

The architects of the policy were clear that change on this scale, requiring as it did, a change in the behaviours of thousands of staff, could only work if those staff were effectively engaged:

> *'Part of it is cultural shift - as part of a social movement that we need to take responsibility for our own part. And then the authorities providing you with the wherewithal to do it. Given the opportunity, people have shown they are very willing to play their part.'* (National Policy Lead)

In this conception, the national role was to stimulate a debate, to refine and improve the Principles and overall framework, to support local innovators (by addressing structural impediments, sharing good practice, and lauding their achievements) and using whatever levers are available (notably through the planning and performance management regimes) to stimulate change. Care was taken to ensure that the launch of the policy at the Welsh NHS

Confederation conference was immediately followed by a series of practical actions. For example, there was a recognition that many innovators, isolated in their part of the service, needed help to tackle bigger structural elements:

> *'Your ability to make a change has got to do a lot with where you are in a system and how amendable the system is itself to make a change…..I think its's partly because of being anxious about that kind of reaction, that I thought we needed a few system wider demonstrators.'* (National Policy Lead)

Making outpatient services more prudent became a focus of attention:

> *'Outpatients is full of people turning their tiny bit of the cog and if you said to them – we want all this to change, they wouldn't know how to make that change from where they are. But if you could take something like that and show that it could be done differently then you might give some hope to people in different parts of the system.'* (National Policy Lead)

Eye services also attracted attention, as a system demonstrator of slightly different characteristics:

> *'It's different to outpatients. It connects the whole pathway. It sees huge volumes of people. It's overwhelmed by seeing patients in the way that it sees them now – so if you could see them differently. So how would you apply the principles to that strand – as a slice of the whole system, the numbers are big enough, you could then do it in another system where there are lower numbers.'* (National Policy Lead)

In these areas, Government was trying to follow through on its desire to create practical demonstrators of the possibility and desirability of change, without turning Prudent Healthcare into a top-down and micro-managed process. Instead, in the first two years at least, local actors were left to determine their own priorities. And this approach was reflected at Health Board level. In one, for example, typical of many in this respect, enthusiasts were invited to identify themselves:

> *'It's from the bottom up – whoever has come forward.'* (Local Senior Manager)

A very modest central, dedicated resource was then made available to support what were essentially clinically-led initiatives, with the consequences that take-up was patchy:

> *'It's about organisational commitment, resourcing, strategic alignment… But rather than impose it – we've set up a small team and they're acting as a catalyst for the conversation… some teams got this – saying absolutely yes, and are running with it, others a bit more ponderous around it but are starting to engage in it now, and there are a few where we're not quite there.'* (Local Senior Manager)

> *'How do we reflect the work in the IMTP? Having a section as [Prudent Healthcare] makes it sound like an initiative – and it's not it in the organisational plan. It's not something that we want to pigeon hole as a project.'* (Local Senior Manager)

In another Board, a more centrally-led approach was tried at first, but then abandoned because it was not delivering the level of engagement that was recognised as essential:

> *'The Director of Public Health led a cross cutting Prudent Healthcare theme – looking at big ticket issues across the organisation – but this approach didn't work so well. It felt like PHC was an add-on…..We have tried to make sure that the principles, philosophy and activity don't get into a stream of work or consciousness that feels like an add-on….we've tried to make it everybody's business every day.'*(Local Senior Manager)

The person with lead responsibility for Prudent Healthcare now

> *'…has no staff whatsoever to work on Prudent Healthcare – it's just her plus goodwill!'* (Local Senior Manager)

A third Health Board adopted a similar approach, placing great value on Prudent Healthcare as a way of analysing its services, but not as a top-down series of activities, with the associated performance management and behaviours. It was useful – and would have longevity – if it assisted such reflection:

> *'If it is a lens – it will stick around - If it's a programme it won't stick around*.' (Local Senior Manager)

The Prudent Principles were described by senior member of that Board's team as a *'coat hanger'* on which topical issues could be hung, thereby facilitating their scrutiny:

> *'It doesn't generate 'new' streams of work, or prompt new kinds of solutions, but it provides a focus… Prudency has become a real test against which everything that is done is measured.'* (Local Senior Manager)

There has been some debate, however, about the best balance between 'top down' and 'bottom up' - about the extent to which the Minister and Government should require the NHS to make specific changes to make services more Prudent, as opposed to allowing services to formulate their own response to a set of Principles. (This is closely associated with the question of metrics – what precisely was Prudence expected to achieve – which is discussed below.) While most of the people we interviewed in Health Boards and Trusts welcomed the fact that Prudent Healthcare was not micro-managed from Government, and that there was considerable scope for local interpretation, some argued for greater clarity on the nature of the change required, and insistence on its achievement:

'I'm more of a benevolent dictator than a distributive leader ... We do want it to be bottom up but unless we get some direction [it won't happen].' (National Policy Lead)

The adoption of three national foci for Prudent Healthcare in 2016 (see Appendix 1) in part reflected a different approach from Government – one more orientated towards achieving demonstrable changes in a fairly short period of time.

A relatively long timescale

Some interviewees highlighted that some work that aligned strongly to a Prudent Healthcare approach was already underway in Health Boards before launch of the policy in 2014. It was acknowledged that these were pre-existing priorities:

'This is not a new thing – we've been at it for a while. [The Medical Director] took a paper to the Board in 2013 – it wasn't called Prudent Healthcare…I think it was about clinical effectiveness in care delivery. It's not something the board have really pushed, it's just grown, and we've taken opportunities.' (Local Senior Manager)

Although the timescale for Prudent Healthcare was not quantified at the outset, the assumption among the architects of the policy was that it would take beyond the current term of the Assembly (to 2016) for the Prudent Healthcare policy to start to show results. It was possible to start making simple changes early on, for the immediate benefit of all concerned, but the scale of the task would require that effort to be sustained:

'We all need it to be better so we all have an interest to re-engineer it. It's not so difficult really because the work we do we are generating for each other…. ourselves. So if we just stop generating some of that work that would make life a lot easier. We can do that almost tomorrow… don't refer unless it's really the right thing to do…or if you do refer get the hospital to answer with a phone call or whatever it is. We can do things differently tomorrow that would reduce the workload and costs we face. Potentially we can free ourselves up a little bit and be a bit more longer term.' National Policy Lead)

'Up close, cultural shift looks impossible – but you can achieve it. It's a long haul. Changing the relationship with the public was always going to be slowest – because that's the biggest cultural shift.' (National Policy Lead)

When asked about the timescale it will take to implement PHC, one National Policy Lead responded:

'Some of them can happen quite quickly…it depends on people having the vision to want to put them into place…and not many people do…we have to do what we can to keep pushing it and providing the leadership tools and enablers.' (National Policy Lead)

It was therefore an important test for Prudent Healthcare when a new Cabinet Secretary was appointed after the election: would he clearly and enthusiastically endorse the policy of his predecessor? He did, and indicated on many occasions that it would remain a priority through to the next election. However, choosing to emphasise three specific areas for progress inevitably had the effect of requiring progress in a somewhat shortened timescale than that envisaged at the start. It also helped to move the emphasis away from individual (and sometimes rather disconnected) prudent initiatives towards large-scale, systemic change. The intention became to:

> *'Take two or three of those really big things that the health service does all the time and say right, we're going to grapple with this. And the way we do this today will not be the way we do this in two years' time. That will be a different sort of challenge… because it won't be about a few individuals with initiative and enthusiasm. It will be about the whole system being shaken up – and use the facts. Saying look, this can be done, now let's tackle something that lies beyond individuals.'* (National Policy Lead)

The change of Ministerial leadership coincided with a growing emphasis on the need to deliver change in many areas within timescales which were felt to be more appropriate given the escalating challenges which the NHS faced. Prudent Healthcare was also affected by this imperative, and timescales were more frequently discussed, and the demand for demonstrable impact grew.

Broad Engagement

Prudent Healthcare challenges conventional views of the purpose of healthcare, since it emphasises outcomes rather than the more common preoccupation with activity. This requires substantial engagement:

> *'Prudent Healthcare is fundamentally about how we view health and wellbeing – both as citizens and consumers but also as people we work in healthcare. That only happens when there is significant buy in.' (*Professional Leader)

There was a deliberate attempt from the start to take the message of Prudent Healthcare directly to clinicians and others at the heart of the NHS, and not to rely solely on the hierarchical communication lines of Health Boards and Trusts:

> *'You need to connect that to people wanting to be part of something and know that they are going to be supported in doing so.'* (National Policy Lead)

> *'I think what (PHC) immediately brought is a lot of clinical interest – so the clinical teams were really interested in the patient reported outcome stuff, they were really interested in the ICHOM work. They were really captured by the thought of being able to compare and contrast their outcome, not only within their clinical teams but actually clinical teams in a sensible way across…*

internationally…but also, to be able to understand the granularity at a local level at a team level – and aligning what patients were saying and what they were actually doing in a clinical setting.' (Local Senior Manager)

The aim was to get people:

'Across the system to expect top down involvement but not to be driven top down …to allow it to be a broader discussion beyond the usual suspects… there was a danger that you would just ask Chief Execs to sit in a room and come up with another great concept and I think (the Minister) stepped aside from that.' (National Policy Lead)

'Part of it is cultural shift - as part of a social movement that we need to take responsibility for their own part. And then the authorities providing you with the wherewithal to do it. Given the opportunity, people have shown, they are very willing to play their part.' (National Policy Lead)

Other policy initiatives relied on a similar model of change. For example, the development of Primary Care Clusters was in part effected through channelling resources directly to the Clusters and encouraging Health Boards to allow them to develop with a 'light touch'.

Getting the message right for these audiences was a key early challenge – to make clinicians and others realise that this was a serious attempt to improve the quality of care, to deliver better outcomes, and to improve their own job satisfaction, primarily by doing things that add value:

'It was from the very beginning very, very simple – if you haven't got the resource, how do you try and give up activity that is of low clinical value, and recycle that to activity to something that is of better clinical value. If (we) couldn't get the health service interested, then there was no point – (we) had to start with people (we) had the best access to and then see where (we) could go next to new audiences. The first thing was to get people involved in the best provision of health.' (National Policy Lead)

This was echoed by a local clinical leader:

'People get now that the pot is not overflowing and we do need to be a little more careful… about what we do, and actually patients might like something different.' (Senior Clinical Manager)

The next stage, which had to follow on rapidly, was to demonstrate to these audiences that there was actually some substance to these ideas – that concrete changes could be described and realised, that would make a worthwhile difference and start to implement the Principles:

'If you want to create a movement around something, you have to demonstrate that something is changing. Otherwise it's just a slogan and nothing has changed. I was always keen to try and

find practical things we could point to – so people could see that things could be done differently.' (National Policy Lead)

Before the formal launch of the policy:

'We got people around the table. We asked them to look at clinical areas (pain management, orthopaedics) then asked them to look at problems with a PHC lens and asked them what they would do - What would you do differently, how would this service look, if you were looking at it through this lens?'(National Policy Lead)

Partly as a result of this approach, and from the fact that senior people in the NHS recognised the Minister's own personal commitment to the policy, a personal element started to become apparent:

'The final bit the model of change felt a bit more personal. If you heard the Minister speak on these issues as he was cajoling the systems differently along the way it was quite a personal connection with him in his Ministerial role… staff felt motivated by that….Ministers are there to be at the top of the tree and the hierarchy… I thought that was quite an unusual aspect… people were warming to a Minster reflecting in quite personal terms… some of their own personal philosophy.' (National Policy Lead)

Some interviewees discussed the difficulty in getting some clinical groups to commit to the difficult changes sometimes required by Prudent Healthcare:

'It's about appealing to people to actually no longer provide services that they just would not accept themselves or for their family, but we do routinely. For me if I was a GP I would think it never acceptable for anybody would have to wait 4 months for an answer to my question… never acceptable. We should always provide an answer where we can within a few days…we have become tolerant of this delay which doesn't benefit anybody and some people will be lost in that. We have become tolerant of the fact that we harm people in hospital at the rate they do… we mustn't be tolerant of that… we wouldn't be happy if it was our mothers.' (National Policy Lead)

Learn from each other and share good practice

Part of the notion of a 'social movement' which was to drive – and embody – Prudent Healthcare was that change would be hastened and scaled up by different elements of the service learning from each other. This is not a new concept, and has been applied – with mixed success – to most major policy developments in recent years. It was envisaged that the learning would take place at the level of detailed service redesign – at a *granular level* (Local Senior Manager) and by becoming an established concept in *the way we do things in Wales*. Many people argued in our interviews that there was strength in numbers:

'There's something about a ubiquitous concept that isn't just about a single Health Board... I would see it as part of a cultural change within the NHS in Wales…Why does it matter what other Health Boards do? Because staff and patients move between HBs, and if you want a social movement, the more people involved the better... if you're hearing a concept discussed not just within but also out with... there comes a point where you've got to hear. It's important that all levels of the clinical community are engaged in this.' (Senior Local Manager)

There was also a sense in which people within the same team could learn from each other. One successful clinical pioneer of prudent approaches described how he approached a mixed set of clinical colleagues:

'A few swear they will never change… but actually, you leave them out of it, you don't waste time with the difficult few…because once everything else changes, they think oh, I'm being left out here a little bit, so they join the pack. So I never waste too much time with the difficult few, because there are always going to be the difficult few. But if you can achieve change with the rest, then fine…..It's picking the right people at the front end to become involved and then spreading it. Once that clinical buy-in was crucial…once we had it and you get all the evidence out there as well… even the most intransigent of people, if you give them decent evidence will sit back and think…and often will change.' (Senior Clinical Manager)

Much of the reluctance to change stems from a concern to avoid patient harm. Once a more prudent approach has been tried and becomes familiar, people are more prepared to adopt that approach:

'It's a clinically safe thing to do.' (Senior Clinical Manager)

But this often depends upon the change happening in a service with which they are familiar, so that they are able to form a judgement about it which satisfies their own levels of proof:

'We are not risk averse, we are change averse sometimes.' (Senior Clinical Manager)

Set within a new legislative framework

Government figures whom we interviewed were clear that the Prudent Principles fitted well with the requirements of the *Wellbeing of Future Generations Act*, and that this was important in the policy's success and legitimacy:

'We've got the right legislative framework, so the requirement to work with other public sector organisations in a very upstream way is already there in the Wellbeing of Future Generations Act…..also, the principle of co-production or the fundamentally different power relationship is implicit in the wellbeing of Future Generations Act as well. The Commissioner says that her favourite of the 5 ways of working is involvement which I call co-production…so that's a good start, but then there is just awareness…people need to be aware the demand we behave so

*passively around is actually generated by us and within our own immediate direct day to day control'. (*National Policy Lead)

Perhaps not surprisingly, the wider legislative context of the policy was very seldom mentioned by interviewees from the NHS, who were universally concerned about the potential of Prudent Healthcare to transform services, and improve health outcomes, and made little or no explicit reference to the connections between this and the Act. An observer from Social Services remarked on what she perceived as a crucial difference between the outlooks of health and social services towards legislation:

'The difference between health and social care is that health are not held to account – legislatively. The Social Services and Wellbeing Act is sort of the legislation that supports implementation of PHC.' (Local Middle Manager)

OTHER KEY FACTORS AFFECTING THE SCALE AND PACE OF IMPLEMENTATION

Alignment between Prudent Healthcare and existing local initiatives

As we have seen, most Health Boards did not wish Prudent Healthcare to constitute a programme of activity divorced from other work within the Board. Their intention was that it should not be in an organisational 'silo'; rather it should help to shape work which might already be contemplated or already in train, and should be widely adopted. Many of the people we interviewed argued that Prudent Healthcare had rarely triggered change which was not already taking place. What it had done with some success was to enable greater progress in areas which had proved difficult hitherto:

'Prudence fits with a number of things we have been trying to grapple with for years: waste, harm and variation; PREMs [patient reported experience measures] and PROMs [patient reported outcome measures]; clinical outcomes; wider population-based outcomes; INNU [interventions not normally undertaken]; Choose Wisely; shared decision-making… I think its keeping the conversations alive and going... There have been conversations for 20 years on INNU, but they came and went and were not systematically embedded and revisited; often only triggered where there was a need to save money towards the end of the financial years… We've put in a useful concept that won't go away, we've got to keep paying attention to it, and we can keep using it, as well as the tools, to get to where we need to be.' (Local Senior Manager)

'Some things would have been going on anyway, [but] I think it wold have been very difficult without Prudent Healthcare - it provides sufficient challenge.' (Local Middle Manager)

People could cite specific projects which, because they were now perceived as being 'prudent', had significantly more traction and likelihood of success:

'It raises profile because we have to report on PHC – so the Director of Finance gets to see the outcomes of the programme… he starts to see that prevention pays… we saw it as a vehicle to

promote public health – and raise the profile of the work we were doing.' (Local Middle Manager)

'It's had a lot more visibility - we report a lot more regularly on it through the health board.' (Local Middle Manager)

It also helped to sharpen the thinking behind proposed new service developments, and to ensure that they remained focused on outcomes:

'It gets *people to think twice, to look back at PHC principles to check what they're doing – it's a really quick initial check and helps to shape the project plan. [It] helps people to check projects that have been running for years – and to check how their projects align with Prudent Healthcare.'* (Local Senior Manager)

There was also some evidence that the advent of Prudent Healthcare might be contributing to a different emphasis, helping people to cope with significant financial pressures by focusing more on outcomes and added value:

'Because we've been living in austerity – and we've have all sorts of cuts… prudent really focusses the mind and really focusses services.' (Senior Local Manager)

But not everyone was convinced:

'PHC policy has perhaps given more focus to some clinical areas – but there are no real examples of work that wouldn't have happened without PHC.' (Senior Clinical Manager)

And clinical engagement has not been universally successful. When the immediate pressures of insufficient capacity present daily frustrations to clinicians, their interest in Prudent Healthcare may not be apparent:

'A lot of the responsibility is on the profession I don't think many of my colleagues would see delivering PHC a main priority. Priorities are needing to free a bed – and access to therapy. They can't get CBT.' (Professional Leader)

Prudent Healthcare and finance

The potential financial implications of moving towards a more Prudent pattern of healthcare were the subject of the first phase of this study (see Chapter 2), and are reported elsewhere[25].

The linkages between adopting more Prudent approaches and the financial regime of the NHS are important. One great opportunity reported by many was the opportunity it gave to

[25] http://www.health.org.uk/publication/path-sustainability

engage clinicians in a discussion about resource utilisation by focusing on how best to add value to patient care:

> *'We know, that going at doctors at budgetary management is the wrong way to approach it but when you can align resources to clinical care pathways and outcomes, they're really up for a conversation.'* (Local Senior Manager)

It can open up a new approach to clinicians' engagement:

> *A rate limiting factor was cited as not having strategic buy in and having a reactive approach to cost saving….'this absolutely sounds brilliant, I want to get on board with this, but I've just spent two hours with my divisional director, him telling me that I'm over spent on my budget and we know that the Health Board has got a deficit'. So there is the reality of today, trying to make ends meet, versus actually this will give us a strategic approach to marry some of these things in for the future.'* (Local Senior Manager)

When it comes to implementing prudent changes, it was important that this more constructive tone continued, and particularly avoiding any notion that becoming prudent was just about taking money out of the budget. One successful clinical leader reported:

> *'To get real buy in of the surgeons we had to make it clear that something had to go back in to improve the pathway, not necessarily to those surgeons, but to improve the Musculoskeletal type pathway, so it wasn't just a cost- cutting exercise, we've had some savings that have come out of it, but equally we've had some reinvestment, which is the important thing I think… Since I've been a [clinical manager] we've been hammered with [Cost Improvement Programmes] so you've got to trim bits of a service just to provide a reduction in your budget every year… it was about 5% so that's a big chunk of money that you have to suddenly take out of a system… and I think that is a disincentive for many people to change the practice… you know how difficult it is for medical people to change behaviours…if there is not carrot it becomes more difficult.'* (Senior Clinical Manager)

> *'We made sure we had the right people in at the start, we had people from finance in at the start as well and made it very clear at the meetings that some of this isn't releasing cash for them to spend somewhere else.'* (Senior Clinical Manager)

But this can be difficult, and the desire for prudent approaches to be *cash-releasing* cannot be allowed to stifle innovation:

> *'If we have such a pressurised system that if we take away a few slots they don't just stay empty they fill up with something else, because the pressure on the system is such that everything is just filling up every time you make any space – actually what it does then, is reduce the back log. Reduce the back log need for doing any waiting lists so it becomes more efficient, but sometimes the finance guys don't see that directly because there is not: right we'll stop this clinic and we save this much. Slight leap of faith but we got the right finance people involved and they could*

see it. It took a while – historically in the NHS, you've got to close this ward and we can't at the moment, but it does take pressure out of the system.' (Senior Clinical Manager)

Some were concerned at what they regarded as 'mixed messages,' when additional money was released towards the end of the financial year to provide for additional activity to reduce waiting times, even though such activity was not particularly Prudent:

'Extra funding at the end of the year to reduce waiting lists – paying for expensive procedures privately (hip and knee replacements).' (Local senior manager)

There was some support for Welsh Government ensuring that its policies were consistent in supporting more Prudent approaches, and particularly for the creation of a resource to fund the double-running and other transitional costs of prudent changes:

'The hard edge is the Welsh Government… they have to realise they have to have a transition fund, they have to look in a very serious way in which way the money is distributed. In fact there was a recent Northern Ireland report looking at a new system. What they said is this is what you lot have to do but it's going to be led by the government showing that they are really committed to this that it's not going to change, it's going to deliver benefits and you're going to get on with it, and therefore construct their policies in that way. Now I don't think we've got that yet.' (National Policy Lead)

Leadership challenges

As with any major process of change, effective leadership is a key determinant of success. One element is maintaining focus and momentum:

'I was always trying to work out with Ruth, what can we do next, sometimes it's just symbolic stuff, it doesn't necessarily change directly, but maybe sends a message. So you can see something. Maybe a PHC publication that people might read. Always keeping the show moving along. Be anxious that you might run out, energy might dissipate, it might be one of those shooting stars, that in 10 years' time nobody can remember quite what it was. Energy might dissipate…. I guess the danger of that is that success becomes just movement…as long as things are happening.' (National Policy Lead)

Another element is about the ability to make difficult decisions about the future of services:

'It's about leadership. Willingness to challenge some vested interests as well. The health service is not very good at that…it's very accommodating. Always trying to find a way of making everyone happy.' (National Policy Lead)

Ensuring that clinical and managerial leaders work together, with a common set of goals and assumptions, is one gift that Prudent Healthcare can offer:

'I think what Prudent Healthcare also was is actually provides common ground for clinicians and managers and it says that everybody should be interested, it's not just a clinical or management issue.' (National Policy Lead)

A lot of this work is led by clinical leads…if you understand the nuances behind the service… they are the key people who make the change. That isn't disrespect to managers. I don't think they understand the service or the interactions we have with patients to drive the change that is needed. Very often it's not the clinicians that don't want the changes….they don't feel empowered or have the ability to do that.' (Senior Clinical Manager)

When asked who has to be involved one Local Senior Manager responded that:

'The team….includes people from finance and workforce: some of the specialist nurses have done a fantastic job. We've done quite a lot of work on activity based costing….to align some of the cost of the service with outcomes.' (Local Senior Manager)

Within Health Boards and Trusts, the predominance of 'silo working' can perpetuate imprudent approaches, leading to artificial divisions along the patient pathway (for example, between primary and secondary care) and between elements which need to work together to deliver the same elements of care. One interviewee had experience of a management structure that fitted well with a Prudent approach, and then witnessed its disruption:

'We had an MSK [Musculo-Skeletal] directorate…..and that really made things sensible, in terms of all the right stakeholders joined up, all run by the same management team. So it was an end-to-end pathway… within the same directorate things like chronic pain, rheumatology, osteopathy some of their students joining in… around patients and NICE guidelines… but then it was pulled apart, bits to primary care, bits to (one locality), it's all been fragmented… you lose that connected approach to things… much more difficult to institute change.' (Senior Clinical Manager)

Leaders can use a variety of levers in the system to help the process of change. The planning system is one obvious one:

'My role has been to ensure PHC approach is in the IMTP and business plans.' (Local Middle Manager)

In theory, the planning process is a good way of creating the multi-disciplinary and multi-organisational working which is needed. But it may not yet be operating optimally:

'For me one opportunity we have which we don't take at the moment is the planning process. Firstly all of our plans and we have these stonking great big plans, should be prudent plans. Basically hospitals should have plans to make populations less dependent on them, so they have to find different way of dealing with whatever comes their way …often by being in the community providing a more proportionate response not wasting money time and effort. The opportunity of a plan is that it's a vehicle for engagement because I can't see how (Health

Boards) can deliver on a plan unless every clinical service element in the organisation understands the part they have to play in that plan. So every service needs to have a plan which would be a prudent plan generally a shrink strategy which in hospitals you want clinicians to be actively trying to put themselves out of business. They never will…I want them to have mechanisms to understand what a more prudent set of pathways would be…we are starting to see that… cardiologists who are usually the most unlikely to change because current situations suit them well….actually they are starting to look at how they respond to GP referrals in a way which eases demand… everybody needs to be doing that in the same way. That's the opportunity of the planning process - you need to engage everyone so that they all knew what part they play in this. The trouble is still a piece of paper… loads of pieces of paper sitting on a planner's shelf… I don't think that it's something that everybody in the organisation identifies with.' (National Policy Lead)

National and local levers all need to be informed by the need to be more prudent, and this still has some way to go:

'A lot of the delivery groups, the millions of pounds given to the delivery groups (are) being used in a prudent way. A lot of our investment is quite targeted on prudent activities… The efficiency through technology fund investments, funding tele-health, tele-medicine, remote monitoring, and some patient flow programmes. Things that would make us less imprudent. There are quite a lot of tools and enablers in the system…we have to keep having these conversations…it's a leadership issue in the end.' (National Policy Lead)

Measuring progress – what, how, or even whether

The question of what should be measured in relation to Prudent Healthcare, or indeed whether such measurement is desirable and how those measurements might be used, was hotly debated amongst our interviewees, with considerable variation of opinion. All were agreed, however, that there is currently no clear set of quantified intended outcomes for Prudent Healthcare, nor any comprehensive set of milestones.

Some argued that some sort of measurement of the progress of Prudent Healthcare was clearly desirable, although there were different views as to who should take the lead on this, national or local:

'I don't think you can simply wait until a decade has passed to look back to say it was good, bad or to say it was ugly…. so for me…. this next three-year planning cycle should be the moment when we should expect Health Boards to have got more mature and actually have some key milestones.' (National Policy Lead)

'I would have hoped that if you are establishing a new way of working and a concept to a vision that you would have had measurable outcomes at the beginning…and I would have expected you to periodically assess… you would look at how you would achieve each of those… how can

you expect to measure outcomes when people are not given parameters...I would be looking at where the pressure points are and has prudent health care had an impact….the pressure points are in primary care.' (Professional Leader)

Others argued that such an approach would almost be wrong in principle:

'Prudent Healthcare is difficult to measure, but this is not necessarily a bad thing. There is acceptance and buy-in around Prudent Healthcare, partly because it is not seen as something people have to do.' (Local Middle Manager).

'We don't performance manage it…trying really hard not to performance manage it…We're going with the flow...that's been the approach so far and I don't feel from the Board they want to control it too tightly.' (Local Senior Manager)

'[Health Board] have taken a very light touch on Prudent Healthcare… to date…they have tried not to silo-ise it by making it a 'project', but at the same time have left it very loose at a strategic and operational level along the lines of "we know that we are doing it, but don't ask us to measure its impact or identify where it's happening.' (Local Senior Manager)

Many recognised the need for clear objectives and milestones, linked to both formative and (at some point in the future) summative evaluation and the measurement of progress, but struggled to identify what might be appropriate metrics:

'a Prudent Healthcare system is quite a sophisticated healthcare system, so measurement of it is difficult… because a lot of it is about understanding individuals' lives and helping them decide what's best for them.' (National Policy Lead)

'I talked about value – something about what you put in and what you put out and the ratio between the two. I'm sure it can't be just economic. There's got to be the added value to patients. I suspect regrettably it is all about individual opinions. Score on a scale of 0-10, were your needs met? Is your wellbeing better? At the moment I can't think of anything objective – I'm sure there are some metrics – they will all by proxy. Admission for harm, drug related harm, use of investigations, complications from surgery, reduction in mortality. No single one would be useful – but a combination would be useful.' (National Policy Lead)

[Prudent Healthcare is] being called a 'social movement' – which is a cop out for not doing things very quickly because social movements take time to do. That's an easy thing to fall into – and then you can't evaluate it because you can't evaluate a social movement. I think evaluation is a fair aspiration if you have a set a Principle that you use to deliver Prudent Healthcare. That you have to have some way to show people that there has been a positive change.' (National Policy Lead)

'I think there should be some concept of what difference are we expecting Prudent Healthcare to make and how would we know if that difference has occurred and the more difficult question

– how do we know that Prudent Healthcare made that difference, and that at the end of the day, might be impossible, because there's always so many other things going on that you're not going to have a controlled study.' (National Policy Lead)

Part of this concern was the use to which such metrics might be put, with a fear that hard performance management of some simplistic measures would be counter-productive:

'I think Prudent Healthcare requires behaviour change, therefore if we measured that behaviour change and we know that is so difficult, so you may have to look for proxies. The whole idea/concept of what is appropriate and what is necessary, how do we measure that and in who's eyes? Who really knows what is necessary or appropriate…. it's only the person that is experiencing something to know that it is inappropriate. It will annoy people and not leading to behaviour change.' (National Policy Lead)

One interviewee alluded to the long history of national and local tension over who should set direction in matters such as this:

'Welsh Government struggle with this – they mandate and people say, you're telling us what to do, and when they don't mandate, people say you don't tell us what to do…there's never going to be a perfect solution… but you have to hold people to account.' (Local Senior Manager)

These comments relate to the measurement of Prudent Healthcare as a programme. At the clinical level, there was a widespread recognition that more data on patient outcomes, patient experiences, and the efficacy of interventions was needed:

We don't have patient level data to join up the data we have. We don't have the ability to look at the whole picture from - primary and secondary care data. We need detail. We need to know what happened after hospital.' (Local Middle Manager)

'What the patient feels – and reports how they feel about an outcome. We don't have that routinely available for all of our patients.' (Local Middle Manager)

The development of standardised measures for outcomes and patient experience would prove to be a key enabler of Prudent Healthcare, provided that such data was available at the point of co-productive conversations, used appropriately:

'PROMs/clinical outcomes are a precondition for much of this, but simply introducing PROMs alone is not sufficient - needs to be linked to a sensible conversation with the patient - which in turn requires them to reach the patient record. English experience demonstrates this: they did PROMs big time but its gone nowhere because there wasn't a system which was easy to use, ubiquitous and linked the PROMs data with the patient record. Prudent has been a vehicle by which people have coalesced around the conversation… and it's a non-threatening vehicle... it hasn't got targets associated with it.' (Local Senior Manager)

Permission to challenge

Many of the interviews we conducted for this phase of the work, and many of the workshop sessions and interviews for Phase 1, raised the issue of 'permission'. Many staff, especially those not at the top of their organisation's hierarchy, felt that they did not always have permission to change services in a more prudent direction. Sometimes this was because of a reluctance to challenge local, powerful interests. On other occasions, the scale of change required was beyond their immediate authority and they felt that they would not be supported as the ramifications of change reached beyond their own department. This was for many a major rate-limiting factor.

On the other hand, several interviewees argued that Prudent Healthcare actually gave them that all important 'permission', and the courage that goes with it:

> *'Having more challenging conversations, for example, with surgeons about variation and necessity of procedures. For example, reducing variation in orthopaedic implants. PHC has made these conversations possible.'* (Local Senior Manager)

> *'Prudent allows challenging the way things are done. For example, there's a shortage of doctors and nurses – I can ask if there is another way of doing things. Are there other professionals that can work to the top of their licence?'* (Local Senior Manager)

> *'One of the most positive aspects of Prudent Healthcare is that it gives cover for difficult and awkward conversations, especially around workforce and the 'only do what only you can do' principle. She argued that it could help to open up conversations that could otherwise easily be closed down.'* (Local Senior Manager)

> *'We need to give 'permission' to people to have conversations about end of life much earlier than they might otherwise want to or choose to – this would be in everyone's best interest.'* (National Workshop Participant)

> *'It's an agreed position and I don't there's ever been a sense of people moving together in the same way together before. We've only ever worked prudently if our budgets have been cut. There is an awareness that this is public money and resources are limited but 'Prudent has honed peoples thinking and honed the right to challenge. Before prudent people would think you're just trying to take my job of me or you're trying to cut costs, give us cheaper material. There was cynicism and prudent has broken through the cynicism.'* (Local Senior Manager)

THE EMERGENCE OF CLEARER NATIONAL DIRECTION

In February 2016, *Prudent Healthcare Securing Health and Wellbeing for Future Generations*[26] (see Appendix 1) was published, which set out three areas for 'collective national action' in 2016/2017:

[26] Welsh Health Circular WHC(2016)11

- Reducing unnecessary and inappropriate tests, treatments and prescriptions, and ensuring people are able to make informed decisions about the care they receive.
- Radically changing the outpatient model, making it easier to get specialist advice in primary care settings.
- Developing strong public service partnerships and integration to provide the right care, in the right place, at the right time.

With the Circular was a document outlining developments to date and recommendations to focus Health Board activity with the three priorities.

This was a new emphasis in the national approach to PHC. For the first time, Welsh Government was attempting to prescribe certain areas where the NHS was expected to respond. Policy makers agreed that the intention for Prudent Healthcare policy was to stimulate discussion but also to catalyse action in key areas:

> *'If it can allow you to have the right kind of conversation then that's OK…. but we do need to see some evidence and some tangible outcomes on the ground.'* (National Policy Lead)

We found awareness among Health Board Managers with regard to the three priority areas was low, with many commenting that they were unaware of the published paper or Circular:

> *'If it was a re-focussing conversation, I was unaware of those three targets.'* (Senior Clinical Manager)

One Public Health Director commented on frustration that the national priorities were too late to be integrated into the three-year planning process for 2016/2017.

Many policy makers explained that the intention for early embedding of Prudent Healthcare policy was to allow organic uptake by Health Boards. It was agreed that after this initial period, it was hoped that the national directive would catalyse significant, tangible progress in selected areas:

> *'I think the three areas were just about highlighting that we needed the evidence base to kind of manoeuvre about a bit more of a pace having allowed the early evolution….it just needed to be something more significant at this stage.'* (National Policy Lead)

It was also recognised that although national priorities were set, wider work on implementing Prudent Healthcare was already underway was not being discouraged:

> *'So I certainly don't describe it as 'let's remind ourselves the only three things we are doing around Prudent Healthcare are these three areas….you have a lot of clinicians talking about a much broader setting that's going on.'* (National Policy Lead)

> *[On delivering PHC on areas outside the 3 national priorities] 'I think it is acceptable… but the 3 areas that we have highlighted are nationally driven…so a Health Board that have said we are*

incorporating with the national areas…here's our bit……I'm happy to plug into it…but here's what we've really grabbed as well, that's fine.' (National Policy Lead)

There was also recognition that the priorities were not intended to reduce Prudent Healthcare to a set of actions for Health Boards. Policy makers explained the intention of Prudent Healthcare as a movement was very much compatible with providing some national guidance on where efforts should be concentrated. The role of the priorities was seen to be a mechanism by which to catalyse and report progress on prudent activity:

'I think we need to do the movement approach alongside those three… but I think we are in a setting where we have to accept that the NHS and public services more broadly have to be seen to be delivering… We need visibility around people understanding that this is now more than the underlying concept there are some ways of making this a bit more real for people in their own clinical environments when we actually decided that was why we needed the three in the first place.' (National Policy Lead)

This perspective was further articulated by a policy maker who saw how having three priorities might be seen as a potential contradiction, in comparison to the initial way in which Prudent Healthcare launched without any specific guidance around areas for action. The apparent contradiction was explained by arguing that Prudent Healthcare was very much still intended to be used as a 'lens' and that the intention remained for Prudent Healthcare to be incorporated into broader work of the Health Boards. The three chosen priority areas were also described as having the potential to make a 'system' change, which is in keeping with the original plan for the policy:

'It may be a contradiction about but focussing on the three things….but our basic focus is to ingrain them within our three year planning process to say that it is the lens by which we do everything and it is a challenge to ourselves centrally. However as part of the process there we are trying to make sure we can unlock these three areas that we think would make a system difference but actually the real focus is about people applying a PHC philosophy right through and making it very visible within their three year planning process… Delivery isn't just about whether you are hitting an ambulance target or not…it's about whether you have been able to push a different approach in a different way in the system. You want Prudent Healthcare to demonstrate that it can do something in those three areas.' (National Policy Lead)

A number of policy makers also explained the logic behind choosing these specific national priorities. Underlying the areas chosen was the intention to apply a 'prudent' approach to parts of the heath service and wider public services, where, if change was realised, the impact would be visible and measurable.

'What's the point of going at outpatients …because there's a system that's generating contact with three million every year, for a three million population….in the Prudent Healthcare world that doesn't seem like that's the right ratio…every single person on a ratio basis….there must be a different way of organising ourselves at the moment.' (National Policy Lead)

A number of policy makers also expressed the view that a holistic approach to application of PHC would offer the most benefit to population health. In response to debate over whether public health should be a target for PHC since it wasn't included in the three national priorities, one policy maker commented:

> *'My answer wasn't to say well we are only doing these three things…so please don't think about it in that way.'* (National Policy Lead)

This view was reinforced by another policy maker who stressed:

> *'In the best example a mature Health Board would emerge and say look at what our system looks like because we have actually done our whole plan through the PHC lens and it feels very different ….I would hate to be critical to say that I told you to just focus on outpatient transformation….not on medicine management as two examples.'* (National Policy Lead)

On the subject on whether the three priority areas would be updated or remain as they are and how progress might be measured, one policy maker commented:

> *'My expectation on delivering these three isn't …in ten years' time there we are …we are still going…..we are expecting to be setting out some milestones… which has been the challenge.'* (National Policy Lead)

And with regard to expectations for the next 18 months to three years:

> *'I think outpatients will be in a better place over the course of the next 18 months, three years….at least then we know then if something different emerges.'* (National Policy Lead)

There was also concern expressed over a perceived tendency to change goal posts before change has been achieved:

> *'I think the test that for Prudent Healthcare on the three areas we have highlighted here is ….We need to see that people can convert it at a more significant level….the danger of the NHS generally and occasionally the NHS in Wales is at the point when we are about to deliver the thing that we want, we change our mind and move onto something different and that has happened over time and I think we need to be disciplined in those three areas….to make sure that we thought it was appropriate there was an evidence base available. And we do need to change them.'* (National Policy Lead)

CONCLUSIONS

This chapter has identified many of the key success factors for the implementation of Prudent Healthcare since its launch in 2014, and also the rate-limiting factors. Key issues have included:

- a philosophy and set of Principles which appeal to people's professionalism and values;
- a developing critical mass in the workplace/services;

- an approach shared across Wales;
- a determination that Prudent Healthcare should infiltrate all the work programs, rather than become a silo of its own;
- on a more granular level, the identification of specific points in the pathways and services which need to change, for example the need for a shared conversation at this point on outcomes, carried out by specific professionals with access to specific information.

Some people are very enthusiastic, even evangelical, about its potential to transform services for the better. When asked if Prudent Healthcare had influenced their work a Senior Clinical Manager responded:

> *'Yes it has… I think it was written with my name on it….when you are looking at Prudent Healthcare it's everything that any of us would operate by… [Our next project]. I wouldn't have thought of it unless prudent health hadn't been in my own brain… I don't see it as separate from just common sense to be honest.'* (Senior Clinical Manager)

Others may endorse its values and objectives, but see little traction so far:

> *'Well, what has it achieved so far? It's on the Launchpad but the countdown has stopped. As a concept it's unimpeachable – as a vehicle for change, it's too nebulous and ill defined.'* (Professional Leader)

And others take a more nuanced view:

> *'I'm happy that it has a currency… I'm happy that it's not controversial to talk about it which I think is not because it's been demanded it's because people have been able to reconcile it with themselves…we have got some examples of it working in practice… and some changes, but they are not sufficient to be confident that we have had the step up that we had been expecting originally on the back of it… I would have liked to have probably within this last year to have got to a better place…on some of our testing of the practical outcomes of it…and it has felt sometimes like a little more in the treacle than I would have expected and wanted…not sure if that's because we've applied some of our normal managerial approaches that can get in the way of something that was a bit organic in the first place. I don't think we are in a bad place for what we want to deliver…I think we have got a much more spread place ownership of it within in our system.'* (National Policy Lead)

Every interviewee recognised that Prudent Healthcare still had a long way to go, and that it demanded some quite fundamental changes of assumption and approach. Achieving greater and faster progress would require a delicate balance between direction and accountability, and something more organic:

> *'I think Phase 2 is about outcomes, tractions, resources released, quality outcome achieved... I don't think we can gently carry on…thinking it sounds like a good thing. It has to demonstrate that this has some outcomes in it. What I don't want to end up doing is killing off what has been*

a more organic development and a philosophy by intense central monitoring ….so there is a danger of asking the wrong questions if we are not careful… we are trying to change our system anyway from some of our traditional measures…we are trying to go a bit more into the outcome space.' (National Policy Lead)

CHAPTER 5 - A PRUDENT WORKFORCE

> *'I came to believe later on that more immediately to hand was redesigning the workforce. That was the one you could get on with fastest and you might have the most immediate benefit from.'* (National Policy Lead)

There was a widespread recognition that significant changes were needed to the workforce if Prudent Healthcare were to become a reality, requiring changes to workforce configuration, individual jobs and roles, and even to the ways in which staff carry out their roles. Without such changes, progress towards a more prudent service would be slowed, or even prevented. On the other hand, such changes in themselves could prove a spur to more Prudent Healthcare.

This chapter considers what those changes might be, and upon what they would depend. It then explores what progress has been made to date, and how such changes might be expedited in the future.

WHAT IS A MORE PRUDENT WORKFORCE?

This section starts with the macro - How should the workforce model in healthcare be re-designed to make services more prudent? - and proceeds via the meso - What new roles and jobs are required? - to the micro - How can individual professional groups and professionals themselves work more prudently? The implications of each for policy, practice and education are considered in turn.

A more prudent workforce model

Many examples were adduced by interviewees and in our workshops to support the proposition that the current workforce model does not always support, and in many cases actively undermines, Prudent Healthcare. Many argued that it was simply too easy to see a doctor (as opposed to another professional) in primary care, and that the public (and perhaps the NHS itself) was more used to specifying the access to services based on 'labels' (doctor, nurse) than on competencies (which set of skills are required for this need). It was argued, therefore, that services should:

> *'…focus more on competency based interventions rather than professional based interventions. We have got to turn the workforce model on its head.'* (Local Senior Manager)

Experiments which allowed patients greater discretion about the appropriate professional for them to access - for example, direct access to physiotherapy services - often resulted in more effective, acceptable and cost-effective (i.e. More Prudent) Healthcare. In other cases,

however, there appeared to be an expectation amongst the public that referral to more 'specialist' provision equated to 'better' care, even though there was little evidence to support this, leading some to advocate for the notion of 'good enough' care as a design principle.

There were several approaches to re-designing a model which currently encouraged an imprudent miss-match between staff and need:

> *'We asked what can be done at each stage by non-medical and in fact, non-professional roles.'* (Local Senior Manager)

This sometimes translates into a model in which more non-registered staff are built into the patient pathway to relieve the registered professionals from tasks for which they are not needed:

> *'There's the only do what you can do stuff going on, so we're not using experienced surgeons to just do follow-ups – we have other clinicians to do that, so I think it aligns very nicely with the whole prudent health thing.'* (Senior Clinical Manager)

> *'A lower level workforce, through competency based assessment have built up a portfolio of things they can do to support the team… so rather than looking at the old traditional roles – we're looking at how these roles… take on huge parts of the role that used to be medical or nursing … but also to streamline the process for the patient as well… so they may be assessed by those individuals very quickly at admission. ..alongside an advanced nurse practitioner…They undertake all the task orientated parts of that assessment….and that allows to get through to the area where the senior clinical decision maker much quicker. They are band 3.* **'** (Local Senior Manager)

The reference in this quote to the banding of the staff is important. It reflects the fact that one motivator for these changes is to reduce the cost of the service. However, advocates of this approach would argue strongly that this is not the prime motivator. Much more important for them is freeing the resources of highly-paid staff to 'do what only they can do', and to speed and rationalise the care pathway, in the process improving the quality of care and the patient experience. Currently accepted banding for particular roles sometimes prove to be inappropriate, when they are scrutinised through a Prudent Healthcare lens:

> *'Our smoking cessation advisors are band 5 – the ones we trained are band 3.'* (Local Middle Manager)

Ensuring that staff banding matches the requirements of Prudent Healthcare can be a complex task. The skills escalator approach, which ensures that bands match tasks, but also that staff can progress in accordance with the needs of a prudent service, has merit:

'We use the skills escalators – band 2, tool them up to band 3 and 4 and then do a degree to band 5.' (Local Senior Manager)

Other changes to the model which have proved more prudent include a re-design of the multidisciplinary teams, to ensure that the right mix of skills and knowledge is available flexibly, when it is needed, and in a way which enhances the skills of the team members. This can in turn lead to the identification of even more prudent ways of delivering care. A pharmacist reported that he was:

'…employed by nephrology, no longer are we a support service, we're integrated into the frontline. So that has allowed us to adopt a lot of principles of Prudent Healthcare, we're part of frontline care and the multidisciplinary team'.

When asked how does that impact how you deliver Prudent Healthcare?

'Historically, pharmacy is a support service, to multiple specialties – and you're assigned a speciality. The way that we work, is that we have a medicines service for nephology – so we're employed by renal services and involved with specifically re-designing services…. rather than work in professional silos and financial silos means narrow minded thinking – when you're working for a speciality so you're looking at efficiencies across a system.' (Senior Clinical Manager)

Many of these discussions about the workforce model still have a long way to go before new models are established. But useful questions are being raised, and new propositions explored. In end of life care, for example:

'We need to take stock what the tasks are and who does what. For example, district nurses could be effective specialist generalists, rather than having too many specialists involved in the discussion and the care – families get very confused about who the right person is – district nurses are a scarce resource.' (National End of Life Workshop)

A frequently-reported constraint is proving to be the shortage of key staff groups, and the implications this has for workforce planning. For example, a more prudent model of care might involve more work being done, by a variety of professionals, in a primary care setting, perhaps resulting in fewer referrals to secondary care, and putting fewer patients on the escalator towards inappropriate specialist provision referred to above:

'Sometimes staff have to work below the limits of their licence because there aren't enough lower grade staff.' (Professional Leader)

'One of the problems of Prudent Healthcare, not a problem, but one of the challenges, is for services like audiology we've not had plans for expansion. For many years, we've been planning ahead if you like, to sustain a relatively stable number of workforce. But just now in the last

year or so…, there are two big things that have impacted on us. One is the probable expansion of primary care audiology and big and very likely effect from the planned care pathway board where a lot of Ear Nose &Throat demand will be passed to audiology so we'll be needing to find a lot of additional audiologists in a relatively short space of time. Which is why I mentioned skill mix and ways of fast tracking people into the service. So that's one of the big things we see. Prudent Healthcare really means that you have to use all of your clinical professions more to make up for that fact that there are aren't enough clinical personal out there.' (Senior Clinical Manager)

Many of the interviews and discussions highlighted the risk of unintended consequences as a result of a redesign of the workforce model. Some staff groups will be expected to see different cohorts of patients, and to share care in new ways. For generalists like GPs, for example, this could exacerbate a problem with de-skilling. In simple terms, they will still be expected to provide (or at least coordinate) care for a wide variety of people, but may progressively lose (through lack of practice) the wide skill set required for this. This may have consequences for the sustainability of care, and may even impact on professions' sense of self-worth. As one GP expressed it:

'I'm interested in the threat to status. How far will they resist that… maybe not status but a skillset? An advanced skillset is built on a basic skillset. And taking away responsibility means less practice…So advanced skills are compromised… For example – antenatal care. In primary care we used to do much of this. Now it's over to midwives… Doctors handed this over to midwives…then there was a complex problem so when it's handed back GPs can't deal with it because they can't even deal with the basic skill set'… Another example – of de-skilling. Specialised clinics. For example, diabetes clinics. If one GP is doing diabetes… then the other partners lose their skills. We become de-generalised. The status threat is that you are taking things off me... I'm a lesser person because I now have a lesser skill set. Then when a complex problem presents itself you can't deal with it because you haven't had exposure to the basic problem. So it's a question of how much you can take away… before you can't practice as a GP. There is a risk of it happening in small practices – because if that particular person is not there than the whole practice loses that expertise… in the community we aren't working in big enough groups for that to happen. The question is – will we lose that overall understanding of what is going on with an individual…. Is that a loss?' (National Policy Lead)

'People are handed off into very different and specialised teams – which can have the unintended consequence of colleagues in primary care feeling de-skilled around end of life – there is an infrastructure that mitigates against good inter-disciplinary working.' (National End of Life Workshop)

New roles

One specific aspect of the workforce model re-design discussed above may be the emergence of entirely new roles, as people come to realise that the current jobs and roles are not

prudent. There were few examples of entirely new roles emerging, however. One example which is already starting to materialise in Wales is that of Physicians' Associates – biomedical science graduates on a two year programme are trained to do lower skill clinical work than doctors. More commonly, people were contemplating new roles for existing staff:

> *'Every few years we have a review of schizophrenia – we don't come out too well in Wales. Some of the aspects of PHC where things are going well are liaison services. You can make a huge difference by increasing liaison services. And money has gone into that – that's good. And it's prudent.'* (Professional Leader)

> *'The serious illness conversation will help non- specialist end of life colleagues to be trained to have these discussions – SNODS (Specialist Nurses in Organ Donation) had not been previously trained, and it's about giving people the support to take part in these conversations.'* (National End of Life Workshop)

Quite often, the process of service change and role redefinition occur simultaneously, and are driven by a variety of workforce, quality, financial and other factors, and can respond to the changing expectations of the workforce directly affected:

> *[On how the job role of GPs is changing in instances where a telephone triage system has been introduced] 'They have satisfied young GPs who are prepared to do telephone triage who go away on different days and do a completely different job…come back refreshed and ready to go. It seems to be to be an emerging model*.' (Senior Clinical Manager)

As roles change, attention needs to be given to any unintended consequences:

> *[On the impact of taking audiologists out of regular roles to staff clinics in primary care] 'Maintenance of skills – and network of staff – you have to ensure that people are not working unsupported and in isolation. You want to have people to spend more time with their peers.'* (Senior Clinical Manager)

New ways of working

The ways in which professionals go about their daily activities are, of course, in constant flux. In some cases, Prudent Healthcare has added a new lens through which people can reflect on how they do their jobs. The notion that staff should spend more time working 'at the top of their licence' has captured many people's imagination, partly because it emphasises the contribution which working more prudently can have for job satisfaction:

> *'Healthcare professionals working to the top of their licence – for example nurses providing rehydration therapy/ fluid rebalance in the community, to allow patients to remain at home - if that is their preference.'* (Local Senior Manager)

Staff may be more willing engage in discussion about role change if it is likely to enhance their own satisfaction, and the prospect of spending more time doing those tasks for which you have been particularly trained, is engaging:

> *'In particular, under the 'only do what only you can do' principle – working to the top of your licence has become a focus for organisational development. It has really resonated with clinicians because traditionally, when the organisation has looked at cost savings, it has looked at low hanging fruit. For example, the number of phlebotomists was reduced – which resulted in junior doctors doing more phlebotomy, which is not cost effective. Taking a prudent approach, when the acute medicine model was redesigned a new role – band 4 Medical Technical Assistants - were introduced to do a range of medical procedures (ECG, phlebotomy, putting lines up, managing venflons). Previously, advanced nurse practitioners were trained to do these tasks (band 7). It was 'only do what you can do'. Prudent Healthcare was responsible for this. It legitimised the conversation with clinicians.'* (Local Senior Manager)

On other occasions, role change is almost dictated by other changes. In one GP practice, for example:

> *'It's a natural evolution….I don't think you can stop it happening…we had a partnership meeting last night that is an example of how we have had to adapt….we are now no longer 4 full time GPs which we were 5 years ago… we are now 7 part time GPs… that's the natural thing… that's what everybody wanted when they came to our practice…all the young GPs said they don't want to work full time… we want part time work because we want another interest… don't want to just do telephone triage 4.5 days a week …I think it's right I don't think I could do telephone triage full time… it's exhausting work.'* (Senior Clinical Manager)

Whole professional groups, including those in 'supporting' roles, can be affected by such discussions about role:

> *Our (pharmacy) technicians are looking to be trained [in co-production]. How do they use those principles to deliver their role... Pharmacy is very much responding to a situation. So we are moving from a back room function to frontline delivery… pharmacy is becoming more co-production orientated… we're talking to patients.* (Senior Clinical Manager)

This can have implications for future education, too:

> *'From an undergraduate perspective going through training to undertake those vocational careers – unless it was a little more 'touchy feely' - in our undergraduate training we had nothing about how to structure a conversation or a consultation.'* (Senior Clinical Manager)

HOW TO CREATE A MORE PRUDENT WORKFORCE

A more prudent workforce will therefore work within different models, develop new roles, and will requires new ways of working for most teams and individual staff. How will this happen?

These are not entirely new concepts, of course, and arguably one of their strengths is that many people have already recognised their value and legitimacy. Interestingly, unlike in some other aspects of Prudent Healthcare, the rhetoric here finds a ready echo, with the phrase 'only do what only you can do' being picked up quite often:

> *'Only do what you can do – is one of the main things audiology has been working to for a long time.'* (Senior Clinical Manager)

But some have reacted against this slogan, seeing it as restrictive rather than permissive – I other words, you must not do anything other than the minimum, and must not do 'someone else's job':

> *'Midwives in particular were kicking out about only do what only you can do….they were honing on the negative aspects.'* (Professional Leader)

One key lever for creating a more prudent workforce has been listening more closely to what patients want. This may require a special exercise in organised listening, or it may simply involve a recognition of what professionals already know from their daily contact with patients. But its power, as a motivator and an informer, has been demonstrated on many occasions:

> *'In eye care, there was a new treatment which took off – there was the financial cost and the staffing was just not there at a rate we could just not keep up with it. What we did was the traditional thing of how can we provide the same service that we have always provided, trying to recruit across the system. Never involving the patients in what mattered to them – developing different models – but we were harming them as they were going blind. We were so lost in our world that we were not looking at the patients' world. We really could have done better, and handled the whole thing differently. We were undoubtedly doing the best thing we could, but it was in the traditional deterministic way which was not the best.'* (National Policy Lead)

People identified several structural impediments to this sort of change. One was the need to address the need for different numbers of professionals:

> *'I've just put in a workforce submission now for people that won't be available until 2020. There are a couple of different routes into the profession… both need about 3 years training. I think it will be the same for a lot of other professions… if the early stages of prudent seem to work very*

very well, then you are going to need more physios, speech language therapists and podiatrists – more than we would have thought we needed probably.' (Senior Clinical Leader)

Another was the implications for preparation for practice, and for continuing professional development. The impact of more prudent models, particularly in combination with demographic changes, may take some time to become apparent and are likely to be quite complex. One GP reflected on the implications of this:

'If I am brutally honest sometimes when I am phased with someone who is quite complicated I would personally value more medical skill because I'm finding now these patients are getting increasingly complicated and I sometimes think I haven't got enough skill to deal with them… it's a waste of money and I should be more skilled in learning how to deal with congestive cardiac failure in a patient with renal failure because the drugs counteract with each other. I could do with knowing more clearly what a physician would do with that patient… as the new generation of GPS come though… they will naturally know it and be trained in it. Whereas older GPs who have lost touch with all that medicine… need to be retrained… i think it will naturally sort itself out as time goes by because patients with complex needs will be in the community they cannot be in hospitals. Hospitals are too small for this number of patients… we are only beginning to see the tip of the iceberg. It's only now I regularly see 93 and 95 year old… can you imagine in 10 year time…all going to be in their 90s and going to have fairly serious health problems… that whole hearted GPs need to be highly trained to deal with them.' (Senior Clinical Manager)

But being more prudent can help:

'My own practice becomes more complicated and more difficult so I have to allow the time….but I have the time and that's because I'm not seeing ear wax, coughs and colds any more'. [this is because a primary care triage system has been introduced] (Senior Clinical Manager)

There was recognition that traditional planning assumptions in healthcare, and the historical balance of investment, would now have to be changed if a more prudent workforce were to emerge:

'We have allowed our system to default to a traditional hospital building.' (National Policy Lead)

A key mechanism would have to be the Health Boards' Integrated Medium Term Plans, and the planning activity which underpins them. These in turn would reflect multiple discussions across the care system, involving patients and all members of the multidisciplinary team, scrutinising current workforce deployment through a prudent lens. Primary Care Clusters were useful agents of change here, given their proximity to patients and the public, and their (relative) lack of vested interest in existing patterns of workforce deployment and role. But there were some grounds for optimism:

'It does feel as if there is something [in Prudent Healthcare] that has attracted people in a different way …and has allowed us to use some of the evidence and data around us whether it's' that GPs know they only need to see 40% of the patients if there is a broader primary care team….or 50% of people walking through A&E who simply don't need to be there if they access the pharmacist or minor injuries unit or whatever…that one seemed to get easier to get into a discussion about.' (National Policy Lead)

Many argued that the role of Welsh Government was also crucial in this. It could usefully challenge local practices that are not prudent, such as the use of long term locum posts as a result of inadequate recruitment. It should also be more effective at sharing and helping to scale-up prudent practice, address widespread and chronic workforce capacity constraints (for example, in primary care). It would have to ensure that planning for a more prudent workforce was reflected in the commissioning intentions for professional education and development. Government also needed to be careful that its own performance management regime (for example, what some regarded as a fixation with referral to treatment targets) did not unwittingly drive imprudent care.

Ultimately, traction seems often to be greatest where the changes also result in better work satisfaction for the affected staff:

'One of the things I was more cheered up about. At the workforce front – I think I had some conversations at the very beginning we would have had quite a lot of boundary disputes. The attitude of GPC Wales would have been – that's a GPs job. And why not – and by the end they were much much more, willing to talk the language of how can we free up GPs.' (National Policy Lead)

CONCLUSIONS

Progress is clearly being made in the prudent remodelling of the workforce. Progress is often greatest where staff see the benefit of change, where patients are involved, and where changes have already been explored for some time. Prudent Healthcare provides what many regard as a useful lens through which to examine the workforce, and the slogan 'only do what only you can do', and the desire to work 'at the top of one's licence' appear to find greater resonance than some of the other Principles and rhetoric of Prudent Healthcare. For those who have always been champions of change, Prudent Healthcare, in workforce as in other areas, provides useful support:

'One of the most positive aspects of PH is that it gives cover for difficult and awkward conversations, especially around workforce and the 'only do what only you can do' principle. She argued that it could help to open up conversations that could otherwise easily be closed down.' (Local Senior Manager)

How much progress has been made with the prudent workforce?

> *'If you are scoring the progress do I think it's a 10 out of 10? Absolutely not…. but it does seems people have been able to get their hands on this one and understand what it means. Whether it's understanding a healthcare support worker role for example …... Physician associates coming through in a different way and certainly in the primary care arena the development of the ….primary care model…so it's not just about the GP… the cluster model is effectively us trying to drive a Prudent Healthcare system in a different way that says it's not all on the GPs shoulders.'* (National Policy Lead)

Ultimately, policy makers see the argument quite simply:

> *'If you didn't have your back against the wall I feel you would want to do this anyway. Why wouldn't you want to use the talents of the workforce you've got to make the greatest contribution that they can. Why would you not bear down on stuff that does no good and maybe harm?'* (National Policy Lead)

CHAPTER 6 - CO-PRODUCTION

> *'Most important in the concept is working together, getting the patient involved. I think that's a social movement. It's about empowering patients and letting them know they can do it, letting them know they can have some control. It's a mind-set change in the way in which all of us interact with patients.'* (National Policy Lead)

Co-production emerged as a topic of much interest in our conversations with managers, clinicians and policy makers. As well as being identified as the Principle that held most potential to be 'transformative', it was also identified as one where least progress had been made, and that would be most challenging to make progress on. Our conversations helped to identify what managers and clinicians understood co-production to be and what might be done practically to make progress on embedding co-production in the health service. These conversations took place with leaders in the Health Service, non-health public sector employees and leaders, and policy makers.

This chapter explores their perspectives on co-production as a crucial (and challenging) component of Prudent Healthcare, and considers in turn:

- Interpretation and definitions of co-production;
- Pre-requisites for coproduction;
- Embedding co-production.

WHAT IS CO-PRODUCTION? INTERPRETATIONS AND DEFINITIONS

Co-production was described as a 'culture shift' by many interviewees. It was agreed that to make this happen, a fundamental shift in sharing of responsibility and power between the public and the health service was needed. One policy maker summarised:

> *'Co-production is about redefining the relationship between health services and the public…'* (National Policy Lead)

It was also described as a joint effort to improve the way the system works:

> *'It's people going along to their health service which they own and they pay for and having a voice in how they are treated. That's what it's all about. And how they can contribute to make the system work better.'* (National Policy Lead)

There was also consensus from policy makers and clinicians that there was very little progress on embedding co-production to date. One Professional Leader commented:

> *We do very little co-pro. It requires a culture shift, it will require people being comfortable to have a different relationship.*

Alongside the practical steps needed to make the health service more 'co-productive' many interviewees, from policy makers to clinicians, talked about the need for a 'social movement' to underpin this change. In the context of the whole Prudent Healthcare Policy, co-production was seen as a 'different concept'. One local senior manager commented:

> *'Co-production is not part of parsimony – or saving or being 'prudent' it is different – a different concept.'*

There was also recognition by one local senior manager that for some, the commitment to co-production pre-dates Prudent Healthcare policy;

> *'We have had a focus on co-production and have well developed training….We don't know if the principle is actually embedded. There is commitment to the idea of co-production and it predates prudent healthcare.'*

Good communication

All were agreed that good communication was fundamental to working co-productively. Many interviewees, from policy makers to clinical staff, spoke about 'having conversations' when articulating their understanding of what co-production is:

> *'At its purest level it is about having a conversation with a patient'. One patient at a time.'* (National Policy Lead)

> *'It's about teaching people to have better conversations – so they engage in a different kind of conversation.'* (Local Senior Manager)

Another interviewee commented:

> *'Listen to patients – don't make assumptions about what a patient wants or needs.' (*Local Middle Manager)

Consultation and feedback

Managers and clinicians frequently referred to 'consultation' as part of co-production. Some managers also highlighted the non-representative nature of consultation groups. One clinical manager of a large service re-design project commented that:

> 'A*ll feedback is from consultation groups… how do we get the wider public involved*?'

There was also some debate about whether the consultation process is an authentic way of trying to involve patients, or whether it was a 'tick box' exercise:

'They'll say we will consult the patients, or, we'll send them a survey, something added on where the main work is being done without the consent of patients or not even thinking about them.' (Professional Leader)

In addition to formal consultation, many clinicians talked about feedback when describing how they incorporated co-production into their work:

'Representatives from CHC [Community Health Council]... we had patient representatives when we discussed what the project should be doing… we took feedback from patients as to what sort of service they would like and that informed how we set up the service.' (Senior Clinical Manager)

Community engagement

A number of interviewees talked about working with communities as an aspect of co-production. Some leaders described co-production as developing services with 'community involvement'. Examples provided were largely related to consulting with the community to 'develop and tweak' rather than initiating health interventions. There was also mention of 'tailoring services for the patient'. One Public Health Manager observed:

'We don't reach everybody' and asked the question: How do we need to reach out? There is still a lot more that we need to do… we still aren't very co-productive.'

This view was echoed by a National Policy Lead, who recognised the need for more concerted effort to engage communities:

'I think it is about the fundamental shift and actually working with communities and engaging with people who are among the most disadvantaged because unless we do that we cannot be sure that we are engaging with them at all,…so I think we have to actively reach out to people. It does mean working across the public sector with community leaders.'

Negotiating wants and needs

Some clinicians felt that focussing purely on patient needs narrowed the conversation and resulted in less understanding of the patient's position:

'Co-production is the debate that goes on between needs and wants….if you don't address the wants, you won't get onto the needs…… having that negotiation with the patient as to what their wants are or converting what you think they need into actually what they need in order to achieve the outcome that they want.' (Professional Leader)

Several clinicians also described 'negotiation' as a way of being more prudent and an example of co-production:

> *'it's about negotiating with the patient and being realistic about what can be done and what can't be done without writing out lots of prescriptions and lots of tests.'* (Senior Clinical Manager)

This view was shared by primary care clinicians as well as allied health professionals, offering therapeutic and clinical services in secondary care.

Two examples were given of pre-consultation questionnaires being used to allow the patient an opportunity to identify what were the most important areas to cover in their clinical consultation, or to identify their 'wants'. It was explained that although clinical judgment was then exercised to come to an agreement about what should be covered, often the focus for the consultation had shifted and was aligned to what the patient placed importance on. Another interviewee highlighted this type of consultation as 'intermediary co-production':

> *'So there's a heck of a lot of examples of that. So staff have been trained and essentially they are changing the way they are doing consultation – patients are asked what they want the consultation to be about – what's important – so the clinician gets this beforehand. Once there they discuss that and they pick out with the clinician they pick out the 3 things they are going to cover and that's what they call co-production. That's intermediary co-production.'* (Professional Leader)

And went on to explain addressing wider 'needs' of a patient is closer to real co-production:

> *'If the three things included for example social prescribing – what's important to you in your life? If shared decision making includes that person making an active contribution to the outcome/success of that consultation its co-production. If it's just a really good consultation, it's a consultation.'* (Professional Leader)

Co-production means different things to different population groups

It was broadly agreed that receptiveness to co-production varies with population group. For example, managers and clinicians highlighted examples of older people wanting more direction and were:

> *'More likely to say they wanted the doctor to tell them what to do.'* (Local Senior Manager)

In contrast the experience of other clinicians in secondary care was that older people were equally willing partly to manage their conditions remotely and were not 'afraid' or 'unable' to use the internet to do so. Examples were given of patients with low mobility opting to use online feedback tools, over visiting a busy outpatient department for a follow up.

Another common observation was that although co-production had much potential to encourage people to take more control of their health, people with relatively good health

from higher socioeconomic groups were more likely to be 'reliant on themselves' and less 'reliant on the health system'. One clinician commented:

> *'I think it has an exciting potential…to really change and encourage people to be more reliant on themselves and less reliant on the health system. I think it is hard to achieve. We are seeing a segment of the society who take more interest in aspects of their lives. But it may be people who are already doing well [worried well].' (*Professional Leader)

There was also recognition from clinicians and managers that a co-productive approach is not always possible or what the patient wants. Another clinician made the observation that:

> *'People don't spend a lot of time thinking about health. People don't think about making healthy choices, unless there's buy in. People don't think about health until something goes wrong.'* (Professional Leader)

Co-production between patients and professionals

Collaboration between patients was also given as an example of co-production - although this was much less frequently discussed. In this case, patients with similar health needs were bought together at a specialist outpatient group:

> *'You've got a whole bunch of patients in the same sort of area in terms of needing to lose weight, got joint pain so there's some collaboration there between individual patients and the professionals working there.'* (Senior Clinical Manager)

A much more commonly-cited example of co-production was between professionals:

> *'Treating non-doctors and non-clinicians as equal partners was a core to making this successful. The radiographers input was as equal as radiologists and my input, and as fundamental as primary care.*' (Senior Clinical Manager)

There was also reflection that the intention of the policy was that co-production should be about more than interactions between health professionals and patients:

> *'It's not saying we are only going to have co-production with patients. It's saying everybody who owns and pays for the health service should get the best service and should be involved in designing and influencing the decisions on themselves and the decisions on the organisation.'* (National Policy Lead)

Involving patients

The concept of involving patients was a core part of how co-production was commonly described by clinicians and managers:

'Involving patients with choices, the exercise and lifestyle choices – patients were very much involved with that so it's a bit of co-production there.' (Senior Clinical Manager)

One Health Board described their approach to co-production in a 'more proactive and structured way' by developing a Patient Experience Advisor role who placed involving patients at the centre of their role. The same Health Board described developing processes to enable patient involvement:

'In considering how to make the hospital environment more prudent we have focussed largely on involving patients more….a research project with… University is looking at how to include survey questions to wifi access…. so that patients are prompted to answer questions for access to wifi.' (Local Senior Manager)

For some clinicians, patient-centred care and a co-productive approach were synonymous, whilst others saw a clear distinction between the two approaches:

'There have been other approaches – such as patient centred care - but no-one took much notice of that.' (Local Senior Manager)

'No [co-production is not patient centred care] co-production it's a tool towards patient –centred care.' (Professional Leader)

Engaging people in service re-design

There were many instances where clinicians and managers described engaging patients in service re-design as being co-productive. One clinician described a process where patients were asked about how they would invest savings to improve services and these views were taken on board in service re-design:

*'We asked patients if we had re-investment money what would they like to see – improved access to tertiary care. A point of contact with multiple access… person, telephone, digital systems. So they could access their own drug therapies/drug results. So that was enabled by reinvesting drug savings into improved support.' (*Senior Clinical Manager)

On how to engage the public successfully on large service re-design projects, one clinician commented on the importance of high level buy in; there has been a very clear message from the Chief Executive and the Chair of the Health Board (on involving the public). It was also highlighted that 'patients understand service re-design':

'There has been a very clear message from the chief exec and the chair of the health board. Hundreds of people turn up to those, from the general public. It's a rolling programme of trying to engage the public. People get service re-design.' (Professional Leader)

Shared decision making and informed choice

Decision making was a central topic in conversations relating to co-production. There was agreement that shared decision making was a 'general Principle' of co-production. Better decision making or joint decision making was also frequently used as a means of describing a co-productive approach:

> *'What is needed for shared decision making in co-production: Asking both sides to be as honest and open as possible… what works and doesn't work. Risks and benefits… to both sides. Sharing responsibility and to be less controlling. For patients – it's about being open and honest about your wishes and feelings and taking some responsibility for what happens.'* (Professional Leader)

It was however also noted that shared decision making was only a part of taking a co-productive approach.

Clinicians often talked about 'informed choice' as being a central part of co-production. This was viewed as a positive outcome of talking a co-productive approach and a frequently sited example of co-production in practice. The following statement was from a clinician who had undertaken co-production training:

> *'People go away from us without taking a hearing aid that they are not going to use – that has increased quite a lot [since staff have had co-production training]. And that is a positive thing for clinicians…they know patients are going away happy and informed and they're not just going away and taking something they're not going to use.'* (Senior Clinical Manager)

Another clinician explained:

> *'As a GP – I've had endless debates – on the whole it's about 50/50. Patients say – yes, I'd like to have it [the PSA test] others say no. What is different [if taking a co-productive approach]? I would start with – that's absolutely fine, if you want the PSA test and that's what's right for you… but now let's have the discussion as to whether it's in your best interests. Because there are implications. So it's patient choice….'* (Professional Leader)

PRE-REQUISTIES FOR CO-PRODUCTION

Acknowledging the wider determinants of health

> *'It's only when people have a belief that their lives are worth living that they start taking care of themselves. I have a life that's precious, I can be something. So that's what we are after. Social justice.'* (Professional Leader)

A number of interviewees acknowledged the impact of the wider social context in which co-production would take place. There was very broad agreement from policy makers, clinicians, managers and co-production practitioners that life circumstances play a large in how successfully people will engage in a co-productive process around health**:**

'At the moment it doesn't seem realistic to expect people to do self-care or self-management it seems ridiculous doesn't it….if you have a chaotic life, alcoholic with 6 kids… are you not going to be a able to manage your diabetes or hyper tension…' (National Policy Lead)

'They decided to take a co-production angle and asked people outside the school gates etc. what is the real problem in their lives and it was most often money. Interestingly they did it in Carmarthen just before the holidays and kids that get a free school meal weren't getting a free meal during the holiday so the prospect was terrifying. So they found out what was important and it was feeding the kids, and mums anxious about teenage children going off the rails. And those two problems are so powerful it's no wonder they didn't find time to go for a walk or travel to a nice shop to buy vegetables.' (Professional Leader)

It was also acknowledged that for co-production to be successfully embedded in more disadvantaged communities there would need to be a suitable engagement process:

'It has to be some sort of integrated approach….peer activist or champion…it doesn't have to work in a particular way but have to make sure everybody has a chance to do self-care, self-management.' (National Policy Lead)

It was also highlighted that for co-production to work, the right support would need to be available to enable behaviour change. The examples given were mostly related to lifestyle behaviour change; access to smoking cessation services and support to manage a healthy weight were commonly quoted.

Another observation was the role of primary care in 'doing co-production' and the potential positive impacts of engaging with patients to encourage development of healthy communities:

'I think GPs probably do feel they are too busy to do it…..but it's in their interest to do it because it's a way of becoming less busy…because there is no doubt if you have more engaged communities…..they are the more healthy communities and their demands of primary care will be less.' (Professional Leader)

'The NHS is quite a middle class paradise… we don't always talk quite openly about people who are very vulnerable, or have mental health problems, people who are travelling, displaced or socially isolated, it's not what our conversation is about…' (Professional Leader)

Public engagement and awareness raising

A number of managers spoke about local approaches to engagement as a part of taking a co-productive approach. For example, ensuring interventions were developed in a 'co-productive' way by taking into account the views of the community, for example by carrying out qualitative assessments and through consultation. Workshop participants talked about the risk of 'over asking' with little action. It was also suggested that consultation and engagement with smaller groups of patients or the public on discrete topic areas of interest is a better way to engage than broader conversations.

There were also some examples of clinicians taking a co-productive approach, feeling supported by Prudent Healthcare policy, to have what they described as more challenging conversations to engage patients. For example, Prudent Healthcare has encouraged:

> *'Having conversations about cost of drugs with patients – to reduce waste.'* (Local Senior Manager)

Managers and clinicians agreed that there was a role for Welsh Government to be involved with an awareness campaign around Prudent Healthcare:

> *'It's never been properly launched into the public domain by Welsh Government.' (Local Senior Manager)*

There were a few general suggestions about what this might involve, or look like, one workshop participant commenting:

> *'The minutiae matters… I'd point to social media and the new media to help engage with people, of all ages – we need to have smarter ideas about how to push information towards people – it can divide people, but the debate can be stifled.'* (Senior Clinical Manager)

One interviewee highlighted that there have been successful awareness raising campaigns, for example antibiotic prescribing in England.

> *'Antibiotic prescribing in England is quite interesting. Everyone knows that antibiotics are wildly overused. People have got that message.'* (Professional Leader)

Workshop participants agreed that a communication campaign with 'nuanced messaging'; was needed to contribute to the conversation about Prudent Healthcare with the public. It was also acknowledged, that awareness is but one step in a process that should result in behaviour change:

> *'It's how you bridge the gap between people's awareness of these issues and how they act as social agents when it comes to their own.'* (Professional Leader)

There was also some discussion about whether there was a 'mandate' from the public for taking forward a prudent approach and whether this should form part of an engagement/ awareness raising campaign from Welsh Government.

Addressing public perceptions of the medical model

A very commonly discussed topic was the need for a cultural shift around the prevailing acceptance of the 'Medical Model', which tended to assume that there was a medical 'fix' for most health-related problems:

'We have to recognise there are very powerful countervailing forces….partly public and partly professional. The public still believe that modern medicine is wonderful and there will be a solution for everybody…however old they are and whatever state of terminal illness they are in. We are still in a consumerist society with England still responding passively to consumers' demand.' (Professional Leader)

This was viewed as a pre-requisite for engaging the public co-productively. Many interviewees saw co-production as a process that would lead to less medical intervention, which would need to be accepted by the public if it was to be successfully achieved:

'The public are still on the escalator … if you are going to see a GP… and you get a prescription as a result….or if you get an outpatients appointment brilliant…I'm being taken seriously…….or if you go to clinic and somebody sends you for tests …if you get an operation cos you're really ill ……there is an escalator where the more that happens to you seems better. I think the public are still in that place…I don't think the public will necessarily buy that less healthcare is actually better for them.' (National Policy lead)

Redressing the Power balance between the health service and the public

Many interviewees spoke about a 'power shift' being necessary for true co-production to take place:

'Co-production tries to permanently change the power balance.' (National Policy Lead)

'If you can equalise the power relationship, make that patient an equal partner in a joint enterprise of making things better – than that would be a much more powerful way of bringing about improvement.' (National Policy Lead)

Many clinicians also agreed that sharing power with patients was a challenge to the traditional doctor/patient relationship and would require significant culture change:

'It's the slowest and it is cultural shift… Most people in the NHS are not comfortable with trading power – so that is going to be the challenge.' (Professional Leader)

It was also recognised that redressing the power balance would mean that, in the long run, the health service would be sharing the responsibility for the population's health with the public, which was viewed as a positive outcome:

'At the moment people don't feel they have any power to either influence their own health or health services…as a result of that the health service has the whole problem and to provide the whole solution.' (National Policy Lead)

This point also cropped up in conversations about sustainability:

'I formed a view….one of the most fundamental things that the NHS needs to do to become sustainable is to allow a shift in power.' (National Policy Lead)

Many clinicians recognised the importance of patient as assets in successfully co-producing health. This was echoed in many conversations about the importance of understanding the patient perspective. Clinicians talked about 'really listening', involving patients and having 'better conversations'. Patients were recognised as being 'experts' in their own health:

*'It's about rebalancing the power. So trying to re-balance that. This person has the key if you like. You have two aspects coming together…An expert in knowledge…and an expert in – this is my body and my brain I know what my life is about.' (*Professional Leader)

*'If that power balance was shifted so that the service became more responsive to what people told them….people would feel more engaged, involved and more of a kind of a mutualistic influence then we would start to blur the boundaries and start to get services that really met people's needs…which we don't have at the moment.' (*National Policy Lead)

Responsibility for redressing the power balance was described as lying with the NHS, with clinicians being key actors in making the shift to a more equal re-distribution of power:

'It's largely within NHS's control to allow a shift in the power relationship that is so imbalances…' (National Policy Lead)

'Co-production is always about power and trying to erode the way in which in services, the power sits on one side of the table – you either operate in ways that hugs the power close to you and treats the other person as simply the object of your activity. Or you try and edge your relationship in a different way.' (Professional Leader)

Responsibility

Managers and clinicians agreed that there was need for a 'conversation' with the public about taking responsibility for their own health needs:

'We need a very strong message to citizens that they are responsible for their own health.' (Local Senior Manager)

'We can only go so far without the patient taking responsibility.' (Local Senior Manager)

It was also described as a common sense approach:

'Why would you not want to recalibrate the relationship so that the patient becomes a much more active participant?' (National Policy Lead)

The responsibility for communicating this message was described as 'belonging in every interaction' but also a role for Welsh Government in communicating a broader message. One

national policy lead expressed the view that the public *take a slightly harder line on responsibilities than the professions.* Several managers highlighted examples of areas in which there has been evidence of co-operation from patients and patients taking responsibility for their health. Two areas highlighted in one Health Board were Orthopaedics and Medicines Management. In Orthopaedics the examples related to overweight and obese patients engaging with a weight management approach. This resulted in less referrals to surgery for joint related problems for these patients. And in Medicines Management examples were related to reducing medicines waste.

Sustainability of the health system also emerged in conversations about individual responsibility and health. Many interviewees talked about the health service being unsustainable without citizens taking some responsibility for their health.

Another point raised by both policy makers and clinicians was the translation from awareness to action, with one national policy lead commenting:

> *'It's not just to instigate a conversation with an individual….it is actually you allowing them to go away with some actions as well.'* (National Policy Lead)

EMBEDDING CO-PRODUCTION

> *'We tried to do it all – and that is the biggest failing and biggest recommendation we can give anybody in Wales is… do not set yourself up for a fall – you get the Prudent Healthcare toolkit, you come out and you say, right I'm going to run with this and do it all … you can't it is such a precise change of culture you have to take exceptionally small steps, you have different levels of clinician activation, you have ambivalence ….and you have people who say, yes of course, lets empower the patient to be an agent in their own care, reduce their dependency on us, let's get them living…. Living better on their own with the condition…what will we achieve if we solely base their health needs on the time they spend with us?* (Senior Clinical Manager)

The following section is learning from service areas where a more systematic approach to embedding co-production has been adopted. This includes two services areas, Audiology and Podiatry in ABMU Health board where all staff within the service have received co-production training. The consultation process was adapted to include a pre-consultation questionnaire that prompts patients to share what they would like to cover in the consultation. This is then taken into account by the clinician, who balances clinical judgment with patient preferences of what to concentrate on in the consultation. A case example exploring this process for the Podiatry service in ABMU is given below, in Box 5.

Box 5: EMBEDDING A CO-PRODUCTIVE APPROACH IN ABERTAWE BRO MORGANNWG UNIVERSITY HEALTH BOARD PODIATRY SERVICE

As a Health Board, ABM have been interested in co-production training for about 4 years now – so that was before the launch of Prudent Healthcare Policy. We have input from trainers in the south of England who specialise in co-production and self-management training and have been involved with training all staff in the podiatry service and in other parts of the Health Board too.

In terms of the Podiatry service, we made a decision to systematically train all of our staff and to incorporate coproduction as core part of how we deliver our service. The approach we take has a strong element of encouraging patients to self-manage. By June 2014 all 71 members of Podiatry and Orthotics staff, including administrative staff, had undertaken the 2 day training in co-production and self-management support with 4 week interval between sessions.

Although our interest in taking a co-productive approach pre-dates the launch of Prudent Healthcare policy, it has been a key part of conceiving this project – without Prudent Healthcare it would not have been such a priority to ensure all podiatry staff are trained.

Drawing on the self-management aspects on the co-production toolkit, we have introduced a new system for our patient consultations. Patients are given a pre-consultation questionnaire to complete in the waiting room, as part of this questionnaire, they are asked to tell us to list what is important for them to discuss at the consultation. We ask them to use an 'importance scale' from 1-10 to tell us how important each issue is. Scaling allows us to explore patient ambivalence and raise the importance of health issues where it needed most. We then use this information to "agree the agenda together" and reconcile – with clinical judgment – what to cover in the consultation-exploring with the patient both what they need and what they want. This aligns with Principle 3 and enables us to avoid unnecessary interventions simply because they are clinically indicated and to instead give equal consideration to whether the intervention may help the patient achieve the goals that matter to them. We also ask patients to assess on a scale of 1-10 how confident they are to achieve their goals in relation to each of their issues. Post consultation, we ask patients to report their importance and confidence scores again – to get a measure of how activated patients are to become effective equal partners in their own care. We also ask patients for qualitative feedback. We have seen a shift in confidence scores from below 7 to 7 and above demonstrating that clinicians have effectively empowered patients. The low confidence scores have allowed staff to direct effort and work with patients to overcome passivity and specific barriers to effective self-management. Scaling patient activation to self-manage by measuring self-reported importance and confidence, provides us with an opportunity to direct our support to exactly where it is needed most, to reduce passivity and inappropriate dependency on services.

Activation scores over time are central to our service PROM'S
Although the focus has been on how to make our relationships with patients more meaningful and co-productive, we have found that to apply the other principles, we also need to take a co-productive approach in all that we do, in our interactions with other professionals as well as our patients. For example, In addition to using the training to inform patient interactions – we have taken elements of the co-production training and used them to explore staff activation prior to undertaking PADR's and one to one management supervision meetings. Exploring staff importance and confidence prior to PADR meetings allows reviewers to focus support where it is needed most and has been effective in increasing staff activation and engagement to develop a PADR document which is equally valuable to the individual and service. This has enabled us to eliminate historic and significant waste associated with initiating 90 minute PADR meetings where staff activation to engage in meaningful reflection, objective setting and personal development planning is too low for the meeting to be of real value.

On our journey of embedding a co-productive approach within our service, we have found the key enablers to be; leadership buy in, starting with a small group who are enthusiastic about co-production and essentially, to keep going as this is not a culture change that happens overnight.

Our biggest learning is for each of us to take small baby steps to changing historic practice so that we can sustain momentum and continually improve. Acknowledging achievements along the way is also vitally important.

David Hughes, Podiatry Manager & Clinical Lead

Co-production training

In two examples where a co-productive approach was embedded in a service, all team members completed a two-day training course. This was seen as an essential part of transforming the service and 'bringing staff on board'. However there was a strong view that although the purpose of the training was making staff skilled enough to use co-production' it was also about developing skills in practice and continued improvement. This was a view shared by workshop attendees who agreed that:

> *'It's not all necessarily about training in a traditional sense …. It's learning by doing.'*

There was also recognition that flexibility in application of skills developed is necessary:

> *'We modify it to meet our needs – nobody is going to sit down for half an hour but you use it for your needs…that would be different to the needs of a Podiatrist or Audiologist.'* (Senior Clinical Manager)

It was also recognised that there was variation in how comfortable staff were in taking a co-productive approach – and that this should be expected and not viewed negatively. Finally it was suggested that integrating co-production training in medical and allied health professional education would be a good way to embed the approach.

Training non-clinical staff

Many of our conversations on co-production were limited to the experience of clinical and allied health professional staff, although one manager highlighted the importance of engaging the wider team:

> *'It isn't a tool just for direct patient care – that's one of the good things we did in the beginning… we didn't just bring the clinicians in.'* (Local Senior Manager)

Every single member of the department had training – two full days of training with four weeks in between. In this example, administrative staff were also trained in co-production, alongside clinical staff. There was recognition that the wider workforce also had a role to play in making the health service more co-productive:

> *'It also gave them [admin staff] the tools of co-production to deal with patient problems.'* (Senior Clinical Manager)

Co-production for staff development

Using a co-productive approach to develop staff was also described as another way of embedding co-production in the system:

> *'I designed a workshop in co-production, how to co-produce a management supervision session with staff – so that's another element of how we've used co-production.'* (Senior Clinical Manager)

It was noted that this helped staff see the benefits of using a co-production and that it was adopted because it was an efficient way to approach the process:

> *'Even up to half an hour, they get a very structured conversation… They felt they could tell us what they wanted, what they wanted to achieve and they started coming out with the solutions.'* (Senior Clinical Manager)

Embedding co-production

The workshops identified several facilitators for co-production, and some practical suggestions for embedding it:

Facilitators

- Take small steps
- Accept different levels of clinician activation and ambivalence
- Use simple language – the term co-production can be a barrier
- Make learning bite size and less academic
- If you're not using it every day – something you have to keep using otherwise it gets rusty.
- Make training it bitesize and less academic helps
- Get early leadership buy in
- Picking the right team
- Establish a small group of follower buy in
- Getting managers on board – maybe extra training?
- Chipping away at key people

How to keep staff engaged and keeping it going

- Stop trying to do everything – small steps are key
- Don't remind everyone what they are failing at – draw on positives
- Get examples and real benefits of co-production and Prudent Healthcare. This generates interest and can be expanded
- Very importantly – remind staff of key health outcomes they are working towards, such as reducing diabetic foot amputations, and demonstrate how co-production would help to achieve this

- Share good practice. 'We're a small country, not many Health Boards, let's all be a forum for each other, lets help each other, if you want to set up a co-production project, invite people to come and talk'
- Embedded co-production training in medical education for nurses and doctors

CONCLUSIONS

Interpretations and definitions of co-production were wide ranging, with no examples of a radically new way of doing co-production since launch of Prudent Healthcare policy. It could be argued that many of the processes described as co-productive are well recognised methods that the health service has used to involve patients that pre-date launch of Prudent Healthcare policy. What did emerge from conversations was a real appreciation of the magnitude of change in attitudes of staff and patients if a truly co-productive approach was to be embedded. The following emerged as key points:

- A major shift in the power balance between the public and professionals is key to embedding co-production;
- Sharing responsibility is not only essential for co-production to take place – but for the sustainability of the NHS;
- A targeted approach should be employed to engage communities that could most benefit from improving health behaviours through a co-productive approach;
- Co-production training should be integrated into medical training;
- Co-production is a skill that is developed over time and as part of 'learning on the job'.

CHAPTER 7 - THE IMPACT OF PRUDENT HEALTHCARE

This chapter considers the impact so far of Prudent Healthcare policy in Wales on prevention, health needs and clinical risk; on prudent pathway re-design; and on the impact on primary and secondary care. Other chapters have discussed the impact on the workforce and on co-production. A number of case examples[27] are also included to show how and to what extent Prudent Healthcare has influenced service developments.

PREVENTION, HEALTH NEEDS AND CLINICAL RISK

Discussion about prevention, health needs and risk centred around the first part of Principle 2: caring for those with the greatest health need first. Conversations fell into two main categories: individual need and risk and population prevention. Generally, clinicians interpreted need based on individual need, whereas policy makers, managers and public health practitioners interpreted need as population need. According to policy makers, the intention of the policy was to cover both of these aspects. One senior clinical manager recognised the tension between these two perspectives:

> *'There is a tension between needs of individuals and overall population…we need to accept that there is a tension'*

Several clinicians highlighted the benefit of applying this principle to assist decision making more focussed on patient need and risk, rather than risk alone:

> *'We provided services based on risk, we now have a need based service, informed by risk. We don't see high risk patients if they don't have a need'* (Senior Clinical Manager)

This was further described by one senior clinical manager:

> *'Patients are seen every day, everywhere, in every single NHS building… because there is a risk.. Oh! There's a risk, we've got to see this person again, there's a risk. What are you doing? Just saying hello and making sure you're putting the right document in the notes to say everything is OK [it's] waste.'* (Senior clinical manager)

A case example (Box 6) demonstrates how prioritisation of need has impacted a national approach to assessment of Podiatry cases in Wales.

Box 6: Towards a needs based podiatry service in Wales

I was fortunate to lead a national task and finish group, with representation from each of the Podiatry services in Wales, to develop a system of taxonomy which classifies both patient podiatric need and clinical risk. The Podiatry taxonomy was ratified nationally in 2013 and adopted as standard patient classification by podiatry services across NHS Wales. Prudent Healthcare policy has influenced development of the podiatry patient taxonomy, with the national conversations

[27] Case examples were drawn from interviews and in some instances provided directly by participants.

stimulated by an early Prudent Healthcare paper. We have fundamentally adapted our approach to assessment and treatment planning across podiatry services in Wales, to take into account the prudent approach of 'Caring for those with the greatest health need first'. Under this new approach, each case is given a taxonomy code based on both need (A-G) and risk (1-4), and all cases are then prioritised taking these two factors into account. Explaining the taxonomy code provides a firm foundation to empowering patients as equal partners and supports the process of agreeing an agenda together, where clinical and patient priorities are reconciled. The "common language" relating to podiatric need and clinical risk across the profession has meant that there is a standard approach to assessment and treatment planning across Wales, reducing variation and ensuring those with the greatest need are identified and receive care in a timely manner. Having a needs based service also means reducing unnecessary interventions, which is aligned with a prudent approach. Taxonomy allows longitudinal analysis of need and risk through both the individual patient journey and across whole caseloads; therefore allowing us to identify and manage outliers and review low value interventions where podiatric need is static and not reducing.

Taxonomy is also now part of the Cardiff Metropolitan University BSc (Hons) Podiatry curriculum. I have developed and deliver the lectures to ensure that each of the taxonomy aims and objectives are aligned with each of the prudent Principles. This continues to be an exciting opportunity to foster a prudent culture at the earliest opportunity in the career pathway.

David Hughes, Podiatry Manger & Clinical Lead, Abertawe Bro Morgannwg University Health Board

Another policy maker highlighted the need to balance taking a co-productive approach based on patients 'wants' and clinically identified needs using a more critical approach, based on factoring in need:

> *'I think it's right to ask what matters to them….but they may want to have a whole series of preventative drugs just for the future just in case…that's unrealistic in the way we monitor resources.'* (National Policy Lead)

Leading on from this discussion, another key point raised was the question 'who defines need?' This point was also raised in conversations about co-production. One manager also highlighted the potential impact on current services if criteria for accessing services based on need were introduced:

> *'Who defines need? And we should only be doing what is needed. Some services will stop….Where is the conversation about that?'* (Local Senior Manager)

One Health Board discussed their recent transition from a delivery unit to a commissioning organisation, highlighting their approach of assessing population need to inform service provision. This was seen as a prudent approach, addressing health inequalities:

> *'The work that is done with the commissioning – we work based on need. For example, health inequalities. You have known unmet need and unknown unmet need. Not in touch with service. The commissioning programme is meant to address inequalities.'* (Local Middle Manager)

The role of assessing need to address health inequalities was also highlighted:

'Principle 2. Treating the most needy - the analysis that we do, looking at deprivation and inequality, we have a focus on commissioning at population level. The data helps to inform that.' (Local Middle Manager)

One National Policy Lead highlighted the role of health services taking a more prudent approach to address health inequalities and the impact this would have on overall population health:

'The NHS I think is aware to various extents of the problem of social inequity and outcomes but doesn't necessarily think it's theirs to worry about….they just provide services…you can understand that…we've come from a service based provider system. But that is wrong... Thinking through an equity lens might help organisations feel more in tune to their population and feel a bit differently about how they provide services…I think we should be starting to hold organisations to account on impact equity.....It's no good providing services assuming your whole population accesses them because they don't.'

The important link was also made between this element of Prudent Healthcare policy and how it linked to the *Wellbeing of Future Generations Act*. A number of interviewees recognised the potential to implement a preventive approach with wider public services through this mechanism:

'We've got the right legislative framework, so the requirement to work with other public sector organisations in a very upstream way is already there in the Wellbeing of Future Generations Act…..also, the principle of co-production or the fundamentally different power relationship is implicit in the wellbeing of Future Generations Act as well. The Commissioner says that her favourite of the 5 ways of working is involvement which I call co-production…so that's a good start, but then there is just awareness…people need to be aware the demand we behave so passively around is actually generated by us and within our own immediate direct day to day control.' (National Policy Lead)

This perspective was shared by many interviewees, both in the health service and in social services. One public health specialist explained how this approach might apply to addressing overweight and obesity, as a risk factor for diabetes:

'If you engage with the HB and broadly across the public service, diabetes as an example (there is greater chance of impact). It's not only about prudence in health services, it's about prudence in wider public services. So what are we serving in canteens, what are opportunities for physical activity? They complement each other quite well.'

A case example of how public health work, primarily related to prevention, in one Health Board is aligned to Prudent Healthcare policy is given in Box 7.

Box 7: Public Health projects aligning with Prudent Healthcare Policy

MAMSS

The MAMSS project is a national project looking at alternative smoking cessation models for pregnancy. Pregnant women offered a universal service typically don't engage. in the general population, uptake of smoking cessation services was about 1%, in pregnant women. In the wider population 3-4% of adult smokers engage with smoking cessation services each year. The population of Cwm Taf HB have the highest prevalence of smoking in Wales. We asked the question, if we designed a programme where we met the needs of pregnant women, what would that look like? The smoking cessation service for MAMSS was designed around what pregnant women wanted, which was a specialist, 1:1 flexible support service. Tailoring the service to the needs of the patient is taking a co-productive approach.

The workforce didn't need to be highly qualified, just having the right skills to meet need. In Cwm Taf we trained our maternity support workers in smoking cessation. All midwives were trained to routinely CO test women and refer those who smoked for cessation support with a maternity support worker. This is usually provided in the clients own home. MAMSS Band 3 Maternity support workers are working to the top of their license to deliver a smoking cessation support service for pregnant women. This was traditionally a service delivered by Band 5 smoking cessation advisors. The principle of only do what's necessary is aligned. We tailor the service to how much they need and do no harm. There are no adverse effects linked to a smoking cessation intervention. The pharmacotherapy is provided by community pharmacists as it's within the scope of their qualification. All maternity support workers are using the same approach. All pregnant women are routinely CO tested by midwives during their booking appointment. This approach is aligned with reducing inappropriate variation.

Bump Start

Excessive weight gain in pregnancy is a significant risk factor for low birth weight babies, especially pre term births. The Bump Start programme is a public health approach to addressing obesity in pregnancy. The weight management programme delivered as part of Bump Start is based on the Doncaster model (cited in NICE PH27, Weight management before, during and after pregnancy). Bump Start worked co-productively to develop training with input from Doncaster midwives.

The Bump Start programme is an example of professionals working to the top of their license. A Band 6 dietician and a Band 7 specialist midwife deliver the service. Women are seen at routine appointments and there is also support from a community midwife at key points if there is excessive weight gain. This service targets pregnant women who are obese (BMI ≥35) with the aim of reducing low birth weight babies who are born early from complications associated with maternal obesity. These pre term babies have poorer educational outcomes and are more likely to be obese as children and to develop associated chronic conditions. The Bumpstart programme addresses inequalities in health. The evaluation is on-going and will utilise the SAIL database. Part of the evaluation is working out cost of reduced time in hospital and reduced time in neonatal care.

Joint Care Programme in Orthopaedics

In Cwm Taf, 62% of patients who needed knee interventions were obese, compared to 28% of the general population. The public health team developed a 16 week course called the Joint Care Programme, to be offered to people as an option to support weight loss, before referral for surgery or as an alternative to surgery. The service is delivered by Local Authority exercise referral staff in community venues such as leisure centres and community centres promoting easy access for patients. This approach is based on evidence that weight loss reduces the need for surgery. If a patient is able to lose 5% of their body weight then the need for surgery is reduced. The outcomes overall were an improvement in Oxford knee scores equivalent to that of knee replacement surgery.

Prudent Healthcare policy helped to raise the profile of the work as it prevents the need for surgery for many patients and will also improve health and reduce associated inequalities in health.

Cardiovascular risk reduction programme – CVD Health Checks
The cardiovascular risk reduction programme is based on the Inverse Care Law, Julian Tudor Heart observation that people that need care most are least likely to get it. The programme was introduced maybe two or three years ago. The idea was that if we could target the population who were at risk of CVD disease (from lower socioeconomic groups) at an appropriate time, we could prevent CVD developing. The programme aims to encourage lifestyle behaviour change to reduce risk of developing CVD. We targeted 8 GP practices initially to take part in the intervention, which involved a one to one conversation with a trained Band 3 lifestyle support worker, who carried out a Health Check and then referred into lifestyle support and/or primary care. The Band 3 lifestyle support workers are an example of 'working to the top of your license' making the most effective use of all skills and resources. This programme is directly targeted at deprived populations to address the Inverse Care Law and inequalities in health experience by this population. The consultation involved a session with a computer programme and visual aides to assess and demonstrate risk. The approach was very much centred around working with people to assess risk. The programme is now being scaled up to reach a larger proportion of the population.

How Prudent Health policy has influenced public health work in Cwm Taf Health Board
All of these examples align strongly with Principle 2: caring for those with the greatest health need first; and making the most effective use of all skills and resources.
The reporting structure within the Health Board has increased the profile and visibility of this work, especially with the Chief Executive and Director of Finance. Prudent Healthcare has been a vehicle to help us demonstrate that prevention pays and to raise the profile of public health work in the Health Board.

Angela Jones, Consultant in Public Health, Cwm Taf Health Board

PRUDENT PATHWAY RE-DESIGN

> *'Since there has been a concept of PHC it has been easier to get in everywhere; there is more engagement around delivery of chronic care pathways. It's not just clinicians operating in isolation - there would be meetings around stroke, diabetes pathways.'* (Local Senior Manager)

What is Prudent Pathway re-design?

A number of areas of consensus emerged from discussions on what a prudent pathway is. Firstly, from workshop discussions to interviews with managers and clinicians, there was agreement that the patient should be 'at the centre' of pathway re-design. There was talk about addressing patient needs holistically, both in terms of meeting the best outcome for the patient and for efficiency in the system:

> *'At its heart PHC should be about redesigning health services and wellbeing and people's use of them, in a way that is* sustainable.' (Professional Leader)

In terms of how this would happen, there was much discussion about the role of co-production in pathway re-design. Discussion in a national workshop raised the question of

how to integrate the patient perspective into pathway re-design in a way that is meaningful, and managing to balance this with clinical knowledge:

> *[We need a] 'Mutual set of objectives…we need to determine what people want and the pathway is designed around that. So can we know what a pathway is until we have asked the patient what they want?'* (Senior Clinical Manager)

Other key discussion points were centred around balancing patient wants and needs and also between risk and need. One clinician at a workshop asked rhetorically:

> *'Do we need to see patients every 6 months? Who do not have a current need to be seen?'*

Leading on from the discussion about putting patients at the centre of re-design for improved patient health outcomes, there was also concern that managing patients in a mechanistic way was leading to inefficient, silo working. Clinicians commented:

> *'If conditions are managed in a very mechanistic way we may not understand impact on other parts of the pathway….seeing a patient holistically…. whole person care planning reduces this from happening.'*

> *'Parts of the system block others….you need cooperation across the board.'*

So managing patients holistically was seen as being prudent from the perspective of patient outcomes and also making the system more efficient.

Workshop participants talked about avoiding a 'reductionist' approach and tendency to 'fragment the service'. There was also discussion about highly specialised and over-complex treatment as being imprudent:

> *'Imprudence comes from highly specialised over complex approach/ treatment.'*

What makes prudent pathway/service re-design possible?

Through conversations with clinicians involved in re-design projects that had been both successful and those that had not worked so well, a number of points emerged that were considered key for prudent pathway re-design. First, the size of the pathway was identified as a key factor in determining success. Clinicians commented on the difficulty of moving resources in the health service, with pathway size being a key determinant on how successfully this could happen:

> *'Our learning was - we picked too discrete an area in atrial fibrillation. You need to have a pathway approach. How do you define spend along a pathway? And you can't wait for perfect - you have to go with the best information you have. We need to build capacity but let it not stop us*.' (Local Middle Manager)

'We learnt that we need to pick enough of a pathway – the pathway is fundamental to be able to shift left. To be able to move resources in a health board is difficult. You can't always move things, it would undermine capacity. You have to be able to shift resources - so the pathway needs to be big enough.' (Local Middle Manager)

A case example from Abertawe Bro Morgannwg University Health Board highlighting a successful pathway re-design project is given in Box 8 below.

Box 8: Programme Budget Marginal Analysis (PBMA) approach to improving Muscular Skeletal patient outcomes within existing resources.

The ABMU Commissioning for Quality team in partnership with Swansea Centre for Health Economics at Swansea University, facilitated a clinically lead Programme Budget Marginal Analysis (PBMA) approach to improving Muscular Skeletal patient outcomes within existing resources.

The project identified interventions that were considered not to benefit patients or improve their outcomes which when reduced/ceased could release staff, theatre and clinic capacity. In addition cash savings were identified through clinical agreement on changes to the procurement of related clinical equipment. The project used resource released from secondary care to fund a community based prevention and self- management service aimed at further reducing surgical interventions for patients with osteoarthritis where appropriate.
This work aligns with Prudent Healthcare policy in the following way:

- Patient views have been taken into account in re-designing the pathway, through a co-productive approach.

- A major focus of the PBMA approach has been to maximise use of all skills and resources, shifting resource along the pathway for maximum patient benefit.

- Reducing ineffective interventions aligns with the third principle of 'only do what is necessary, no more no less and do no harm'.

Full case example provided in Appendix 2

Kerry Broadhead, Commissioning Lead, Abertawe Bro Morgannwg University Health Board

Leading on from this point, flexibility in pathway re-design across primary and secondary care and flexibility to respond appropriately as new information comes to light through the process was also highlighted:

'Some of what we are doing is pathway based. We started looking at drugs for asthma and ended in redesigning the respiratory pathway to actually get across primary and secondary care agreement as to what the pathway should look like. [We got] agreement that we were going to modify the way in which asthma inhalers were utilised because we were high dispensers of the wrong types of inhalers, so they got clinical agreement on that… and then they looked across the pathway [pharmaceutical pathway] as to where they might invest the savings [pharmaceutical savings] into the best place in the pathway to actually improve prevention, so they decided a proportion should go into pulmonary rehabilitation.' (Local Senior Manager)

Clinicians and managers involved in service and pathway re-design raised a number of facilitators and barriers to service and pathway re-design. Facilitators were identified as a *'can do'* attitude by staff involved, a willingness to start in '*small pockets'* and getting started, despite not having the perfect data/resources. It was noted that there is *'always a reason not to'.* Barriers were identified as a '*fear to work innovatively'* for some clinicians this was related to a fear of not having 'cover' if they worked outside of their usual job role. Another barrier was described as having an overly process-driven approach with management and evaluation of projects.

One senior clinician who had experience of a successful national service re-design project made the observation that the integrated nature of the NHS in Wales, that was *'fluid around the boundaries'* made it conducive to working in an integrated way, which is an essential for regional and national re-design of pathways and services.

A case example of countrywide collaboration is given in Box 9 below. The Welsh Renal Clinical Network (WRCN) is given as an example of prudent working with a strong focus on co-production and partnership working.

Box 9: Prudent kidney care for Wales – the success of countrywide collaboration

The national approach: Renal services across Wales are coordinated (and commissioned) by the Welsh Renal Clinical Network (WRCN). Aligned with two Welsh principles, **Prudent Healthcare** and an **integrated health system,** the Network has been bold. Open-minded to reform and innovation, it has invested into different ways of doing things. The success of the Network perhaps lies in its makeup and its working. To deliver reform at scale and speed the Network has engaged with our most important stakeholders – our citizens. People delivering patient care are much more likely to be listened to by our citizens than they will our policy makers. The Network is a multi-professional team that includes people delivering patient care. It has recognised that frontline staff need to part of the policy making and that they are key to delivering the change at the coalface. The Network has been bold in working with partners in industry and the public service, exploring untested ideas for doing things differently; but with proper, proportionate and robust evaluation. Predicated on the **Once for Wales** approach the Network is less tolerant of differences in our system to remove waste and inefficiency. The speed and spread of reform has reduced inappropriate variation, ensuring what works well for one part of Wales works well for all of Wales, and disinvesting into things that don't work well or are not cost effective. The can-do attitude of the Network is palpable and its mechanisms for delivering national strategy, audit, comparative benchmarking and therapeutic tendering have produced many examples of large scale service modernisation that are delivering better, more innovative care at significantly lower cost. Many millions of pounds year on year have been liberated for reinvestment; how to reinvest has been guided by patients, enabling the service meet demand, deliver treatment firsts, adapt to the needs and expectations of patients and embrace digitalisation and new technologies so it is fit for the modern era. Chronic kidney disease is just that; chronic. The Network has been keen to bolster the interface between our care setting. Focusing on flexible access to specialist services, underpinned by digital and physical outreach services, our patients and our primary care colleagues are shored up to enable supported self-care. What kidney patients can achieve in terms of self-care and health literacy is inspirational when they are given the correct support, tools and resources.

Christopher Brown, Consultant Pharmacist, Abertawe Bro Morgannwg University Health Board

A number of interviewees who had some experience of pathway re-design made the observation that short term targets and budget constraints can hinder attempts to re-design a pathway:

> *'Middle management ……people are too concerned with balancing budget month to month to reorient a service.'* (Professional Leader)

Where there were examples of successful pathway re-design, a key facilitator was re-investing money into developing services:

> *'So it was designed not just for saving money – better pathways for patients and the opportunity to invest in other pathways.'* (Senior Clinical Leader)

It was also agreed that re-investing as a result of taking on board patient perspectives is a *'motivator'.* This view was also echoed by workshop participants, who agreed: [it's] *important to keep some return into service…. [but] not always easy'.* It was noted that investment is needed but this is not easy because there are competing targets and pressures that are more immediate such as the referral to treatment targets.

Another significant element of service re-design focussed on workforce development. A case example is given in Box 10 below.

Box 10: Development of the Medical Technical Assistant (MTA) role

'There is huge potential for making our services/NHS more prudent through workforce development – the thinking is not new, but PHC helps to provide a focus'.

The purpose of the MTA role was to bring patients through the A&E system more efficiently, and to reduce overall time spent waiting for minor medical procedures, that could be done competently by well trained lower grade staff.

The starting point for designing the MTA role was focussing on what patients needed at each point in the pathway, and then looking at the skills necessary to meet those needs. Staff who were previously at Band 2 were then trained up to Band 3 level, with a focus on developing competencies that were essential for treating patients at each point along the pathway. This included learning to cannulate, take bloods and catheterise. There are now 9 Band 3 staff who have been trained to deliver the MTA since inception in October 2015.

The development of the Medical Technical Assistant role has drawn on four of the Prudent Healthcare Principles but there has been a particular focus on part of Principle 2; 'making the most effective use of all skills and resources'. The role has also encouraged communication and a co-productive approach between professionals, particularly across bands, from MTA assistants to consultant level. There has been a very enthusiastic embracing of the new roles by staff, as they are now working to 'the top of their licence' and have good job satisfaction. A facilitator for this work was identified as picking roles where staff are 'ripe for development'.

Kath McGrath, Assistant Director of Operations, Cwm Taf Health Board

PRIMARY CARE

> *'We don't map everything we do across the principles – but Prudent is what primary care are focussing on…. making sure GPs are prescribing only what's needed and most cost effective…'* (Senior Clinical Manager)

Typically, as the first point of contact for the health system, the role of primary care has been given much consideration in the conversation about prudence. Many clinicians talked about broadening access to a range of pathways from primary care, with increasing emphasis on matching patient need more accurately with services provided:

> *'I feel its primary care's responsibility to help patients understand where they need to go with their problems. It became a bigger project when we were encouraged to go into cluster working. It was a true collaboration between two practices doing two very different things …we were just triaging and using telephone advice for a lot of problems whereas another practice in our cluster was triaging but also referring directly to a physiotherapist that they were using in their practice and they said that was an amazing freeing up of time for the GPs, and of course the patient actually does get the better service.'* (Local Senior Manager)

A case example highlighting the improved efficiency and patient outcomes for an Audiology service embedded in primary care is given in Box 11. Historically, patients would be seen in primary care by a GP and then referred to Ear Nose and Throat in secondary care for a range of treatments. Introducing an Audiology service in primary care has meant patients are able to be seen by an audiologist who is also able to carry out treatment. This meant less waiting time for patients and also reduced number of face to face appointments with GPs, where it was more appropriate to see another professional.

Some policy makers also described primary care as being a key point of contact because it frames the way in which patients interact with the system further along the treatment pathway. One National Policy Lead commented:

> *'It's about getting downstream… building up an experience with patients that means it influences the way in which they engage with any contact that they have had….best area to develop that would feel first point of contact which is primary care… I agree if your first contact with your GP or with your primary care professional perhaps rather than just the GP frames the way in which you are going to interact with the service in the future. I think you would feel more informed and educated and you probably follow that experience through after.'*

It was also recognised that re-design of specific pathways starting in primary care would impact others:

> *'It is Prudent to reduce pain med prescribing – but how do you do that without involving the whole pain management pathway?'* (Local Senior Manager)

Another point of consensus was the benefit of applying 'only do what you can do' to primary care in thinking about service re-design and a more prudent primary care service. Several examples were given of allied health professionals working in primary care, primarily to reduce the number of patients GPs routinely see who could be seen by other professionals.

'A lot of activity going on….driven by a number of elements. A lot of it is driven by quality agenda…. and making sure that patients are seen by the most relevant professional as early in the pathway as possible… that previously has usually seen the GP….a combination of drivers…one is General Practice sustainability, and another is patient quality… and that's probably the key driver.' (Local Senior Manager)

'Our pharmacists are triaging patients….so GPs are only seeing who they need to see. Our [pharmacy] technicians are looking up to be trained [in co-production]…. how do they use those principles to deliver their role?' (Senior Clinical Manager)

'111 for example….working alongside GPs; Shown a reduction in appointments….load of data that shows this….we're stopping appointments, advising patients, keeping patients at home.' (Senior Clinical Manager)

Box 11: Development of Primary Care Audiology Service

The audiology service in ABM HB, is now part of primary care delivery unit, which has made a very big difference in terms of access to decision makers interested in this project. Audiology services are usually in the same organisational structure as ENT, within a surgical directorate, so management may have traditionally been less receptive to ideas about development of a primary care audiology service. Being embedded in primary care made a big difference. There was interest and buy in about ideas that have been discussed at national level in relation to development of audiology services, in relation to taking some of the pressure off GPs and providing an effective service for patients. There was also recognition that there are many services that are provided in hospitals that could be provided in primary care - that was the basis for the initial conversation.

Stakeholder groups were set up in February 2015 with the pilot launch of the service in August 2017. The pilot has covered 11 GP practices with sites in Swansea, Neath Port Talbot and Bridgend.

We found that GPs and cluster leads have been very much on board - resistance has been low. At a national level thinking about audiology services has been in line with Prudent Healthcare policy and aligning our work with Prudent Healthcare policy and has been useful in applications to the workforce development fund.

The audiologist in primary care is a one stop shop. For example, Audiologists have been trained to do wax removal and they also carry out hearing assessments. The patient is either discharged from the service or is referred to their GP; roughly 45% of patients are being discharged; 35% are referred to Audiology because they do need a hearing aid or they have tinnitus; 15% require an ENT opinion and 5% need to be seen by the GP. There will be a significant reduction in demand on GPs.

How this approach aligns with Prudent Healthcare

Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production;
All audiology staff have had co-production training and are encouraged to use a co-productive approach in their consultations. Emphasis is placed on ensuring that patients are aware of their treatment options and that they don't feel obliged to take on any form of management if they don't feel they need it. Audiologists also use a pre-consultation questionnaire. It helps our patients to think through what they wish to achieve from their appointment. The approach is really adapted based on need – there isn't a uniform approach to being co-productive.

Principle 2: making the most effective use of all skills and resources

Making the most effective use of all skills and resources has been at the centre of this service. We were trying to reduce number of face to face appointments with GPs, whilst ensuring that patients are seen in a timely way and by an appropriately trained health professional, to meet their needs, as soon as possible. Having a primary care audiology service means that many ear and hearing related cases can been seen and treated in primary care by an audiologist instead of waiting to be seen by a secondary care specialist. We used the approach that if patients had symptoms with ears or hearing instead of seeing their GP in the first instance, they would go to an audiologist. The audiologist takes a history and does hearing assessments, ear-care and then along with the patient, makes a management plan.

We have reviewed our skill mix and are using increasingly higher levels of Bands 2, 3 and 4 staff as part of the audiology service. We constantly review what can be done by what grade staff with the aim of making the most effective use of our resources. We need to use our more highly skilled staff for the primary care approach and these staff are then backfilled by appropriately trained staff.

Rhys Meredith, Audiology Service Manager, Abertawe Bro Morgannwg University Health Board

This sentiment was echoed by a local senior manager who describes primary care as being 'the driver for prudent' and needing to address the need for more time for each GP appointment. For example, to include lifestyle behaviour advisors to provide a service at GP surgeries to free up GP time to 'do what only they can do'. This was also described as potentially being more acceptable to patients too.

Patient pathway, or pathway for the public?

Although primary care was recognised as a key point for pathway re-design as it is the first point of contact for a patient in the health system, where was recognition that the patient or public pathway is a series of choices before arriving at primary care? One workshop participant raised the point *'where does a service start?'* There was consensus that patient empowerment and an opportunity to influence lifestyle behaviour comes before primary care. There was also consensus that *understanding* and *buy in* from the public is needed to influence choices early on in the pathway.

It was recognised that wider public services, education and housing also have the potential to impact health outcomes and that engagement with a 'public' pathway should start before a patient presents at primary care and with wider public services:

> *'I think health is missing at the moment from most of these arrangements…if health joined in …significant advocacy and leadership function, then it could really help galvanise the whole of the public sector and part of the co-production around primary care means that you may end up with primary care resources that are very much about non health…so if you are in Cardiff you may have a job centre as part of your primary care response, a children's centre, you may have parenting or antenatal classes…whole host of different activities not just health. Health cannot any longer stand apart from the rest of the public sector….it needs to become part of it and work with it…it's got a powerful role to play which is missing…the Wellbeing of Future Generations Act may take us in that direction.'* (National Policy Lead)

Many interviewees also talked about prudence being a shift away from the medical model. One policy maker described the potential role of primary care in re-directing patients down a non- medical pathway. A more integrated primary care system with closer links to social services and wellbeing and lifestyle support services was also described as being prudent:

> [One GP] *'asked her population what services they wanted and as a result she had 85 trained lay counsellors associated with her practice….. that's free…. that's people supporting each other…..co-production…… you are providing a whole range of non-medical responses to people. You are not medicalising people…giving them tablets…putting them on clinic pathways – wonderful!'* (National Policy Lead)

A case example of successfully working across public services to improve outcomes for women at risk of domestic violence is given in Box 12 below.

Box 12: Domestic Abuse and Violence

Following a joint thematic review by the Chief Constable and the Police and Crime Commissioner it was identified that responding to domestic abuse and violence was primarily a police issue, with the police tending to be involved when women were at high risk of serious harm, and that as a result the majority of services were geared to responding to victims considered to be at high risk of serious harm/death. The review highlighted that there was limited early identification and access to interventions via other agencies, in particular there were many missed opportunities within health settings.

The thematic review was being undertaken at the same time that the Violence against Women, Domestic Abuse and Sexual Violence Wales Act (2015) was under construction and it was evident that there would be a duty on Public Bodies to take a more proactive approach to the identification of and provision of support for victims affected by domestic abuse and violence, this statutory duty is known as Ask and Act.

As a result significant conversations were undertaken with the relevant health care leaders to identify solutions. As a result IRIS was introduced in Wales in 2014 by the Commissioner, bringing an established licensed model to Wales for implementation. The intention was twofold, 1. To improve health responses to victims and increase confidence to report, making it everyone's business, and, 2. Meet the statutory requirements of Ask and Act within a primary health care setting,

This work has been led by the South Wales Police and Crime Commissioner's team, IRIS National lead (New Link housing), University Health Boards, Heads of Safeguarding, Directors of Nursing, Midwifery and Patient Services. Lead clinicians for the LMC and Primary Care have also been involved in the development of the work. The above have been involved in concept discussion and agreement to pilot, and make a contribution to the delivery and implementation costs.

However it is important to acknowledge that the Commissioner has been responsible for the delivery of IRIS in Wales and has and continues to be the substantive funder. The model requires a partnership approach between health and third sector specialist agencies, drawing on their respective expertise and influence.

How the IRIS case example is aligned with Prudent Healthcare principles:

Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production:
It has developed a new way of working within primary care, an increased awareness within participating practice teams of indicators of domestic abuse/violence, resulting in in more GP's asking patients about domestic violence and abuse, it has enhanced record keeping (as a result of targeted training and the provision of a care pathway with a single point of contact for referrals from GP's).

Care for those with the greatest health need first, making the most effective use of all skills and resources
As a result more GP's are routinely asking patients about domestic abuse and violence than prior to IRIS implementation

Do only what is needed, no more, no less; and do no harm
IRIS model is working well, the GPs ask the question, and refer to a specialist who can assess risk and need and provide support or refer onto appropriate services.

Reduce inappropriate variation using evidence based practices consistently and transparently.
The IRIS training is delivered to all participating practices, and the IRIS model is adhered to ensuring patients in IRIS aware practices are more likely to benefit from early identification and intervention thought accessing primary health care services.

Janine Roderick, Consultant in Public Health, Policy Lead for Public Health and Policing in Wales

End of Life Care

In a workshop bringing together a range of End of Life (EoL) clinicians and managers, there was significant discussion on building community resilience as a key element of enabling 'prudent' End of Life Care. A number of resilience-building initiatives, such as Compassionate Communities in England were referenced as good practice examples. Clinicians highlighted advance planning and supporting carers in their roles as practical elements of providing End of Life Care.

The view that longer term planning is key to end of life was shared with policy makers. Additionally, the concept of avoiding a mechanistic approach also re-surfaced in conversations around EoL care, with both policy makes and senior clinicians:

> *[End of life] 'It's not just to do with cancer. It can be a machine breaking down and how to best fix it. It happens to us all, it's inevitable and we should be looking at planning for end of life several years before and the health systems should also be doing it that way. It is a priority because in changing that element of life you have to change what's happening before that in order to arrive. [It's easier to understand what it means and why you'd want it] I agree you've always got that dilemma – do you compartmentalise it? People have said to me, prudent pharmacy, prudent diabetes, and prudent lymphedema. That's not the way to do it. It should be lymphedema with a prudent approach. Instead of having to think to yourself in diabetes what am I doing that shows we are doing the principles. You should be doing that anyway – tick. That's the message because it's not just something we should be doing ad hoc here and there. Even if it takes longer we should be doing it as a system.'* (National Policy Lead)

Again, the risk of providing 'fragmented' care in managing EoL care was highlighted by participants in the EoL workshop.

Senior clinicians recognised the importance of taking a co-productive approach around EoL care. Whilst it was agreed that EoL presents a significant time to get co-production right, it was also acknowledged that it is a complex issue. The question was raised *'is it [co-production] always what people want or need? '.*

Finally, one policy maker highlighted the potential of EoL care to make progress on applying a prudent approach:

> *'End of life care - another way of approaching it would be to take something that would appear to be a really rich scene where there is so much going on where everyone one knows, understands. Everyone will be in that situation. Another situation would be to take an area like that….and really major on that.'* (National Policy Lead)

The TalkCPR Project in Box 13 below highlights a successful example of improving communication to improve patient involvement in important end of life decisions.

Box 13: Communications in End of Life care

The aim of this project is to improve communication and dialogue between patients with palliative and terminal illness and their healthcare professionals about 'Do Not Attempt Cardiopulmonary Resuscitation decisions'. Four videos hosted on a website aim to describe some of the main areas to consider when discussing this important topic. Videos were co-directed by patients, in order for them to help explain relevant issues surrounding this sensitive subject. In addition, videos for healthcare professionals with guidance and tips on how to start these conversations sensitively and professionally are also available on the http://TalkCPR.wales website. We also aimed to clarify some of the common misconceptions surrounding CPR, allowing natural death and DNACPR towards the end of life in a news article. This project is referenced in this Guardian article and can be found here http://www.theguardian.com/healthcare-network/2016/feb/03/casualty-cpr-fails-cancer-doctors-let-patients-die

This project supports Prudent Healthcare:

•Public and professionals are equal partners through co-production:

DNACPR discussions are some of the most sensitive and delicate in healthcare today. Many palliative care workers have experienced that patients want to be involved in these decisions and are not usually offended by their healthcare professional bringing this up. The TalkCPR videos and website encourage this dialogue, try to inform about the challenges of CPR and encourage open communication. They were made, produced and reviewed by patients and carers in Wales, and are all the more powerful for it.

•Care for those with the greatest health needs first:

The videos are aimed at patients with palliative and life-limiting illness, as well as their carers and their healthcare professionals. There are tips on how to frame these conversations within the wider care that will be provided.

•Do only what is needed and do no harm:

More should be done to prevent modern medicine from automatically defaulting to cardiopulmonary resuscitation in palliative care patients. Admission to hospitals and ITU in situations where a prior, honest and candid discussion with a seriously ill patient may have elicited that they would rather remain at home, are a missed opportunity. DNACPR forms do not preclude

patients from very active treatment and the treatment ladder approach in the Top Tips video makes sure that only those procedures are considered that patients would feel appropriate, no more, no less. We checked carefully with our user groups that these videos were not insensitive or harmful, and in fact some responses felt that they could have been more explicit and blunt. But overall view was that we got the balance right.
•Reduce inappropriate variation through evidence-based approaches:

Videos are being rolled out via the DNACPR implementation group to each Health Board and Trust in Wales and are also available on Howis. Two English Trust have approached Public Health Wales and asked whether they could use the videos in their own setting, and Pulse magazine have written a feature for GPs in the UK, on this novel video and website approach to get patients and carers to take a lead on DNACPR. Videos are available in English and welsh and provisions have also been made for blind, partially sighted and deaf patients.

Dr Mark Taubert, Clinical Director/Consultant in Palliative Medicine, Velindre NHS Trust, Cardiff

SECONDARY CARE

A number of wide-ranging case examples from secondary care were provided by clinicians and managers as part of this study. The following case studies are included in this section:

- Musculoskeletal MRI service improvement project from Hywel Dda UHB
- Orthopaedic pathway re-design from ABMUHB
- Patient Experience Advisor role as part of Neath Port Talbot 'Prudent Hospital' initiative in ABMUHB
- Prudent kidney care for Wales – the success of countrywide collaboration
- Post kidney-transplant services: a case study of aligning service with Prudent Healthcare principles ABMUHB
- Implementing ICHOM's standard set of outcomes: Parkinson's disease at Aneurin Bevan Health Board

The case example in Box 14 highlights the role of Prudent Healthcare in progressing a service improvement project in Hywel Dda Health Board. Prudent Healthcare Policy was marked as a central factor in progressing this initiative, by securing senior clinical and management buy in. The case example below demonstrates the significant improvement this approach made to reducing unnecessary procedures, with an 80% reduction in unnecessary scans whilst the service improvement methodology was in place.

Box 14: Musculoskeletal MRI (Magnetic resonance imaging) Improvement project

Radiologists were receiving a high volume of routine requests for MSK scans from GPs, which resulted in a large workload and time pressure to review and scrutinise requests for scans. Additionally, there was no access to a MSK GP specialist or MSK radiologist in the Health Board, so if a clinician was unsure about whether to request a scan, or subsequently had difficulty interpreting scans, there was no specialist to consult with for further guidance. This resulted in a tendency to over refer.

An improvement methodology was suggested that would address these issues. Firstly, a multi-disciplinary group with wide representation from clinical specialities was set up. Two fundamental changes were implemented through this group. Firstly, the group put together updated pathways

and referral criteria for Lumbar spine, Cervical Spine Pathway, Nerve Root Compression, and Knee. Secondly, for the duration of the project the group met weekly and scrutinised all requests according to accepted criteria for imaging and the new referral criteria put together by the group.

How this project is aligned with the Prudent Healthcare principles

This project involved working co-productively with professionals across a range of disciplines. A range of professionals have been equally important in successfully implementing the improvement methodology. By reducing the number of unnecessary routine scans enough capacity was released to ensure that patients with the most need were able to receive the necessary intervention (in this case MRI scans) in a timely manner. This also aligns with the 'do only what is needed' aspect of Prudent healthcare, since the number of unnecessary scans was reduced.

How Prudent Healthcare policy has impacted this work

Prudent Health Policy was instrumental in securing senior strategic buy in for this new approach. The improvement methodology was a significant change to procedure for the Health Board so required considerable clinical buy in and co-operation for successful implementation. This was partly achieved due to approval from the Medical Director, demonstrating how the project was aligned to Prudent Health policy was helpful is making the case for this project and securing subsequent buy in.

Impact

In two reviews in February 2016 and July 2016 there was an increase in the number of requests for scans that fulfilled criteria and some evidence of improvements in practice around provision of clinical information on scan requests:

Review Feb 2016

- 82 out of 299 (27%) requests fulfilled criteria
- Majority refused due to lack of clinical information
- Many illegible requests
- Some requests with no clinical information

Review July 2016:

- 457 out of 1165 (39%) requests fulfilled criteria
- Majority refused due to lack of clinical information
- Improvement in clinical information provided
- Evidence of change of practice

Since completion of the project, scrutiny of requests for scans and interpretation of scans now sits with the Radiology department who continue to use the criteria developed by the project team to assess cases. Initially, there was a spike in referrals for scans as the new procedure was handed back to the department, but since embedding of the process within the Radiology department this has now stabilised and overall the number of referrals remains substantially lower than at the start of the project.
Sian Anson, Service Improvement Project Manager and Owain Ennis, Consultant Orthopaedic Surgeon, Hywel Dda Health Board

In considering how to make the health service more prudent, many interviewees expressed the importance of avoiding 'silo' working and the importance of working in an integrated way

across parts of the health service and between health boards. These two case examples demonstrate these principles in practice.

Box 15: Post kidney-transplant services

The Welsh Renal Clinical Network (WRCN) has delivered across Wales a programme of modernisation for the way kidney transplant recipients are managed. The prescribing, supply and monitoring of anti-rejection medication have been repatriated (in place of the GP) to the specialist centres. This has enabled controlled switching of these medicines to lower cost options. The outcome of this initiative is a service with lower per patient cost, removing the risk of inadvertent brand switching, centralised procurement of quality approved brands and increased patient access to and contact with specialist renal teams.

NHS Wales has moved at pace and at scale (and with innovation) to complete the change. The programme in Wales has been carefully planned by the medicines management arm of the Network, which is led by a highly specialised renal pharmacy team. It is this team that delivers the service day to day from the three regional centres across Wales. While the national programme delivers many advantages for NHS Wales, for the purposes of this report the model delivered from the Morriston Renal Centre is an example of how the experiences of the kidney transplant recipients of South West Wales have been bettered by this initiative.

How this model of kidney care aligns with the principles of Prudent Healthcare

Public and professionals as equal partners through co-production

Redesigning post-transplant services has been achieved through close collaboration with patients. Patients understood why change was necessary and the benefits it would bring; they would shape the look of the new service, identifying how saving they helped create would be used to improve their care and their experience. Direct access to secondary care was established at their request. Patients wanted improved support, a single point of contact which could be made in person, over the phone, by email, by text messaging or through the website. Patients wanted to have their ad hoc blood tests taken near to their home, at a place and time of their choosing, safe in the knowledge it would be digitally available for the specialist centre to review. Patients wanted easy access to their blood results, drug lists and dosing instructions in a way they understood and in a way they could choose - on paper, digitally through their smart phones or home computer or through conversation with the specialist centre (and in Welsh if they wished to do so). They wanted direct access for themselves (their carer or their GP) with a familiar person from the renal pharmacy team where they could discuss their treatments, their medication supplies, their concerns around drug levels or drug interactions. They wanted a one-stop shop for all their needs, blood tests, drug supplies, education and access to the multi-disciplinary team and all at the same time as their clinic appointment; they wanted not to wait or be subject to treatment delays, expecting the service to be ready in advance of their arrival at clinic. The service responded to make every contact count. Coproducing the service with-patients for-patients meant that individually they are equipped with the tools, resources and health literacy needed to be equal partners in their own care.

Care for those with the greatest need first making the most effective use of all skills and resources

Digital innovation and workforce modernisation has been key to delivering change. Pharmacist independent prescribers, supported by their up-skilled technical and clerical staff, work at the top of their professional license to manage high-risk medicines through a consolidated eRecord. This enables blood results and clinical notes to be digitally housed, allows electronic prescribing, automated dispensing, automation of patient literature and communication with primary-care and

creates the platform by which patients digitally access their own treatments. This patient-centred professional-integrated approach removes professional silos and creates a controlled environment to manage high-risk therapies by experts in that therapy. A lean medicines-management process and an appropriate skill mix means clinicians have more time with each patient and liberates time spent on administrative burdens to spend on patient care or more complex cases.

Do only what is needed and do no harm

Patients now have the support and resources to be active and equal partners. Patients can make informed decisions and are vigilant to potential sources of error or harm. The knowledge in primary care around medicines management for renal transplant patients is limited. Repatriated services have led to a reduction in inappropriate/too frequent or infrequent monitoring and failure to identify unwanted effects. Missed appointments have fallen by over half. Secondary care prescribing, supply and monitoring has minimised the risk of inappropriate brand switching and allows for greater specialist medicines management. GPs continue to have an active role in prescribing for transplant patients, including the prescribing of all other drugs the patient may require. The robust mechanisms for communication to primary care, and to patients mean both parties are kept fully informed of patients' medication regimen to support safe prescribing and avoidance of clinically significant interactions with other medicines. The improved value of renal transplant services (improved access, health literacy, safety) through repatriation has delivered significant cost savings by utilising secondary care contract drug prices and controlled brand switching to approved lines; providing only what is safe and what is necessary.

Reduce inappropriate variation – through evidence based approaches

Centralisation does not lead to reduced access or greater health inequities - quite the reverse. Though an established mechanism of regional collaboration and an insistence on a Once for Wales approach, the renal network is delivering for all of Wales. It has created the architecture for change. Not only is variations reduced but inefficient or poor aspects to kidney care have been removed and replaced with modern, innovative practices fit for the modern era; these are translating into better outcomes for patients and the way staff, and patients alike, feel about working within the system.

Christopher Brown, Consultant Pharmacist, Abertawe Bro Morgannwg University Health Board

The role of primary care in determining much of the patient flow into secondary care was also highlighted. Case example from a primary care Audiology service (Box 11) highlights an outcome of this service is less pressure on Ear, Nose and Throat in Secondary care. In addition to the direct impact of service re-design in primary care, the nature of interactions with patients in primary care was seen as having a key impact on secondary care. Participants from a national workshop agreed that referring more selectively to secondary care would be a prudent approach, with one participant commenting:

> *'Is it the secondary care physician's responsibility to decide whether a patient should lose weight or have a knee operation? Should they have been referred to secondary care in the first place if there were other less invasive pathway options (weight loss)?'*

In ABM University Health Board, Neath Port Talbot hospital is the focus of a 'Prudent Hospital' project. Although the project is in early stages, it is anticipated that it will contribute towards defining what an integrated Prudent Healthcare system looks like and how the concept of

Prudent Healthcare works with Local Authority partners, as well as defining enablers and barriers. A case example from Neath Port Talbot is given in Box 16 below where the Patient Experience Advisor role has been developed to assist in improving integration of co-production into service re-design.

Box 16: Patient Experience Advisor Role - improving services co-productively, as part of developing a 'Prudent' hospital

The Patient Experience Advisor (PEA) is a new role. The PEA role is proactive and seeks to understand from the patient's perspective, what would improve hospital services. The patient experience advisors also act as a central contact for any complaints, queries or issues patients raise.

The advisors spend their time on wards, speaking to patients and getting feedback directly and in the form of a survey about patient experience and whether patients would recommend the survey to their friends and family. The role is strongly aligned to Principle 1 – the model for this role has been to take a co-productive approach to improving services.

There is recognition that the role is in its infancy and that as it develops there will be scope to develop further and assess how the co-productive approach is having an impact.
NPT hospital is a Prudent Hospital so thought has gone into how to align roles with the vision to make the hospital more prudent. The patient experience advisor role was developed as a key way of making the patient experience a more co-productive one, and to allow patient experience to be at the centre of service developments.

Angharad Higgins, Neath Port Talbot Hospital, Quality, Safety and Improvement Manager, Abertawe Bro Morgannwg University Health Board

Finally, the case example below from Aneurin Bevan Health Board demonstrates how the Prudent Healthcare approach has been interpreted locally, and merged with the Value Based Care concept in Gwent. Background of the project and learning is given in Box 17 below.

Box 17: Implementing ICHOM's standard sets of outcomes: Parkinson's Disease

Background

This approach combined a pre-existing interest in value-based healthcare and the use of ICHOM (International Consortium for Health Outcome Measurement) with adoption of Prudent Healthcare, seeing the three as being complementary.

GETTING STARTED
It was important to identify a department in which to pilot an ICHOM Standard Set on a small scale. This was essential to ensure feasibility and impact before scaling across the organisation. ICHOM's Parkinson's Disease Standard Set was identified as a relatively simple model to begin with.

1. Process-mapping
ABUHB subsequently process-mapped the pilot implementation clinics from patient, clinician and informatics perspectives. They produced a gap analysis of what, where and how each metric was measured. This allowed them to create a plan for any missing outcome metrics. Through process-mapping all three perspectives, the timing and manner of data capture was designed from concept to execution to cause minimal disruption to normal patient and clinician flow.

2. IT/Informatics restructuring

A data mapping and gap analysis exercise was undertaken in order to identify the data gaps between the ICHOM Standard Set for Parkinson's Disease and what the clinic was already collecting. The biggest gaps in the Parkinson's Disease clinic between current data collection and the Standard Set were the use of patient-reported outcome measures (PROMs).

ABUHB developed a home-grown electronic data capture platform that allowed for the accurate capture of PROMs by the patient through the use of a tablet computer in the waiting room. The system was created with the Parkinson's patient population in mind, and the user interface designed to make data entry as easy as possible at every step.

EARLY RESULTS

The early benefits were clear to all involved - patient information collated via PROMs was immediately available at the clinician's fingertips, streamlining history-taking and focussing the consultation on what matters most to the patient. There were limited delays within the clinic, as patient data collection occurred outside of physician-facing time, and remaining data items were pulled from pre-existing clinical and administrative data sources. Getting patients to complete PROMs questions on iPads in the waiting room was stimulating patient-patient conversation and helping them structure their thinking prior to their appointments. Other key pieces of information - such as drug adverse reactions and allergies - became more readily available and understandable due to a common data entry format across domains.

Lessons learnt

1. **The IT team need to be on the Front line**
2. **Front-load support systems and manage expectations, especially IT**
3. **'Out of the box' IT solutions are less burdensome**
4. **Provide real-time data that clinicians can use immediately**
5. **Top-level commitment to both arms of the value equation**
6. **There is no 'team' for this - it should transcend all teams**
7. **Small, incremental improvements rather than mass overhauling**
8. **Frame the initiative in the right way** Use of common language from the management played a big role in engaging clinicians, finance and managers, which aligns interests across domains.
9. **Make it user-friendly** If the clinician and patient-facing elements of the data collection system are not easy to use, they will not be used and data collection will be deprioritised
10. **Take a long-term view**

Adapted from:
Arora J, Lewis S, Cahill A. Implementing ICHOM's Standard Sets of Outcomes: Parkinson's Disease at Aneurin Bevan University Health Board in South Wales, UK. London, UK: International Consortium for Health Outcomes Measurement (ICHOM), March 2017 (available at www.ichom.org)

CONCLUSIONS

Prudent Healthcare has clearly impacted on prevention, health needs and clinical risk; on prudent pathway re-design; and on the impact on primary and secondary care. The influence may not always have been direct or easy to discern, but it has generally been welcomed as helpful by many of those engaged in moving services in a prudent direction.

Many of the case examples of Prudent Healthcare work have not been solely initiated by the policy. In many cases, the Policy has helped to progress work in ways such as facilitating buy in from management, but it is difficult to identify a direct impact of the policy. The case studies also illustrate how staff have 'adopted' what they regard as the key elements of Prudent Healthcare to facilitate change to which they were already committed.

CHAPTER 8 - CONCLUSIONS

This chapter explores what the evidence presented so far might suggest as answers to four key questions about Prudent Healthcare in Wales:

- What is Prudent Healthcare?
- What has happened as a result of Prudent Healthcare?
- What has determined the success of Prudent Healthcare?
- Where does Prudent Healthcare go now?

What is Prudent Healthcare?

As the research has revealed, this is not an entirely straightforward question, and it certainly does not have a single answer. At one level, it was clearly a Ministerial policy initiative, which has subsequently been adopted by his successor as Cabinet Secretary, and which would now appear to have currency at least until the end of the present National Assembly term.

But what has been the nature of that policy initiative? How was it supposed to make change happen? Thinking on this has developed over the course of the policy. In practice, Prudent Healthcare has appeared to be all of the following:

A rallying call for change

Particularly in its early stages, Prudent Healthcare was an attempt to inspire, motivate and enable key stakeholders in health (and to a lesser extent in social care and the other public services) to change the way services are delivered and what they do, so as to achieve the four Principles of Prudent Healthcare. This in turn was intended to make services 'better' – according to the Principles – and more sustainable.

This conception of Prudent Healthcare did not involve a detailed implementation plan, and the associated performance management processes. In fact, the Minister was careful to avoid what some would regard as the dead hand of top-down policy. He was clear, at least in the first year or so of the policy, that such an approach to implementation would be counter-productive. The emphasis was to be very much on winning the enthusiasm of key stakeholders, particularly the clinicians, who would have the best understanding of what prudent would mean in their areas of responsibility, and the managers whose role was to facilitate the implementation of the clinicians' good ideas.

However, this was not a naïve wish that, somehow, 'good things would happen'. Instead, a lot of work went in to developing thinking about what prudent would actually 'look like' in practice, and about addressing the structural and other factors which might stifle change in

its early stages. There was a clear intent to demonstrate to clinicians and others that change really could happen.

There has been some discussion about what was meant by 'sustainability' in the context of Prudent Healthcare, and this has been an area where policy makers have trodden carefully. They were careful not to define Prudent Healthcare in terms of its financial impact – it was explicitly *not* an attempt to save money, for example. Rather, the intention was to ensure that services delivered more 'added value' (ultimately as defined by service users and citizens), in ways which people appreciated as being more appropriate and beneficial, and involving less wasteful effort. To the extent that this was successful, it was reasonable to assume that it would be a more efficient service; whether it would actually be 'cheaper' would depend on a variety of other factors (for example, changes in the extent of need and demand) which were largely unpredictable, and beyond the scope of Prudent Healthcare. These complex dynamics were explored in phase 1 of the work.

A framework of analysis

For many people, especially those clinicians, planners, managers and others charged with making change happen in the NHS, Prudent Healthcare offered a useful framework as they went about their roles. It provided an attractive set of questions to ask in relation to existing services or plans for new ones. The Principles covered most of the dimensions which they would wish to consider anyway, and expressed them in ways which had ready currency. For example, 'only do what only you can do', and 'do only what is needed, no more, no less' – together with the local variations which emerged of these slogans – were adopted as a useful communications tool and *aide memoire*.

So for these people, Prudent Healthcare was adopted largely because it was helpful, rather than because it was mandated. Their adoption was pragmatic, and often partial, based on pre-existing understandings of the key challenges and opportunities locally, In relation to pre-existing local understandings and determinations of those challenges and opportunities. For example, a Health Board which was already trying to change the balance in its workforce better to match seniority of staff with level of need, enthusiastically adopted the second and third Principles, because they were helpful; another which was already focused on tackling waste, harm and unjustified variation picked up the fourth Principle; and so on.

A Driver of Change

This 'pick and mix' approach was anathema to some, who regarded Prudent Healthcare as a coherent whole, seeking to change fundamentally the way services were conceived and delivered. For them, change would not occur if only some elements were addressed, because

such an approach did not recognise their inter-dependence, and fundamentally lacked ambition.

There has, therefore, been a strand of debate as Prudent Healthcare has developed, which has urged a more directive, 'top down' approach. This would involve a combination of nationally-led initiatives, seeking to make provision more Prudent 'once for Wales', together with closer direction and accountability of local implementation of Prudent Healthcare, with the usual paraphernalia associated with implementation metrics and benefits realisation. Advocates of this view express some frustration with the 'rallying call' approach, seeing its relevance as being confined only to the earliest stages of the policy. These views link to a wider debate about how strategic change of any sort is best implemented in the Welsh NHS, whose design features currently include very large local health statutory bodies, and little national infrastructure analogous, for example, to the 'regional' tier of the past. Such a structure has stimulated much debate about where the organisational locus for strategic change should sit.

A Plan

To some extent, the 'rallying call' and the 'driver of change' approaches were synthesised in the development of a more explicit plan for Prudent Healthcare in 2016. In part stimulated by the reflections of an OECD study of health policy and implementation in the UK[28], this new approach represented something of a midpoint between the two alternatives, setting out as it did three foci for Prudent Healthcare, for which all health bodies were expected to formulate an approach. There was to be a relatively 'light touch' accountability process, requiring bodies to demonstrate their progress against locally-led priorities, and an emphasis on learning from the work of each other.

Progress against this plan has been mixed, and we encountered relatively little enthusiasm for it. In broad terms, those advocating the Driver approach found it a little anodyne, while those who relished the freedom of the rallying call slightly resented having to follow three national priorities, for which they did not feel equal enthusiasm. Progress against the foci is somewhat unclear, in part because objectives at the start were not very explicit, but in general it would appear that progress has actually been rather modest.

Two other facets of this question have been explored during the research. First, how '**new**' was Prudent Healthcare? It would appear that the constituent parts were already familiar to people, but that their combination and prominence *as a whole* was new. There is general agreement that each of the Principles were already familiar, and there is much evidence of focus and progress on each of those issues in NHS Wales for many years, perhaps with the

[28] http://www.oecd.org/health/health-systems/oecd-reviews-of-health-care-quality-united-kingdom-2016-9789264239487-en.htm

exception of Co-production (Principle 1). However, many people in the NHS were encouraged and to some extent enthused by the appearance of a coherent policy, clearly very much supported by the Minister, which differentiated NHS Wales from the rest of the UK, and which stimulated a similar set of conversations and effort across the nation.

Second, was there a **shared understanding** of the Principles? It was striking, throughout the interviews, workshops and other work, that people seldom discussed the Prudent Principles as an indivisible whole – most focused on just one or two of the four, and ignored the others. This was in part because they struggled to remember them – people frequently misquoted or even changed the meaning of some of the Principles – and in part because they felt they did not have equal salience. For example, interviewees and participants only found one or two Principles relevant to their work and interests. Also, some interviewees and participants occasionally referred to being 'prudent' as being synonymous with spending less – Prudent Healthcare was equally good but cheaper care. This is quite striking, given that our interviewees and participants were generally well informed about this aspect of policy, and tends to reinforce the point that popular understanding of being 'prudent' is probably much less nuanced and sophisticated than was intended by its authors.

People often revealed their own informal 'ranking' of the importance of the Principles. As we have reported in the findings chapters above, many people thought that the first Principle – about partnership and co-production – offered the greatest potential to improve the 'prudence' of care, while simultaneously being the most difficult to realise. On the other hand, tackling waste, harm and unjustified variation was seen as having been a core item on the agenda of most health organisations for some time prior to Prudent Healthcare, and one which was relatively well understood, albeit with much more still to offer.

What has happened as a result of Prudent Healthcare?

The problem of attribution is clearly a difficult challenge in answering this question, and understanding what would have happened *without* PHC is largely a matter of (informed) conjecture. We frequently pursued this issue with our informants, and what follows relies heavily on their collective views.

In general, the Prudent Principles have commanded overwhelming support, as being in accordance with most people's values, and as addressing important issues for the quality and sustainability of care. It has been helpful that they have been discussed and endorsed across the whole of Wales, thereby enabling cross-Board discussions and comparisons. It has also been helpful that they have been so enthusiastically and authentically endorsed by Ministers, and have sufficient longevity to counteract the cynicism which often accompanies transitory policy enthusiasms.

So far, the response of the NHS has been overwhelmingly pragmatic. There are many examples quoted in the earlier chapters of local stakeholders adopting those Principles which they regard as being helpful to address the issues affecting them, and in the process, capitalising on the strengths outlined in the paragraph above. There is also some evidence of people using Prudent Healthcare as an analytical framework to set their own agendas, and of using the principles as a 'check list' when developing or appraising local plans and business cases. This can be used to address relatively simple questions, such as 'what is the most prudent configuration of the workforce in a particular service?' as well as more complex questions such as 'which approach to service delivery would add most value?'

Of the four Principles, the one which has probably seen least progress has been the first – on partnership and co-production. Two reasons for this have emerged. First, the concept has proved to be quite complex and not always easily understood. We have reported several examples where 'co-production' has in practice been regarded as being almost synonymous with 'customer feedback' – asking patients what they thought of the service they have received. In other instances, very little attention has been given to the 'production' aspects of the term, with little regard being paid to the complex opportunities to support patients/service users to produce their own health – all too often the discussion focuses on how to improve 'compliance'.

Second, co-production requires considerable re-design and re-creation of existing systems and beliefs. These range from the time requirements of co-productive engagement (felt to be considerably more than normal appointment slots) and the skills they require, to beliefs about the 'incompetence' of patients and the difficulties and undesirability of transferring power from clinician to patient. Co-production also often transfers the focus from the purely clinical to the much broader circumstances of people's lives and their communities, and the support and social capital available to them, which are areas with which many clinicians feel uncomfortable and incompetent.

Prudent Healthcare has at best focused attention on these issues, and has perhaps increased the recognition of their importance. However, it would not so far appear to have materially changed the extent and manner of engagement with co-production, although there are several exceptions to this generalisation, such as the case study on Podiatry which is included in Chapter 7. In short, Prudent Healthcare does not seem to have made co-production a common feature of most care.

There have been some attempts across Wales to explore how Prudent Healthcare might be relevant in other areas of public service provision, including in the third sector, in social care, and in other areas such as housing and policing. In most cases, the face validity of the Principles has found ready acceptance, although the terminology has often required some translation. Many groups and agencies, in part influenced by the Social Care and Wellbeing

Act and the Wellbeing of Future Generations Act have focused more on the question of 'added value' in recent years – how to ensure that their efforts and resources produce the greatest gain – and PHC is an easy fit with this work. Several have welcomed the NHS as a late convert to this endeavour. It is too early to say what impact Prudent Healthcare will have on the ability of public services *as a whole* to focus on these issues.

Finally, what of the public and patients? Our respondents often described public engagement with Prudent Healthcare as being one of its greatest potential rate limiting factors. So far, the focus has been largely on Prudent Healthcare gaining traction *within* services, but public support will be crucial for many of the changes which Prudent Healthcare will soon trigger. Overwhelmingly, respondents identified this as the area where least progress had been made. They thought that the concept of Prudent Healthcare was complex and difficult to communicate, and would often be tainted by association with resource constraints and 'budget cuts'. They were concerned that politicians – who hitherto had almost ignored PHC - would be tempted to exploit it unhelpfully if it ever gained sufficient public currency to be a political tool. This was particularly unfortunate because in fact, if effectively communicated, the public would probably respond warmly to the Principles, since they would result in much better care and outcomes[29]. Encouraging examples of prudent discussions with patients on end-of-life care or on musculoskeletal services could be harbingers of real progress, but they were still isolated and atypical.

What has determined the success of Prudent Healthcare?

It is difficult to describe how successful Prudent Healthcare has been. Some reasons for this are not surprising, the most obvious being the difficulty of attribution and isolating the confounding variables, which have been mentioned above. Any policy initiative introduced into the dynamic complexity of the NHS is unlikely to have a simple and easily identified cause and effect relationship. But PHC presents a set of challenges of its own, which stem from the fact that there has been little explicit statement of its intended outcomes and timescale. It is not clear, in fact, how such impact should be measured – there are no clear metrics of success.

This is not by mistake. As discussed above, Prudent Healthcare was conceived from the outset as more of a rallying call, leading to a 'social movement', than what the NHS is used to from a Welsh Government policy. So it deliberately has no specified end-point or milestones, there is no implementation plan (*pace* the three foci described above) or allocated responsibilities. It is therefore unclear what it should have achieved by now, and whether it is broadly on track

[29] Since the fieldwork for this research was completed, the Welsh NHS Confederation agreed to produce for Welsh Government 'a comprehensive strategic communication and engagement plan, which will drive a compelling and persuasive prudent healthcare "offer" to the Welsh public' (Welsh NHS Confederation (March 2017) *A Public Engagement and Communications Strategy for Prudent Healthcare* Cardiff: Welsh NHS Confederation)

or not. Most interviewees and participants expressed their own views on these questions, but they are just that: their own.

Most would argue that progress against the four Principles could broadly be characterised as follows:

Principle	Progress
Principle 4. Reduce inappropriate variation using evidence based practices consistently and transparently	Rank 1st: Most progress. This is a long-established priority for the NHS so has professional acceptance and is gradually being fuelled by better evidence on outcomes and efficiency.
Principle 2. Care for those with the greatest health need first, making the most effective use of all skills and resources	Rank 2nd: Second most progress. Key staff shortages and emerging new roles have helped, and also sometimes benefits from a link to cash-releasing savings.
Principle 3. Do only what is needed, no more, no less; and do no harm	Rank 3rd: Emerging evidence is starting to support this, but progress to date has been limited by the availability of good evidence and the association with 'cost containment'
Principle 1. Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production	Rank 4th: Least progress. Still requires considerable public and professional understanding and engagement, service redesign, professional training and transfer of power from professional to patient

But these are essentially unverifiable and for discussion.

It is possible to discern various factors which have helped and which have hindered progress towards greater prudence. Supportive factors, which have been discussed in the previous chapters, have included professional engagement with the Principles, familiarity with some elements, alignment of managerial and clinical interests and enthusiasm, universal adoption of the Principles in Wales, and (light touch) accountability for progress.

Several rate-limiting factors have also emerged, and have been discussed previously. Perhaps the three which have generally been regarded as most significant are:

Too many other priorities

Senior clinical and managerial leaders report that other more 'urgent' priorities – such as addressing financial pressures and access-related performance targets – demand time and

attention which could otherwise have been devoted to Prudent Healthcare. To some extent, therefore, this is a zero-sum game – the more time spent on the urgent, the less time is left for the important, including Prudent Healthcare. Some of these other priorities have also been criticised as being themselves 'imprudent', in that they tend to drive behaviours which have insufficient regard to Prudent Healthcare Principles. For example, partnership working and co-production do not necessarily correspond with nationally-determined performance targets; meeting annual financial targets is not conducive to longer-term, planned re-design of care. Others have argued, however, that Prudent Healthcare is itself the means by which more efficient and cost-effective care is provided. Meeting Prudent Healthcare Principles is therefore the means by which access and financial targets can be met sustainably, and there is no inherent conflict and no zero sum game. In practice, of course, most interviewees and participants recognised the truth in both of these arguments, and few would only advocate one or the other. The challenge is to find ways of meeting short term targets while also transforming care to be more prudent, and thereby sustainably effective and efficient. And most were struggling to do so.

Rigidity of current service patterns and behaviours

The practical challenges of effecting prudent change often include the inter-dependency of services, and the risks (often poorly quantified in advance) of making changes to services to vulnerable people. These are often compounded by scepticism of change, inadequate evidence on effectiveness and efficiency, and a variety of factors which appear to be outside local control, such as the rigidities of ICT systems. Current services have usually developed over some time, and professionals have direct or indirect experience of previous attempts at change which have failed to deliver the promised benefits. All of these problems have been overcome in many cases. However, considerable time and skilled effort is required to do so, which links to the point above.

Lack of resource

Change often requires additional resource, either to employ the change leaders described above, or to meet the costs of temporarily double-running existing and more prudent services. Lack of suitably qualified staff for new roles can also be a constraint. The introduction of Prudent Healthcare has coincided with significant budgetary pressures on the NHS and other public services, and shortages of some key staff groups.

These factors – and many of the others discussed in the earlier chapters - are all very familiar, and would probably apply equally to most other major change projects in the NHS.

A fourth factor was also much quoted – the perceived lack of engagement and understanding among patients and the wider public with Prudent Healthcare. This may not yet amount to

much of a rate limiting factor, but it would become so if more progress were to be made in tackling the other factors. It began with a lack of engagement with many of the problems which Prudent Healthcare was designed to tackle – such as over-treatment, inefficient use of staff, or the problems of unjustified variation in clinical practice. If people did not recognise the problems, why would they engage with the solutions? Prudent Healthcare also required a willingness to challenge the 'medical model' of care, to transfer and accept power and responsibility for co-production of health, and to believe that better care is synonymous with more care. There was also a recognition that people's social circumstances, social capital and economic wellbeing were inextricably linked with their ability to engage differently with healthcare, and that services would need to recognise this and respond accordingly, if co-productive partnerships were to be fostered with all sections of the community.

Where does Prudent Healthcare go now?

Prudent Healthcare remains a top priority for Welsh Government and the Welsh NHS, and this longevity is a key strength. Change on this scale requires many years, and Prudent Healthcare has that lifespan. Much of the organic adoption of the Prudent Healthcare Principles – local actors using them in the ways described above – will continue, and will continue to achieve progress. Prudent Healthcare continues to be supported by those hungry for change, who view Prudent Healthcare as a useful part of their armamentarium.

Work is needed to engage patients and the public more effectively in the Prudent Healthcare agenda. We found many local examples, in every Health Board and Trust, where this was being achieved with patients, but they remain relatively isolated examples. The Welsh NHS Confederation is leading further work on patient and public engagement, which is designed to enhance these local efforts[30].

If the analysis is correct, progress could be further enhanced by addressing the rate-limiting factors described above, and those discussed in chapters 3 to 7. The solutions are not easy, or even always obvious. Changes to NHS performance targets, improving complex change management, and providing additional resources, are all problems because they cannot be solved easily.

There is still a live debate in Wales about whether Prudent Healthcare would now best be advanced by continuing with a more nationally-led approach, with more explicit and uniform objectives, clearer metrics and accountability, or whether the organic, largely opportunistic approach is more likely to be successful. Views on this often reflect people's views on the best relationship more generally between the national and local in Welsh health policy. The nationally-prescribed priorities of 2016 have not gained much traction in the NHS, with many

[30] Welsh NHS Confederation (2017) *A Public Engagement and Communications Strategy for Prudent Healthcare* Cardiff: Welsh NHS Confederation

regarding them as being an unhelpful distraction, often fitting rather poorly with local priorities and not necessarily achieving much. In addition, in the case of Prudent Healthcare, a shift of this nature would effectively redefine Prudent Healthcare itself, away from the original conception of a social movement which was designed to effect change in a new sort of way.

This concern remains. Many of the people we interviewed, or who took part in workshops, regarded progress on Prudent Healthcare as being less than ideal. They were conscious of how much more still needed to be achieved in relation to all four Principles, of the harm caused by further delay (in terms of perpetuating suboptimal care), and of the need to effect radical change more quickly before the demographic and other pressures undermined healthcare sustainability.

So increased pace was a widespread aspiration; but how was it to be achieved? If organic change was inevitably slow, and if nationally-led priorities gain little traction, was there an alternative? This is a simple question, but with a complex and elusive answer. Until it is resolved, there is a host of small changes, described in this report, which may be expected to enhance progress towards more Prudent Healthcare, and towards more prudent public services more generally.

In the meantime, encouragement can be derived from that fact that Prudent Healthcare has so effectively and comprehensively won the hearts and minds of all concerned.

APPENDIX 1 – WELSH HEALTH CIRCULAR

WHC (2016) 11

WELSH HEALTH CIRCULAR

Llywodraeth Cymru
Welsh Government

Issue Date: 15 February 2016

STATUS: ACTION

CATEGORY: HEALTH PROFESSIONAL LETTER

Title: Prudent Healthcare: Securing Health and Wellbeing for Future Generations

Date of Expiry / Review N/A

For Action by:
University Health Boards and NHS Trusts

Action required by:
National Committees
Medical Advisors

Sender:
Dr Andrew Goodall, Chief Executive of NHS Wales

DHSS Welsh Government Contact(s) :
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Enclosure(s):
- Securing Health and Wellbeing for Future Generations active PDF
- Bilingual "Plan on a page" PDF

Our ref: AG/HW

Dear Colleague,

As those of you that attended December's Team Wales event will be aware, over the last five months, a broad range of NHS staff and Welsh Government officials have been collaborating on developing a set of national actions in relation to prudent healthcare, designed to maintain the momentum of the last 2 years and embed the prudent principles in our systems and our daily practice.

There are numerous examples of recent prudent activity and pockets of good practice across Wales, but in this document, leaders from within the NHS have identified a number of particular areas of action that will focus the national implementation of prudent healthcare in a systematic way. These areas have been selected as they touch the lives of many people and because coordinated action taken at both a national level and by all organisations will have a significant impact on the way health services in particular, are delivered and provided in Wales.

The document also highlights broader enabling actions targeted at the public, professionals, and public service leaders, which will be important to making prudent healthcare part of everyday services.

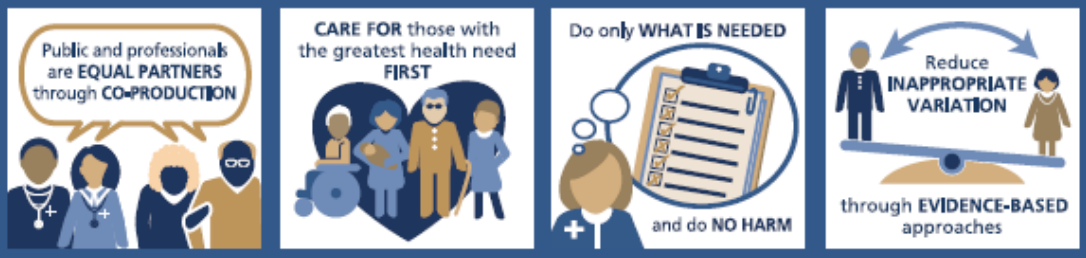
This document is not the definitive 'how to' guide for making prudent healthcare happen because such a guide would miss the point. The prudent healthcare principles need to underpin everything that is done in the Welsh NHS and challenge every board, clinician and patient to think daily about the things they can change and improve to secure better health and well-being.

Included as enclosures are the full active-PDF document and the bilingual "plan-on-a-page" PDF. The latter can be printed easily as a two sided poster or hand out. Please ensure that this is disseminated to your staff.

Andrew Goodall
Director General HSSG
And Chief Executive NHS Wales

#prudenthealthcare

Prudent Healthcare
Securing Health and Well-being for Future Generations



www.prudenthealthcare.wales

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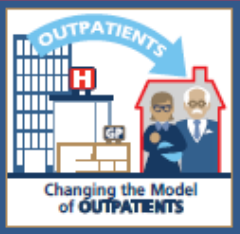
Prudent Healthcare
Securing Health and Well-being for Future Generations

Focusing collective national action around 3 main areas

Reducing unnecessary and inappropriate, tests, treatments and prescriptions, and ensuring people are able to make informed decisions about the care they receive.



Radically changing the outpatient model, making it easier to get specialist advice in primary care settings.

Developing strong public service partnerships and integration to provide the right care, in the right place, at the right time.

Empowering & enabling 3 main groups of people

The public doing their bit to look after their health and wellbeing, with services concentrating on what matters to them.

Enpowering health & care professionals to support patients and the public to make shared decisions about their health.

Creating the necessary conditions to encourage a system-wide focus on value and outcomes.

#prudenthealthcare

What's this document about?

This is the latest phase of work to stimulate and progress debate, momentum and action around the concept of prudent healthcare in Wales. Prudent healthcare describes the distinctive way of shaping the Welsh NHS to ensure it is always adding value, contributes to improved outcomes and is sustainable.

The principles of prudent healthcare are:

- Achieve health and well-being with the public, patients and professionals as equal partners through co-production.
- Care for those with the greatest health need first, making the most effective use of all skills and resources.
- Do only what is needed, no more, no less; and do no harm.
- Reduce inappropriate variation using evidence based practices consistently and transparently.

While the prudent healthcare principles are applicable to all public services in Wales, this action plan is aimed primarily at NHS organisations and describes work to be carried out with partners at a national and organisational level over the course of the next year. The prudent healthcare principles can have a significant impact on the health and well-being of people living in Wales by reshaping health services and rebalancing the relationship between individuals and health professionals. There are three groups of people – the public, professionals and public service leaders - who will be central to making these and other changes happen.

This document is not the definitive 'how to' guide for making prudent healthcare happen because such a guide would miss the point. The prudent healthcare principles need to underpin everything that is done in the Welsh NHS and challenge every board, clinician and patient to think daily about the things they can change and improve to secure better health and well-being.

There will be many other examples of prudent healthcare in practice happening; the principles will underpin the development of services in every part of Wales and they will help shape conversations and consultations in every branch of practice between patient and practitioner.

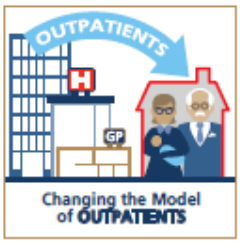
#prudenthealthcare

Where can prudent healthcare have a big impact?

Focusing collective national action around three main areas

The debate and discussion around prudent healthcare in the last few months has identified three priority areas for action. These have been chosen because they touch the lives of many people and because coordinated action taken at both a national level and by all organisations will have a significant impact on the way health services, in particular, are delivered and provided in Wales.

ACTION 1



ACTION 2

ACTION 3

ACTION 1: Appropriate tests, treatments, and medications

a) Why?

When people come into contact with the Welsh NHS, they want to know they are receiving the care and support which not only gives them the best immediate outcomes but also contributes to their longer-term health and well-being. However, there is growing evidence that too many people undergo tests and receive treatments and medications, which have little clinical benefit and, by doing little good, can lead to physical or psychological harm. In the US, an estimated $5bn of medicines are thrown away unused every year and 30% of all medical spending is unnecessary and does not add value in care.

Quite certainly, investing time, energy and money in activity of little value restricts the health service's ability to invest in new, cutting-edge and evidence-based practices. Wales is not alone in facing this challenge; the British Medical Journal's '*Too Much Medicine*' campaign has cast an international spotlight on these issues, documenting evidence of over-medication, over-diagnosis and over-testing. Work being undertaken in Wales places the NHS at the forefront of an international movement to ensure every test, procedure and medication makes a positive contribution to people's health and secures the principle of doing no harm.

b) Actions to be taken over the next 12 months

- The Academy of Medical Royal Colleges in Wales, together with Public Health Wales and the Board of Community Health Councils, will develop the Choosing Wisely campaign for Wales. This will help clinicians and the public to make effective choices about tests, treatments and procedures based on best evidence. The campaign forms part of a global initiative and builds on the success of the Choosing Wisely movement in the US and Canada. The first clinical and public guides will be published in summer 2016;

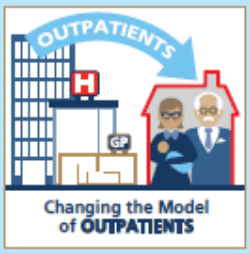
ACTION 1: Appropriate tests, treatments, and medications

> The NHS as we all know is now in enormous difficulty, in a state of huge challenge with great financial constraints as are health systems around the world, and we need clear thinking, courage and leadership. And I think if anywhere can get things right, Wales – the cradle of the NHS - can do it. It's important to feel that [prudent healthcare] is part of a movement around the world, and genuinely it is. The BMJ's Too Much Medicine campaign is one journal working on that; in America, Jama Internal Medicine has the Less Is More campaign; and of course there is Choosing Wisely…and it's wonderful that Wales is signing up to this. This has to be a whole system approach, and with the strength of Wales behind it, it's sure to succeed.
>
> Dr Fiona Godlee, British Medical Journal speaking at the Prudent Healthcare conference July 2015

b) Actions to be taken over the next 12 months

- A clinician and patient-led programme will be developed to reduce the rate of inappropriate antibiotic prescribing in Wales. In the majority of Wales, the rates of prescribing are significantly higher than the UK average. This programme will be overseen by the Prudent Prescribing Implementation Group and adopted throughout Wales. It will ensure the NHS and the public are contributing to the global fight against antimicrobial resistance;
- The Prudent Prescribing Implementation Group will lead a review looking at what changes can be made to the repeat prescription system across Wales to reduce unnecessary and inappropriate prescriptions. The group will also develop ways of helping people make better and informed choices about how and when they request repeat prescriptions, which will improve the take-up of prescription medicines and reduce waste;
- The 1000 Lives Improvement programme will develop a Wales-wide quality improvement approach to reduce inappropriate variation in clinical practice across Wales, for example rates of routine surgical procedures or patterns of prescribing where the variation cannot be explained by clinical need.

ACTION 2: Changing the model of outpatients



Changing the Model of **OUTPATIENTS**

> Having endured eczema all of my life I was referred last September to Glangwili for Phototherapy treatment. I was unable to finish the treatment due solely to the fact that I live in the Northern extremities of Ceredigion. My treatment required two 2 minute sessions per week. I was expected to travel 125 miles on each visit, taking several hours. I felt this was totally unacceptable. Whilst eczema and psoriasis are not life threatening conditions, they reduce a person's quality of life considerably and for me a regular session of phototherapy for around 2 minutes did have remarkable benefits.
>
> Extract from the Mid Wales Healthcare Study (2014)

a) Why?

Approximately 3.1 Million outpatient appointments were provided by the NHS in Wales last year – the equivalent of one per citizen of Wales. A third related to just three specialties – trauma and orthopaedics, ophthalmology and general surgery. However, not all outpatient appointments had a useful clinical purpose and many could have been carried out in other healthcare settings, closer to people's homes. Outpatient departments also face a number of other issues. Unwell people who have to attend multiple clinics report that to be a difficult experience to manage. Staff find that working in a high volume low clinical value setting promotes little job satisfaction. The sheer number of routine contacts make it difficult for secondary care to respond promptly to requests from primary care. All this makes outpatients ripe for radical reform.

Concerted national and local action will be taken over the next 12 months to change the model for outpatients, making immediate improvements to existing services and substantially changing delivery models.

b) Action to be taken over the next 12 months

- A national project will be set up to radically change the outpatient model, ensuring it is easier to access specialist advice to support decision-making in primary care. The early priorities will be to:
  - Support the rapid implementation of the national planned care implementation plans in all NHS organisations for orthopaedics, ENT, urology and eye care. In eye care, for example, new community-based assessment and treatment service for wet age-related macular degeneration (AMD) will be piloted in four areas of Wales, making it more convenient for people to access the right care, in the right place, at the right time. The service will be delivered in the community by optometrists and nurses, overseen by an ophthalmologist.

ACTION 2: Changing the model of outpatients

> Over the past six months, we have started to collect patient outcomes in our Parkinson outpatient disease clinic, focusing on the outcomes that matter to patients and their carers. The process of implementing this work has highlighted the importance of close collaboration between clinicians, managers, and patients to ensuring healthcare is designed to secure improved experience and better outcomes. Focusing on outcomes gives us all a common currency and language to think about the improvements we are going to make and a sense of urgency to get things done. The process has enabled us to begin thinking together about the clinic environment, the staffing we need and whether this is the best way to meet the diverse needs of all of our patients.
>
> Dr Sally Lewis, GP and Value Based Care lead, Aneurin Bevan University Health Board

b) Action to be taken over the next 12 months

This will allow patients to be seen faster and closer to home and free up more time for hospital-based consultants and ophthalmologists to manage the most clinically complex cases. The service is a powerful example of the prudent healthcare concept of only do what only you can do in action;

- In the context of the joint governmental, NHS Wales and ADSS Cymru digital health and social care strategy for Wales, support the completion and roll out of projects designed to improve digital connectivity and the availability of electronic advice using the Efficiency Through Technology fund. The fund will provide £10m investment over the next 12 months;
- Support the Mid Wales Healthcare Collaborative's programme to develop telehealth programmes. This is underpinned by a £250,000 Welsh Government investment in technology – also from the Efficiency Through Technology Fund – to improve access to specialist advice in rural areas, without people needing to travel long distances;
- Roll out new, tested outpatient models, such as Betsi Cadwaladr University Health Board's CARTREF initiative. CARTREF has provided more convenient follow-up appointments in community-based clinics; GP clinics for frail patients and unscheduled care access via video link to senior staff in acute medicine and care of the elderly;
- Clinically-led peer review will be a key feature of the outpatients reform project, starting with those specialties handling the largest volumes of outpatient appointments and using outcomes to focus on what we want to achieve. The peer review will help secure the prudent healthcare principle of reducing variation through evidence based practice.

ACTION 3: Working together to improve healthcare

> Prudent healthcare has to be about doing what is right to make a difference for people. It can't be about determining what is provided on the basis of a label like continuing healthcare or an organisations structure or budget groups.
>
> Ruth Crowder, Wales College of Occupational Therapists

a) Why?

It is clear that prudent healthcare will not happen by the actions of NHS Wales alone. To secure best value from the resources we invest in healthcare in Wales and the best outcomes for people in Wales, we have to move away from an NHS which simply treats the symptoms of diseases – a national sickness service – to a system which tackles the underlying causes of disease and works to prevent ill health from occurring – a truly national health service.

To do this, the NHS must work in partnership with other public sector organisations, the third sector and industry. Through the principle of co-production, prudent healthcare requires organisations to concentrate on what matters to individuals – to create and achieve person-centred care will require meaningful integration, with boundaries within and between organisations becoming seamless. All services must also ensure staff with the most appropriate skills are able to provide care and support to the right people, in the right place, at the right time.

b) Actions to be taken over the next 12 months

- The 1000 Lives Improvement programme will create a national public service task force – involving health, housing and voluntary sector organisations – to change the way the falls programme is delivered across Wales. The task force will identify what works and consider how the programme can be strengthened to prevent falls and, when they occur, reduce admissions to hospital settings;
- The Social Services and Well-being (Wales) Act 2014 comes into force in April 2016. Part nine of the Act creates new regional partnership boards at a health board level to drive the integration of health and social services. Statutory and third sector organisations will work collaboratively through these boards, will improve the outcomes and well-being of people, and improve the effectiveness and efficiency of service delivery;

ACTION 3: Working together to improve healthcare

> Prudent healthcare is about designing a great system aimed at creating public value – an open system that anyone with an offer and a desire can contribute to. It is not only about those on the public service payroll, it's about all of us and the contributions we can make if we are prepared to engage. Where we sit and what we are called is less important than what we can offer; prudent healthcare is a vocational public service calling.
>
> Paul Matthews, chief executive, Monmouthshire Council

b) Action to be taken in the next 12 months

- The £50m Intermediate Care Fund in 2016-17, will develop services to support older people, particularly the frail and elderly, to maintain their independence in their own homes, or return home quickly from hospital, by preventing unnecessary hospital or care home admissions and delays in discharge wherever possible;
- A quality improvement programme will be developed to support primary care, which is designed to identify the innovative approaches to integrate services being advanced by the 64 primary care clusters in Wales and adopt them more widely. The initial focus will be on workforce models; identifying community assets, working with communities, and increasing the focus on self care (where appropriate);
- A review of legislation, guidance, policies and performance measures to ensure they are making an optimal contribution, focusing on the prudent healthcare principle of equity, to support people with learning disabilities access healthcare, social care, wider support and appropriate housing;
- The follow-on strategic framework to *More than just words* will help ensure there is more consistent planning to Welsh-language services so Welsh speakers are able to communicate with service providers in their own language. This will nurture relationships between people and professionals

#prudenthealthcare

Who can make prudent healthcare happen?

Empowering and enabling three groups of people

Empowering and enabling the public, professionals and public service leaders will be key to making prudent healthcare part of everyday services. In each section, we have outlined some of the key actions which will be taken over the next 12 months in Wales to empower and enable each group to make prudent healthcare happen.

#prudenthealthcare

Empowering and enabling... PUBLIC

> We need passion and belief today to help save our NHS. It is everybody's favourite organisation, we all believe in it, and it must not die. And it's not just the health experts that will save it. It's me, my children, my grandchildren, my neighbours, my community, my friends.

Gillian Clarke National Poet For Wales speaking at the Prudent Healthcare conference July 2015

a) Why are the public important to making prudent healthcare happen?

If prudent healthcare is going to happen, we need a new generation of prudent patients and a prudent public. Prudent healthcare is as much about what we can do as individuals to look after our health and well-being as it is about designing public services to respond to the impact of ill health and prevent illness occurring.

The NHS in Wales is free at the point of need but it is not free of responsibility – we all have a responsibility to look after our own health and well-being, supported by the health service, statutory public services and voluntary services.

The day-to-day choices we make, whether that's what we eat or drink; whether we smoke; how much alcohol we drink or how much exercise we do, have an impact on our long-term health and well-being. Poor lifestyle choices can contribute to obesity, a number of different types of cancers, heart disease, diabetes and stroke. Every year, the NHS in Wales treats thousands of people for problems which could have been prevented.

But prudent healthcare isn't just about supporting the public to lead healthier lifestyles and preventing ill health at an individual or population level; it is about supporting people to choose the right type of care they need when they are ill or injured and ensuring people can access the right information and advice at the right time.

The NHS is a large and complicated system, which can often mean when people are ill they reach for the easiest or most familiar front door – their GP surgery or A&E department – sometimes regardless of whether this will provide the most appropriate care for their needs. Prudent healthcare encourages people to consider what care they need, including whether they can look after themselves (self care), and to use the most appropriate service for their clinical need, not the nearest or most familiar.

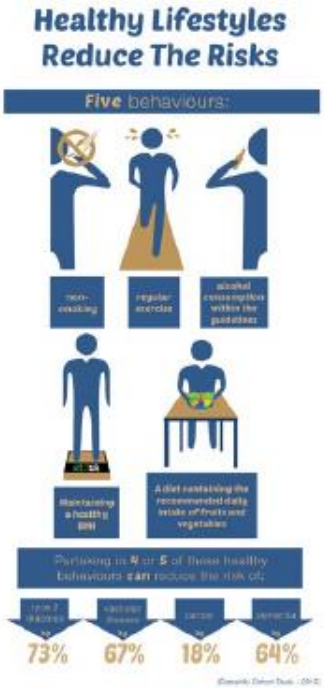
Empowering and enabling... PUBLIC

> How are we going to sell it to the over-anxious mother? The patient demanding antibiotics for a cold? The late night drunk injured in a brawl? The people queuing at A&E because they can't get an appointment with a GP? The frequent 999er calling ambulances for fun? Language is the key to making prudent healthcare work.
>
> We need to understand what our story is and tell it in simple truthful language. Sharing it is the answer to get all of us working together. We need to tell ourselves the story of hope and energy and what we all as one people can achieve.
>
> Gillian Clarke National Poet For Wales speaking at the Prudent Healthcare conference July 2015

The Choose Well campaign and the NHS Direct Wales service helps people to select what service they need. The Welsh Ambulance Service's clinical response model, which was launched in October 2015, is based on similar principles.

People in Wales can and are already making different choices about how they access information and advice about health and health services. For example, the latest available information about NHS Direct Wales, show there were 300,000 calls to the telephone helpline in 2014-15 and more than 4.5 million visits to the website.

Finally, prudent healthcare puts people at the centre of decisions about their own health. Instead of clinicians making all the decisions about treatment, these are shared decisions between practitioner and patient – this is an important part of co-production.



Empowering and enabling... PUBLIC

> What co-production means in practice is acknowledging that everyone is an expert in their own life, everyone has something to contribute, and that enabling people to support each other builds strong, resilient communities, strengthening the relationship between citizens and service providers and improving the outcomes for everyone.
>
> Traditionally, service providers ask the 'tick-box' questions: what do you need; what are you eligible for; how do you fit into the system?
>
> With co-production, the questions become a conversation: what does a good life look like for you; what strengths can we build on; and how can we work with you to achieve your goals? It's not about fitting people into pre-determined services, but about empowering people to contribute to achieving the outcomes that matter to them.
>
> Ruth Dineen, Co-production Wales

b) Actions to be taken over the next 12 months

- A national information campaign will be developed to help the public understand the important role they can play in improving their health and the services offered by the NHS;
- The Making Prudent Healthcare Happen website will be refreshed to allow people to give feedback about services which are doing a good job. This will give other people and services ideas about where they could improve things;
- There will be an opportunity for members of the public to get involved in projects being advanced by a team of people helping the NHS and people to work better together to improve health and well-being;
- The publication of simple information which makes clear the advantages and disadvantages of different tests, treatments, and medications, such as through the Choosing Wisely Wales campaign;
- The co-production network will be further developed. This aims to place the co-production principle at the heart of public services, communities and the lives of citizens in Wales;
- A new deal between the NHS in Wales and the public, based on each partner agreeing to play their part to improve health and well-being, will be developed.

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Empowering and enabling... PROFESSIONALS

"All of us working in the NHS strive to provide the best appropriate care according to need. Sometimes this doesn't happen for a variety of reasons. These reasons might be related to working conditions, organisational issues, workforce skills and numbers or patient issues. Often these can be overcome without making life more difficult for anyone. We should not be expected to work harder but we are prepared to work smarter. We must be open to change and we should expect and demand to be involved in planning change."

Dr Paul Myres, GP and Chair of the Academy of Medical Royal Colleges Wales

a) Why are professionals important to making prudent healthcare happen?

Healthcare professionals are best placed to support patients and the public to make shared decisions about their health and, where necessary, take action to improve health and well-being. However, increasing demands on their time, system constraints and limited space to think about how things could be done differently can result in experiences which do not match either the professional's or the patient's expectations.

Over the past two years, feedback from clinicians in Wales has been that empowering professionals genuinely to follow the prudent healthcare principles will be central to making it a reality. There are already many examples of this happening in practice but it can often be difficult to share and perpetuate good practice and ideas within health boards and across Wales.

#prudenthealthcare

Empowering and enabling... PROFESSIONALS

"Prudent healthcare will help us improve the experience and effectiveness of healthcare for clinicians as well as patients. As clinicians, we should regularly question the need for the things we do every day and consider whether there are actions we need to take that we don't always do currently. We need to be more open, treat patients as partners and experts in their own lives and use our expertise to support out patients and the public to be involved in decisions about their care and take responsibility for their own health. We should expect the professional associations and NHS systems to support us in that."

Dr Paul Myres, GP and Chair of the Academy of Medical Royal Colleges Wales

b) Actions to be taken over the next 12 months

- A set of information and engagement materials, developed with clinicians, which will explain what prudent healthcare is; how it can be described and explained to others; how it can be put it into practice and the difference it could make;
- A range of video examples, which capture examples of prudent healthcare in practice, will be developed together with other practical tools, which healthcare professionals – and the public – can use to help better understand and make prudent healthcare happen in clinical practice;
- Support for learning and development will be available through the annual appraisal process to enable healthcare professionals to more effectively engage in making prudent healthcare happen;
- A skills and career escalator will be developed to help deliver the prudent healthcare concept of only-do-what-only-you-can-do. New roles and access routes will be developed, which will mean that professionals will work at the top of their clinical competency levels through new team approaches to the delivery of patient care.

#prudenthealthcare

Empowering and enabling... PUBLIC SERVICE LEADERS

"As leaders in the NHS we must ensure that our organisational culture, systems and processes are fit to rise to the prudent healthcare challenge. We have a duty to ensure that we properly listen to our patients and the wider community; that we enable our staff to cut through the complexity of our Health Boards and Trusts to deliver the right care, first time; and that that every pound of public money is spent wisely on the NHS."

– Allison Williams, chief executive, Cwm Taf University Health Board on behalf of NHS Wales chief executives and chairs

a) Why are you important to making prudent healthcare happen?

It has been argued that the integrated system of health and care in Wales should ensure best quality; patient outcomes and value are always at the heart of decisions about services.

However, we know that this is not always the case. Sometimes the way things are done has not kept pace with changing expectations and needs. There are also a number of things which could be done at the all-Wales level, through service planning and how we measure success, which will help to ensure decisions we make lead to services that make the maximum contribution to improved health and well-being.

Leaders, managers, and staff with a key role in designing the systems within which professionals and members of the public operate, are central to making prudent healthcare happen. There are things that could be done to help ensure prudent healthcare is always the Welsh NHS way of thinking about how we design, manage and deliver services.

b) Actions to be taken over the next 12 months

- The NHS Wales Planning framework, and associated arrangements, will be enhanced to help ensure the system focuses on those things which add the most value. This will include placing value at the centre of plan assessment and approval arrangements;
- The performance management arrangements will be rebalanced to place a greater focus on outcomes rather than process measurements and encourage innovation, including prevention and primary care. The system will be increasingly measured in a way which informs and drives a prudent healthcare approach. This will build on the pilot of the clinical response model at the Welsh Ambulance Service and the introduction of ambulance quality indicators;
- The development and use of international outcomes-based benchmarking systems to inform and drive change;

#prudenthealthcare

Empowering and enabling... PUBLIC SERVICE LEADERS

"We know that demand is growing and that resources, both in terms of skilled staff and money, will continue to be a challenge. However, we have a unique opportunity in Wales to truly realise the benefit of working in an integrated healthcare system – to break down the barriers between primary and secondary care and use all of our resources to best effect in the interest of great patient care.

Prudent healthcare provides us with a framework and a set of principles to re-cast the relationship between our patients, staff and NHS Leaders so that we all play our part in shaping the services for the future."

Allison Williams, chief executive, Cwm Taf University Health Board on behalf of NHS Wales chief executives and chairs

b) Actions to be taken over the next 12 months

- The three clinically-led national programmes, which have prudent healthcare at their heart, will continue to be national priorities for all NHS organisations:
  - **Primary care** – Continuing the reform set out in our primary care plan and investing in the development of primary care clusters to better match services to need;
  - **Planned care** – Implementing plans for orthopaedics, ophthalmology, ENT and urology. A strong feature of the programme will be improving the way health boards understand and manage the demand for, and capacity of, services;
  - **Unscheduled care** – A refreshed approach to ensure this complex system works seamlessly to provide the right patient-centred response, by the right clinician, at the right time to optimise outcomes. Priorities for 2016-17 will include: developing care standards for each step of the unscheduled journey, focused on improved experience, outcomes and value for money; and advancing an all-Wales collaborative commissioning approach to procuring services from the independent care sector to improve service access, experience and reduced delayed transfers of care.
- The Welsh NHS, working with academic partners, will develop a skills escalator that provides alternative access routes to healthcare professional training – for example training and qualification pathways to support healthcare support workers to become nurses;
- The publication of the NHS workforce review, led by David Jenkins, which covers:
  - The wider application of those models of service delivery at the forefront of integrating health and social care;
  - The workforce with the right staff and skill mix to meet future demands on the NHS;
  - The long-term strategic direction for pay and reward for those currently covered by the UK Agenda for Change contract terms and conditions.

Evolution of prudent healthcare

> By Prudent Healthcare we mean healthcare which is conceived, managed and delivered in a cautious and wise way characterised by forethought, vigilance and careful budgeting which achieves tangible benefits and quality outcomes for patients.
>
> Simply Prudent Healthcare, Bevan Commission, 2013

Prudent healthcare started in autumn of 2013 when the Bevan Commission submitted a report to the Minister for Health and Social Services called *Simply Prudent Healthcare*. It considered how Wales could make the most effective use of the available resources to ensure the consistent and high-quality delivery of services.

In a speech to the Welsh NHS Confederation conference in January 2014, the Minister endorsed the concept of prudent healthcare and called for a year of engagement around the principles underpinning it, including practical testing. Over the course of 2014, testing occurred in defined clinical and treatment areas.

Many people with an interest in using prudent healthcare to promote health and well-being also wrote essays and held debates about where it could have an impact and what needed to happen. The essays were published on the Making Prudent Healthcare Happen website **www.prudenthealthcare.wales**.

The Bevan Commission continued to refine its thinking around the concept before submitting final advice to the Minister in the autumn, defining the four prudent healthcare principles set out at the start of this document.

The related prudent healthcare concept of only-do-what-only-you-can-do – no professional routinely providing a service which does not require their level of ability or expertise remains a powerful one, especially in planning the prudent health and social care workforce for the future.

The Minister for Health and Social Services used his 2015 Welsh NHS Confederation speech to call for movement from debate to action, asking the NHS in Wales to respond through their integrated medium-term plans and setting out priority actions in:

- Primary care;
- Workforce and organisational development;
- Remodelling the relationship between the citizen and the provider (coproduction);
- Over-diagnosis and over-treatment, with an initial focus on end-of-life care.

Progress in these areas and others followed and was highlighted at the first international prudent healthcare summit held in July 2015. In addition to the First Minister's call for prudent public services, the editor of the *British Medical Journal* and key figures from Wales highlighted how prudent healthcare could contribute to shaping the future of the Welsh NHS.

The Minister for Health and Social Services committed to developing a national action plan – this document. This is the result of an engagement process over the past six months involving a range of public service organisations.

Senior leadership support

We are committed to making sure the principles underpinning prudent healthcare guide our distinctively Welsh way to ensure NHS Wales not only survives but thrives in the 21st century, whilst staying true to its founding principles.

We share a strong sense of responsibility to ensure that we have a sustainable health system to serve current and future generations. We are not alone as a nation in seeking to redesign health and social care and prevent ill health; many countries face the same challenges and are keen to learn more about our prudent healthcare approach.

We have a vision of what to do; founded on the most important part of health care – a trusted relationship between the public and professionals, with both playing an equal part in achieving better health outcomes, better quality of care and better value. No single person has all the answers; prudent healthcare offers us a way of building the future together.

We have made a strong start by growing the conversations and seeing action emerge in many different ways. The actions set out here will enable yet more opportunities to get involved and we urge everyone to think about what they can do to take prudent healthcare further into their daily practice.

Dr Ruth Hussey, Chief Medical Officer and
Dr Andrew Goodall, Chief Executive Officer of NHS Wales

Minister for Health and Social Services support

Prudent healthcare transcends all sorts of boundaries – it is not solely confined to the health service; the agenda puts Wales at the vanguard of an international movement and the principles are truly apolitical.

At one level this is not an 'easy' agenda – it deals with concepts which we can all readily accept whilst not being able to articulate in a straight forward way at another. To any 'doubters' I say simply is there one single thing in this document with which you would not wholeheartedly agree?

Our health services are under pressure; the people who work in the health service feel that pressure absolutely every day. But as the First Minister for Wales said when addressing the international summit on prudent healthcare, just as in other tough times, such as post-war Britain, people used the creativity and imagination that they had available to them to make sure that out of the difficulties that they experienced that something better would come. So today, in the challenges we face, I believe that the prudent healthcare movement gives us an opportunity to recreate, reinvent and reimagine that most important of all our public services for the future here in Wales.

The actions outlined within this document come from those that have played a significant role in the prudent healthcare movement over the past couple of years. Perhaps some of the most significant relate to the new bargain, which must be struck with the people of Wales if the NHS is to continue to thrive in and beyond these times of austerity. Prudent healthcare needs prudent patients, if we are to have a sustainable health and care system for Wales for children and our children's children, which is true to the spirit of the NHS that Aneurin Bevan created and fit for the 21st century.

The NHS and social care are here to help us in our time of need but with that comes a responsibility to use its resources wisely. The NHS is free from charge but not free from obligation. This is the new bargain in this ongoing age of austerity - it is the bargain of co-production at an individual and population level.

At an individual level, the health professional and patient must work together, rather than the patient putting their health problem in the hand of the nurse, GP or consultant. The conversation we have with patients cannot always open with the question 'What can I do for you?' as though the encounter is one in which the health service takes onto its own shoulders the whole of the responsibility for that encounter. The actions in this document, including the Choosing Wisely and public information campaigns, will make a significant contribution to changing the conversations that take place.

On a population level, the new bargain means that everyone accepts responsibility for their own health and a responsibility for managing demand on the NHS while the Welsh Government helps create an environment where it is easier to make healthier decisions while also safeguarding an NHS which remains firm to Bevan's founding principles of universality, equity and free at the point of delivery. There are several actions within this document addressing this, including making it easier for people to work together to improve healthcare, radical action to improve high volume services like outpatients; and redesigning planning and performance management arrangements to always concentrate on value.

Of course this document does not cover everything – it is not an exhaustive list of all we need to do to make prudent healthcare happen in Wales. These actions will make an important contribution to helping us work together to design a future for our health service which is in line with the founding principles of the NHS here in Wales but reinvented to meet the very different challenges that we face in 2016 just as it was invented in the years after 1945.

Professor Mark Drakeford AM.
Minister for Health and Social Services,
Welsh Government

APPENDIX 2 - PRUDENT HEALTHCARE CASE STUDIES

IRIS IN CARDIFF & THE VALE

Following a joint thematic review by the Chief Constable and the Police and Crime Commissioner it was identified that responding to domestic abuse and violence was primarily a police issue, with the police tending to be involved when women were at high risk of serious harm, and that as a result the majority of services were geared to responding to victims considered to be at high risk of serious harm / death. The review highlighted that there was limited early identification and access to interventions via other agencies, in particular there were many missed opportunities within health settings.

The thematic review was being undertaken at the same time that the Violence Against Women, Domestic Abuse and Sexual Violence Wales Act (2015) was under construction and it was evident that there would be a duty on public bodies to take a more proactive approach to the identification of and provision of support for victims affected by domestic abuse and violence, this statutory duty is known as Ask and Act.

As a result significant conversations were undertaken with the relevant health care leaders to identify solutions. As a result IRIS was introduced in Wales in 2014 by the Commissioner, bringing an established licensed model to Wales for implementation. The intention was twofold, 1. To improve health responses to victims and increase confidence to report, making it everyone's business, and, 2. Meet the statutory requirements of ask and act within a primary health care setting,

This work has been led by the South Wales Police and Crime Commissioner's team, IRIS National Lead (New Link housing), Health Boards, Heads of Safeguarding, Directors of Nursing, Midwifery and Patient Services. Lead clinicians for the LMC and Primary Care have also been involved in the development of the work. The above have been involved in concept discussion and agreement to pilot, and make a contribution to the delivery and implementation costs.

However it is important to acknowledge that the Commissioner has been responsible for the delivery of IRIS in Wales and has and continues to be the substantive funder.

The model requires a partnership approach between health and third sector specialist agencies, drawing on their respective expertise and influence.

Expectations for the service in the next 12/36 months

To improve the wellbeing of patients affected by DVA
Outcomes:

1. Better access to support and services
2. Modify future help seeking behaviour
3. Improve physical and mental health

Possible measures:
•Level of knowledge of general practice staff about DVA and the help available for those patients affected
•Level of confidence of general practice staff to ask questions about possible abuse in a safe way
•Appropriate referrals are made (in a timely manner appropriate to the needs of the patient and the identified risk) resulting in improved patient care
•Number of patients referred from general practices for help with DVA
•Levels of reporting of 'violence against women and girls' from primary health care settings

•Presentations to General Practitioners for DVA associated ill health
•presentations to Emergency Departments for DVA associated ill health

Short term population benefits:
•Improved recording of DVA in the patients' medical notes
•Improved data collection and analysis of the number of disclosures and referrals

Longer term benefits:
•Reduction in number of repeat victims of 'violence against women and girls' by identifying and intervening at an earlier point
•Improve the safety of patients by reducing repeat victimisation
•Improvements in patients' physical and mental health and quality of life

Enablers:
Strong evidence base, underpinned by:
- Evidence of IRIS model effectiveness (randomised clinical trials)
- Local prevalence, including volume of incidences in surrounding GP Practice areas
- Investment in relationships to establish shared vision
- Good practice guidance (NICE 2014)
- Violence against Women, Domestic Abuse and Sexual Violence Wales Act (2015)
- Co-delivery (clinical lead and third sector specialists)

Barriers:
- Difficulty to secure funding for a new approach
- Lack of a national joined up approach
- Lack of strategy / joined up approach to raising profile of IRIS (marketing/communications)
- Increased earlier identification of victims of domestic violence and abuse has resulted in more demand on limit early intervention services

<u>Impact of the service on patients, professionals and the organisation</u>

IRIS IN CARDIFF & THE VALE HIGHLIGHTS (more detailed information follows)
Since the launch of IRIS in November 2014, 26 surgeries have been recruited with over 160 clinical staff receiving IRIS training. Embedding the IRIS service within the surgeries has provided confidence to GP's to 'ask and act' and has resulted in 140 first time disclosures from victims suffering emotional and physical abuse.

How the IRIS case example is aligned with Prudent Healthcare principles

Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production:
It has developed a new way of working within primary care, an increased awareness within participating practice teams of indicators of domestic abuse/violence, resulting in in more GP's asking patients about domestic violence and abuse, it has enhanced record keeping (as a result of targeted training and the provision of a care pathway with a single point of contact for referrals from GP's).

Care for those with the greatest health need first, making the most effective use of all skills and resources
As a result more GP's are routinely asking patients about domestic abuse and violence than prior to IRIS implementation

Do only what is needed, no more, no less; and do no harm
IRIS model is working well, the GPs ask the question, and refer to a specialist who can assess risk and need and provide support or refer onto appropriate services.

Reduce inappropriate variation using evidence based practices consistently and transparently.
The IRIS training is delivered to all participating practices, and the IRIS model is adhered to ensuring patients in IRIS aware practices are more likely to benefit from early identification and intervention thought accessing primary health care services.

Paula Hardy, Violence Against Women Project Lead, South Wales Police
Janine Roderick, Consultant in Public Health, Policy Lead for Public Health and Policing in Wales

MSK (Musculoskeletal) MRI (Magnetic resonance imaging) Improvement Project – Hywel Dda Health Board.

Introduction
In Hywel Dda Health Board, an MSK MRI MDT improvement project was implemented in response to a sustained month on month increase in routine scans for MSK, resulting in an excessive wait for urgent scans.

Background
Radiologists were receiving a high volume of routine requests for MSK scans from GPs, this resulted in a large workload and time pressure to review and scrutinise requests for scans. Additionally, there was no access to a MSK GP specialist or MSK radiologist in the Health Board, so if a clinician was unsure about whether to request a scan or subsequently, had difficulty interpreting scans, there was no specialist to consult with for further guidance. This resulted in a tendency to over refer.

An improvement methodology was suggested that would address these issues. Firstly, a multi-disciplinary group with wide representation from clinical specialities was set up, this included representatives from;

- MSK Radiologist-HS
- T+O Consultants-OE+AM
- Senior Radiographers-PD+AF
- CMATS Physiotherapist-SE/DN
- Quality & Service Improvement team-MD/SA

Two fundamental changes were implemented through this group. Firstly, the group put together updated pathways and referral criteria for the following areas;

- Lumbar spine
- Cervical Spine Pathway
- Nerve Root Compression
- Knee

Secondly, for the duration of the project (add dates) the group met weekly and scrutinised all requests according to accepted criteria for imaging and the new referral criteria put together by the group.

How this project is aligned with the Prudent Healthcare principles

- This project involved working co-productively with professionals across a range of disciplines. A range of professionals have been equally important in successfully implementing the improvement methodology.
- By reducing the number of unnecessary routine scans enough capacity was released to ensure that patients with the most need were able to receive the necessary intervention (in this case MRI scans) in a timely manner. This also aligns with the 'do only what is needed' aspect of Prudent Healthcare, since the number of unnecessary scans was reduced.

How Prudent Healthcare policy has impacted this work

Prudent Health Policy was instrumental in securing senior strategic buy in for this new approach. The improvement methodology was a significant change to procedure for the Health Board so required considerable clinical buy in and co-operation for successful implementation. This was partly achieved due to approval from the Medical Director – demonstrating how the project was aligned to Prudent Healthcare policy was helpful is making the case for this project and securing subsequent buy in.

Impact

The total number of MSK MRI scans reduced once referrals were reviewed at the weekly MDT meetings instead of going directly to radiology from general practice (Figure 1).

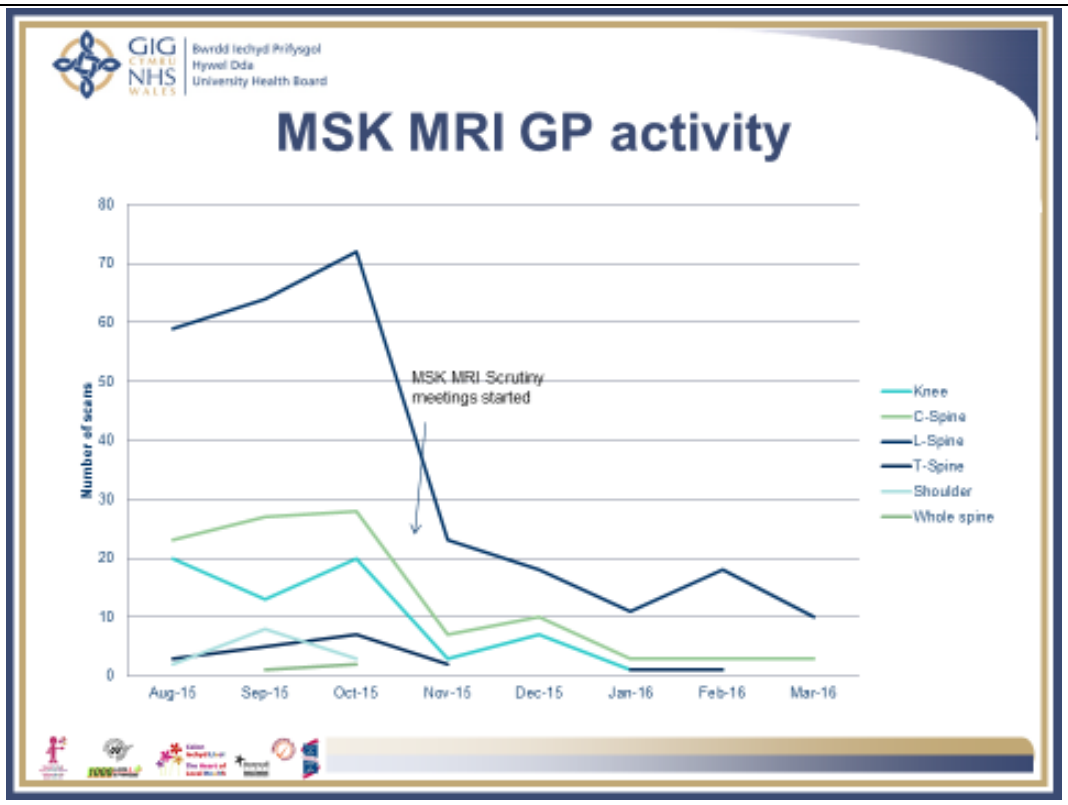

Figure 1:

In two reviews in February 2016 and July 2016 there was an increase in the number of requests for scans that fulfilled criteria (figure 2) and some evidence of improvements in practice around provision of clinical information on scan requests. The following is a summary of findings from the two reviews:

Review Feb 2016:

- 82 out of 299 (27%) requests fulfilled criteria
- Majority refused due to lack of clinical information
- Many illegible requests
- Some requests with no clinical information

Review July 2016:

- 457 out of 1165 (39%) requests fulfilled criteria
- Majority refused due to lack of clinical information
- Improvement in clinical information provided
- Evidence of change of practice

Since completion of the project, scrutiny of requests for scans and interpretation of scans now sits with the Radiology department who continue to use the criteria developed by the project team to assess cases. Initially, there was a spike in referrals for scans as the new procedure was handed back to the department, but since embedding of the process within the Radiology department this has now stabilised and overall the number of referrals remains substantially lower than at the start of the project.

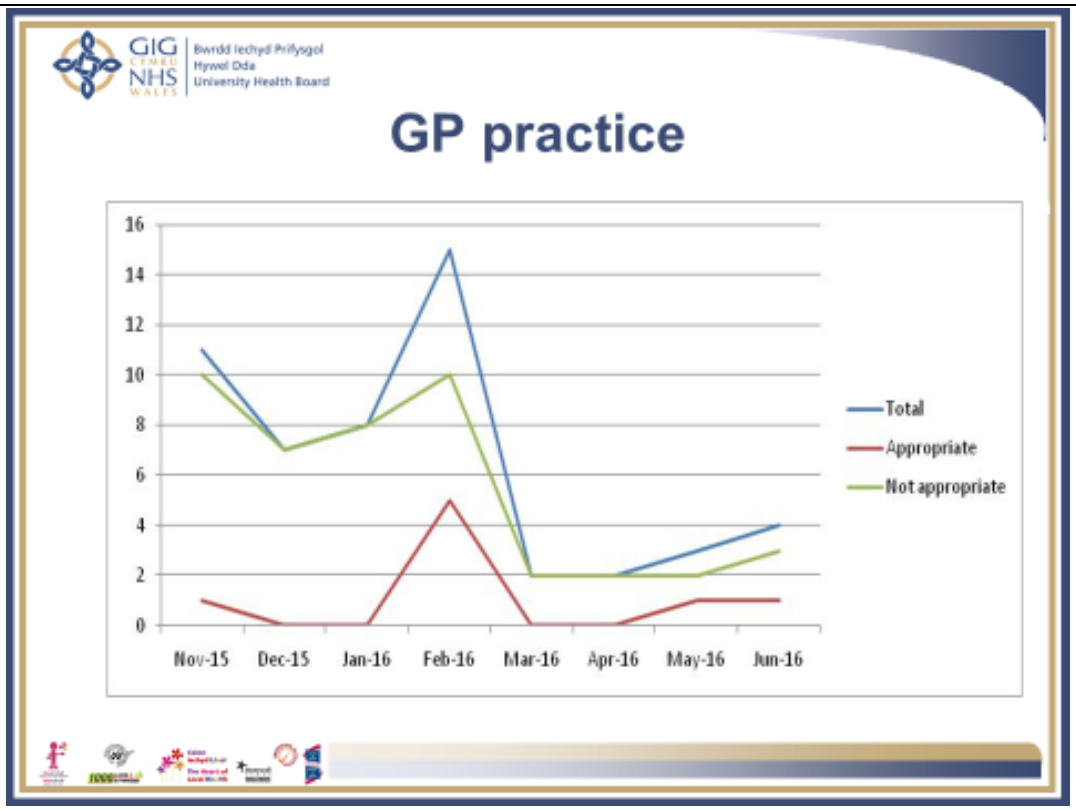

Figure 2: Types of MSK MRI scans from GP practice

Sian Anson, Quality & Service Improvement Project Manager & Mr Owain Ennis, Consultant Orthopaedic Surgeon

Towards a needs based Podiatry service in Wales

We have fundamentally adapted our approach to assessment and treatment planning across podiatry services in Wales, to take into account the prudent approach of 'Caring for those with the greatest health need first'. In practice this has meant developing a new taxonomy that takes into account need and risk. Under this new approach, each case is given a rating based on need and risk, and all cases are then prioritized taking these two factors into account. This approach has meant that there is a standard approach to classifying podiatry cases across Wales, reducing variation and ensuring those with the greatest need receive care in a timely manner. Having a needs based service also means reducing unnecessary interventions, which is aligned with a prudent approach.

Prudent Healthcare policy has influenced development of this new approach, with our initial conversations stimulated by an early Prudent Healthcare paper, just before launch of the policy. A national group was set up to oversee development of the new guidelines, which are now part of the national guidance for Podiatry services across Wales.

David Hughes, Podiatry Manger & Clinical Lead

Development of a primary care Audiology service in ABMUHB

•Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production;
All audiology staff have had co-production training – and are encouraged to use a co-productive approach in their consultations. Emphasis is placed on ensuring that patients are aware of their treatment options – and that they don't feel obliged to take on any form of management if they don't feel they need it. Audiologists also use a pre-consultation questionnaire. It help our patients to think through what they wish to achieve from their appointment. The approach is really adapted based on need – there isn't a uniform approach to being co-productive.
•Care for those with the greatest health need first, making the most effective use of all skills and resources;
Making the most effective use of all skills and resources has been at the centre of this service. We were trying to reduce number of face to face appointments with GPs – whilst ensuring that patients are seen in a timely way and by an appropriately trained health professional, to meet their needs, as soon as possible. Having a primary care audiology service means that many ear and hearing related cases can been seen and treated in primary care – by an audiologist – instead of waiting to be seen by a secondary care specialist. We used the approach that if patients had symptoms with ears or hearing instead of seeing their GP in the first instance, they would go to an audiologist. The audiologist takes a history and does hearing assessments, ear-care and then along with the patient, makes a management plan.
We have reviewed out skill mix and are using increasingly higher levels of bands 2, 3 and 4 staff as part of the audiology service. We constantly review what can be done by what grade staff – with the aim of making the most effective use of our resources. We need to use our more highly skilled staff for the primary care approach – and these staff are then backfilled by appropriately trained staff.
•Do only what is needed, no more, no less; and do no harm.

Reduce inappropriate variation using evidence based practices consistently and transparently.

Stakeholder groups were set up in February 2015 – with the pilot launch of the service in August 2017. The pilot has covered 11 GP practices – with sites in Swansea, Neath Port Talbot and Bridgend.

The audiology service in ABMUHB, is now part of primary care delivery unit– which has made a very big difference in terms of access to decision makers interested in this project. Audiology services are usually in the same organisational structure as ENT, within a surgical directorate – so management may have traditionally been less receptive to ideas about development of a primary care audiology service. Being embedded in primary care made a big difference. There was interest and buy in about ideas that have been discussed at

national level in relation to development of audiology services, in relation to taking some of the pressure off GPs and providing an effective service for patients. There was also recognition that there are many services that are provided in hospitals that could be provided in primary are - that was the basis for the initial conversation.

We found that GPs and cluster leads have been very much on board – resistance has been low. At a national level thinking about audiology services has been in line with prudent policy and aligning our work with prudent policy – and has been useful in applications to the workforce development fund.

The audiologist in primary care is a one stop shop – some procedures are carried out on site – for example, Audiologists have been trained to do wax removal and they also carry out hearing assessments. The patient is either discharged from the service or is referred to their GP; Roughly 45% of patients are being discharged, 35% are referred to Audiology because they do need a hearing aid or they have tinnitus. 15% require an ENT opinion and 5% need to be seen by the GP. There will be a significant reduction in demand on GPs.

There are now 1.5 audiologists covering the pilot areas. Additional training has been given to these audiologists which now enables them to make referrals for further diagnostic assessments which will further reduce demand on ENT services.

Barriers and facilitators

Facilitators
-Re- organisation. Audiology have been placed into primary care unit. This is quite unusual, and has enabled better communication with primary care – which helped in developing ideas.
-ENT, GPs and cluster leads have been on board. There has been good clinical buy in
Barriers
-Continue to run a main service – so there isn't additional resource to run the primary care service.
-Pressure on resources
-Limited funds available. Need to persuade other cluster leads that funding Audiology is an efficient way of using cluster funding
Has PHC influenced the work you are doing?
Yes, PHC aligned with the work we are doing – and has influenced national thinking on audiology services so is an integral part of the thinking behind development of this service.

Professionals
•GPs are able to spend their time more effectively
•Less pressure on ENT in secondary care
•Audiologists are able to work at the top of their licence

Patients

•Have reduced waiting time for hearing assessment, advice and treatment
•Improved access to wax removal/ear-care
•Shorter clinical pathway

Benefit from accessing a service that takes a co-productive approach
- What are the learning points that you think others would benefit from hearing?

Workforce development fund – consistent with prudent
If you're starting - start off small and slowly expand. Split roles - maintaining secondary care role.
Ensure there staff in primary care audiology are not working in isolation
What are your expectations about the impact of this service in the next 12 months / 36 months?
Reductions in referrals to ENT (secondary care)
Reduced demand on GPs
Savings for both primary care and ENT
More efficient service for patient – less waiting for audiology treatments that can be carried out in primary care

Rhys Meredith, Audiology Service Manager, Abertawe Bro Morgannwg University Health Board

TalkCPR Project

The aim of this project is to improve communication and dialogue between patients with palliative and terminal illness and their healthcare professionals about Do Not Attempt Cardiopulmonary Resuscitation decisions.

Four videos hosted on a website aim to describe some of the main areas to consider when discussing this important topic. Videos were co-directed by patients, in order for them to help explain relevant issues surrounding this sensitive subject. In addition, videos for healthcare professionals with guidance and tips on how to start these conversations sensitively and professionally are also available on the http://TalkCPR.wales website
We also aimed to clarify some of the common misconceptions surrounding CPR, allowing natural death and DNACPR towards the end of life in a news article. This project is referenced in this **Guardian article** and can be found here
http://www.theguardian.com/healthcare-network/2016/feb/03/casualty-cpr-fails-cancer-doctors-let-patients-die

This project supports Prudent Healthcare...

- *Public and professionals are equal partners through co-production*:
  DNACPR discussions are some of the most sensitive and delicate in healthcare today. Many palliative care workers have experienced that patients want to be

involved in these decisions and are not usually offended by their healthcare professional bringing this up. The TalkCPR videos and website encourage this dialogue, try to inform about the challenges of CPR and encourage open communication. They were made, produced and reviewed by patients and carers in Wales, and are all the more powerful for it.

- *Care for those with the greatest health needs first*:
  The videos are aimed at patients with palliative and life-limiting illness, as well as their carers and their healthcare professionals. There are tips on how to frame these conversations within the wider care that will be provided.

- *Do only what is needed and do no harm*:
  More should be done to prevent modern medicine from automatically defaulting to cardiopulmonary resuscitation in palliative care patients. Admission to hospitals and ITU in situations where a prior, honest and candid discussion with a seriously ill patient may have elicited that they would rather remain at home, are a missed opportunity. DNACPR forms do not preclude patients from very active treatment and the treatment ladder approach in the Top Tips video makes sure that ***only those procedures are considered that patients would feel appropriate, no more, no less***. We checked carefully with our user groups ***that these videos were not insensitive or harmful***, and in fact some responses felt that they could have been more explicit and blunt. But overall view was that we got the balance right.

- *Reduce inappropriate variation through evidence-based approaches*:
  Videos are being rolled out via the DNACPR implementation group to each Health Board and Trust in Wales and are also available on Howis. Two English Trust have approached Public Health Wales and asked whether they could use the videos in their own setting, and Pulse magazine have written a feature for GPs in the UK, on this novel video and website approach to get patients and carers to take a lead on DNACPR. Videos are available in English and Welsh and provisions have also been made for blind, partially sighted and deaf patients.

Anticipated Benefits

Communicating the concept of DNACPR in a sensitive way requires skill and once it has been discussed it should be documented very clearly, for other healthcare team members to know what discussion has been held. There is a need to explain this procedure better within society, and also to create reproducible ways of giving clinicians opportunities to gain confidence in talking about this topic more.

Measures

- Use of the new All Wales DNACPR form, which came into effect during 2015. This form is used to document communications between healthcare professionals and patients/carers.
- Acceptability and readiness of patients and healthcare professionals to use communication videos on this topic, to help understand what CPR actually is

Intervention

- Roll-out of the All Wales DNACPR Form across Wales, and its uptake and use as a communication tool between healthcare professionals, patients and carers.
- Roll-out of TalkCPR videos, four videos (all aimed at patients, carers and healthcare professionals) co-produced and co-directed by Dr Mark Taubert and stakeholders including patients/carers.

Outcomes

- DNACPR forms obtained from notes in late 2015 and early 2016 contained more information on communication between healthcare professionals and patients/carers than previous DNACPR forms. There was a significant increase in DNACPR forms that were demonstrably discussed with patients and/or proxy compared to previous years.
- TalkCPR videos were acceptable to both patients/proxy, nurses, and doctors and pre- and post- video surveys as well as focus-group results showed a high level of readiness to engage in DNACPR discussions, readiness to show information videos to patients and carers and a better level of understanding about what CPR actually means.

Conclusion:

These short films have been made available in each Health Board and trust in Wales. Three English Trusts have asked permission to use the videos in their own setting, and Pulse magazine have written a feature for GPs in the UK, on this novel video and website approach. A media campaign has made the TalkCPR project very prominent in the public domain, with Benedict Cumberbatch reading out a letter at Hay Festival mentioning this NHS Wales project and a Guardian article on CPR which went viral. Both NICE and the GMC have published the TalkCPR website resource.

It is hoped that the use of video and website information for patients around difficult areas such as CPR wishes can inform part of a more sharing approach, allowing patients and their proxy to be involved in key decisions and providing good quality information.

Dr Mark Taubert, Clinical Director/ Consultant in Palliative Medicine, Velindre NHS Trust, Cardiff

Programme Budget Marginal Analysis (PBMA) approach to improving Muscular Skeletal patient outcomes within existing resources

The ABMU Commissioning for Quality Team in partnership with Swansea Centre for Health Economics at Swansea University facilitated a clinically lead Programme Budget Marginal Analysis (PBMA) approach to improving Muscular Skeletal patient outcomes within existing resources.

The project identified interventions that were considered not to benefit patients or improve their outcomes which when reduced/ceased could release staff, theatre and clinic capacity. In addition cash savings were identified through clinical agreement on changes to the procurement of related clinical equipment. The project used resource released from secondary care to fund a community based prevention and self management service aimed at further reducing surgical interventions for patients with osteoarthritis where appropriate. This work aligns with Prudent Healthcare policy in the following way:

-Patient views have been taken into account in re-designing the pathway, through a co-productive approach
-A major focus of the PBMA approach has been to maximize use of all skills and resources, shifting resource along the pathway for maximum patient benefit
-Reducing ineffective interventions aligns with the third principle of 'only do what is necessary, no more no less and do no harm'.

The Head of Commissioning Development for ABMU, Kerry Broadhead, attended a prioritisation seminar at which Pippa Anderson, Health Economist Swansea University gave a presentation which included an overview of PBMA as a tool for delivering Value Based Healthcare – a concept that fits well with the principles of Prudent Healthcare.
Kerry approached Pippa to ask for support in delivering the PBMA approach within ABMU Health Board. Once secured, several clinicians in key areas anticipated to be open to adopting the approach were contacted.

Dougie Russell, Consultant lead for Orthopaedics and Mike Bond, General Manager for Muscular Skeletal Services were two of the staff that expressed interest in using the methodology within Orthopaedics.

Commissioning organised an event with colleagues from across the Health Board (lead and informed by Dougie and Mike) which included consultants, therapists, GPs, finance staff and relevant operational managers. At this Dougie and Pippa outlined a proposal to test the methodology. After some debate it was agreed that a project team would be formed to take the work forward;

Clinical Lead – Dougie Russell
Operational management lead – Mike Bond
Finance Lead – Charlie Mackenzie

Commissioning Lead – Kerry Broadhead
Commissioning Project support – Patricia Jones
PBMA expertise – Pippa Anderson
Operational project support – Vikki Gibbs (toward the end of the process to support operational planning)

Additionally at this meeting an initial discussion took place on what colleagues considered potential areas of inappropriate variation, areas considered to be low value interventions in relation to delivering outcomes, areas that evidence may suggest could be undertaken more efficiently.

The areas identified for following up by the stakeholders because they possibly resulted in patients under-going interventions of limited clinical value to them and or could be better managed by the clinician and patient agreeing an approach to their care and /or having the potential to be done more efficiently were:

- Knee arthroscopies
- Patient post arthroscopy follow ups
- Prosthesis procurement

Two consultant surgeons played key roles in supporting the wider stakeholders understanding of these areas:

Mr Andrew Davies – in particular his work peer reviewing the knee arthroscopy patient surgical notes
Mr Dave Woodnutt - in particular his work on risk and patient follow up regimes

There were three subsequent stakeholder events involving clinical, managerial and primary care staff as well community health council and local government colleagues. At this presentation of data and information relating to our agreed themes was made. Later once the improvements in practice had been reviewed and the potential value of the resource that could be released was known, stakeholders were asked to present their ideas for how that resource could be better utilised within the orthopaedics pathway to deliver higher value outcome interventions for patients.

All of the above was captured in a commissioning proposal for service improvement and presented by Dougie Russell and Mike Bond to the ABMU Planned Care Commissioning Board. The proposal was recommended by the PCCB to the ABMU Executive Team who approved the proposal.

The relevant clinical teams are now implementing the changes which will be reviewed and monitored by the PCCB.

Enablers to making good progress on implementing this approach

CEO support for re-utilisation of resources within the pathway (subject to significant stakeholder engagement). This was a key incentive for clinical engagement as they felt that they were able to use their existing resources to improve patient care and deliver more for the same and not loose vital resources.

Clinical Leadership – Dougie's role in encouraging and supporting clinical engagement in the process especially when there was scepticism at the start.

Secondary care clinical engagement – e.g. in peer review of case notes, evidence review, data analysis and presentation of this to stakeholders and commissioning team in a way that helped people to understand.

GP and community engagement - helping the work to be pathway focussed, offering another lens, point of view or experience to inform stakeholders' thinking/ideas.
CHC - supporting patient view and experience – helping stakeholders consider patient perspective.

Swansea University expertise in PBMA process and health economics capability.
Project team resilience and commitment to learning on the job and working in new ways.
Finance leads support for developing principles that enabled us to 'shift' resource from acute to community care without destabilising services.

Commissioning team – small but still it was able to facilitate/organise the work happening – this enabled the clinicians time to be focussed appropriately and not on tasks that took them away from their core roles.

Barriers to implementing this approach

Intelligence and information capability and capacity including skills in health economics in house at ABMU and an ability to look at the whole pathway re patient experience, patient outcomes, activity and finance

Clinical anxiety related to lack of resources and potential risks associated with reducing these at a time of such immense operational pressure

NHS finance systems that don't support the shifting of resource within the pathway e.g. from acute into primary/community

Time – of everyone to be able to do this as well as the day job – focus is on operational 'fire fighting' which hampers time to stand back and look at what can be different and listen to each other's experiences and ideas

How PHC is prompting new streams of work

The Commissioning for Quality Team is now undertaking a Diabetes PBMA and looking to develop the approach further within the health board.

The ABMU finance team has developed finance principles to assist with implementing the approach – although these may requiring on-going refinement.

Expected impact of this service in the next 12/ 36 months

- Reduction in prosthesis procurement costs (£231k circa)
- Redesign of Follow Up pathway incorporating Nurse Led services, virtual clinics and a general reduction in follow ups attendances
- Reduction in knee arthroscopies (approximately 27%)
-Launch of pilot for new prevention and self management service
-Evaluation of prevention and self- management service outcomes

The table below shows the number of patient spells reducing (this will continue to be monitored):

Count of unit no admitting primary operation	PROC	Financial Discharge Year	
		2014/15	2015/16
W802	Open debridement of joint NEC	22	21
W822	Endoscopic resection of semilunar cartilage NEC	516	456
W833	Endoscopic shaving of articular cartilage	11	7
W851	Endoscopic removal of loose body from knee joint	15	19
W852	Endoscopic irrigation of knee joint	21	20
W858	Other specified therapeutic endoscopic operations on cavity of knee joint	6	5

Kerry Broadhead – Commissioning Lead, Abertawe Bro Morgannwg University Health Board

Public Health projects aligning with Prudent Healthcare Policy

MAMSS

12/6/13 – 4/2/14 for initial research and then on going

Maternal smoking is an important cause of poor health outcomes for mothers and babies and children in Wales. The MAMSS (Models for Access to Maternal Smoking Cessation Support) project was a national project looking at alternative smoking cessation models for pregnant women who smoke.

The basis for this work is the very low uptake of smoking cessation support in pregnant women. We asked the question, if we designed a programme where we met the needs of pregnant women, what would that look like? The smoking cessation service for MAMSS was designed around what pregnant women wanted, which was a specialist support service. In CWM Taff we trained our maternity support workers in smoking cessation to provide a specialist service for pregnant women. They were all trained to routinely CO test women. Stop Smoking Wales smoking cessation advisors are band 5, we trained our band 3 maternity support workers to offer a smoking cessation service by focusing on competencies, rather than focussing on having a highly qualified workforce. In particular, this project is aligned to Principle 2; caring for those with the greatest need first, making the most effective use of all skills and resource – the service is aimed at those with the greatest need and maternity support workers are working to the top of their licence in this role, so are making the most effective use of their skills. We have also taken a co-productive approach in designing the service (Principle 1). Finally there is also alignment with principle 4 as we have reduced variation by introducing a standardised routine CO testing approach for all pregnant women in Cwm Taff.

Bump Start

January 2015 - ongoing

Excessive weight gain in pregnancy is a significant risk factor for low birth weight babies. The Bumpstart programme is a public health approach to addressing overweight and obesity in pregnancy. The weight management programme delivered as part of Bumpstart is based on the Doncaster model. Pregnant women with a BMI of over 30 or more are offered support from a dietician. Women are seen at routine appointments, and there is also support from a community midwife at key points if there is unhealthy weight gain. The evaluation is on- going and will engage the SAIL database. Part of the evaluation is working out cost of reduced time in hospital and reduced time in neonatal care.

In terms of alignment with Public Healthcare Principles, Principle 2 is particularly relevant, women with the greatest need are prioritised for this service and this is also a good example of supporting professionals to develop competencies to make the most effective use of skills and resources.

Joint Care Programme in Orthopaedics

October 2014 – on going

In CWM Taff, 62% of patients who needed knee interventions were obese, compared to 28% of the general population. The public health team developed a 16 week course called Foodwise, to be offered to people as an option to support weight loss, before referral for surgery. This approach is based on evidence that weight loss reduces the need for surgery. If a patient is able to lose 5% of their body weight then the need for surgery is reduced. The outcomes overall were an improvement in Oxford knee scores.

Cardiovascular risk reduction programme – CVD Health Checks

The cardiovascular risk reduction programme is based on the inverse care law, Julian Tudor-Hart's observation that people that need care most are least likely to get it. The programme was introduced maybe two or three years ago. The idea was that if we could target the population who were at risk of CVD disease (from lower socioeconomic groups) at an appropriate time, we could prevent CVD developing. The programme aims to encourage lifestyle behaviour change to reduce risk of developing CVD. We targeted 8 GP practices to take part in the intervention, which involved a one to one conversation with a trained band 3 support worker, who carried out a Health Check and then referred into lifestyle support and/or primary care. The consultation involved a session with a computer programme and visual aides to assess risk. The approach was very much centred on working with people to assess risk. Ideally, the programme should be scaled up to reach a larger proportion of the population.

For all of these projects there has been strong alignment with Principle 2 of Prudent Healthcare policy;

CVD Health Checks – The Band 3 lifestyle support workers are an example of 'working to the top of your license' making the most effective use of all skills and resources.

All three projects are in line with the second Principle – caring for those with the greatest need first, which is a preventative approach.

How Prudent Healthcare policy has influenced public health work in Cwm Taff Health Board

All three if these examples align strongly with Principle 2: caring for those with the greatest health need first; and making the most effective use of all skills and resources.
Although it is acknowledged that these public health projects were not initiated as a result of Prudent Health policy, the policy has been useful in raising the profile of each of these projects at Executive Board level as it is a requirement to report on the progress of projects aligned to Prudent Healthcare work. Prudent Healthcare has been a vehicle to help us demonstrate that prevention pays and to raise the profile of public health work in the Health Board.

Angela Jones, Consultant in Public Health, Cwm Taf Health Board

Patient Experience Advisor Role at Neath Port Talbot hospital– improving services co-productively, as part of developing a 'Prudent' hospital

Patient Experience Advisors are a new role that replace the older patient liaison role. The fundamental shift between the two roles is the former focussed on complaints – whereas this role is more proactive and seeks to understand – from the patient's perspective – what

would improve hospital services. The patient experience advisors also act as a central contact for any complaints, queries or issues patients raise.

The advisors spend their time on wards, speaking to patients and getting feedback directly and in the form of a survey about patient experience and whether patients would recommend the survey to their friends and family.

The role is aligned to Principle 1 – the model for this role has been to take a co-productive approach to improving services.

There is recognition that the role is in its infancy and that as it develops there will be scope to develop further and assess how the co-productive approach is having an impact.
NTP hospital is a Prudent Hospital so thought has gone into how to align roles with the vision to make the hospital more prudent. The patient experience advisor role was developed as a key way of making the patient experience a more co-productive one, and to allow patient experience to be at the centre of service developments.

Angharad Higgins, Neath Port Talbot Hospital, Quality, Safety and Improvement Manager, Abertawe Bro Morgannwg University Health Board

EMBEDDING A CO-PRODUCTIVE APPROACH IN ABM HEALTH BOARD PODIATRY SERVICE

As a Health Board, ABM have been interested in co-production training for about 4 years now – so that was before the launch of Prudent Healthcare Policy. We have input from trainers in the South of England who specialise in co-production and self-management training and have been involved with training all staff in the Podiatry service and in other parts of the Health Board too.

In terms of the Podiatry service, we made a decision to systematically train all of our staff and to incorporate coproduction as core part of how we deliver our service. The approach we take has a strong element of encouraging patients to self-manage. By June 2014 all 71 members of Podiatry and Orthotics staff, including administrative staff, had undertaken the 2 day training in co-production and self-management support with 4 week interval between sessions.

Although our interest in taking a co-productive approach pre-dates the launch of Prudent Healthcare policy, it has been a key part of conceiving this project – without Prudent Healthcare it would not have been such a priority to ensure all podiatry staff are trained. Drawing on the self-management aspects on the co-production toolkit, we have introduced a new system for our patient consultations. Patients are given a pre-consultation questionnaire to complete in the waiting room, as part of this questionnaire, they are asked to tell us to list what is important for them to discuss at the consultation. We ask them to use an 'importance scale' from 1-10 to tell us how important each issue is. Scaling allows us to explore patient ambivalence and raise the importance of health issues where it needed

most. We then use this information to "agree the agenda together" and reconcile – with clinical judgment – what to cover in the consultation- exploring with the patient both what they need and what they want. This aligns with Principle 3 and enables us to avoid unnecessary interventions simply because they are clinically indicated and to instead give equal consideration to whether the intervention may help the patient achieve the goals that matter to them. We also ask patients to assess on a scale of 1-10 how confident they are to achieve their goals in relation to each of their issues. Post consultation, we ask patients to report their importance and confidence scores again – to get a measure of how activated patients are to become effective equal partners in their own care. We also ask patients for qualitative feedback. We have seen a shift in confidence scores from below 7 to 7 and above demonstrating that clinicians have effectively empowered patients. The low confidence scores have allowed staff to direct effort and work with patients to overcome passivity and specific barriers to effective self-management. Scaling patient activation to self-manage by measuring self reported importance and confidence, provides us with an opportunity to direct our support to exactly where it is needed most, to reduce passivity and inappropriate dependency on services. Activation scores over time are central to our service PROM'S.

Although the focus has been on how to make our relationships with patients more meaningful and co-productive, we have found that to apply the other principles, we also need to take a co-productive approach in all that we do, in our interactions with other professionals as well as our patients. For example, In addition to using the training to inform patient interactions – we have taken elements of the co-production training and used them to explore staff activation prior to undertaking PADR's and one to one management supervision meetings. Exploring staff importance and confidence prior to PADR meetings allows reviewers to focus support where it is needed most and has been effective in increasing staff activation and engagement to develop a padr document which is equally valuable to the individual and service. This has enabled us to eliminate historic and significant waste associated with initiating 90 minute padr meetings where staff activation to engage in meaningful reflection, objective setting and personal development planning is too low for the meeting to be of real value.

On our journey of embedding a co-productive approach within our service, we have found the key enablers to be; leadership buy in, starting with a small group who are enthusiastic about co-production and essentially, to keep going as this is not a culture change that happens overnight.

Our biggest learning is for each of us to take small baby steps to changing historic practice so that we can sustain momentum and continually improve. Acknowledging achievements along the way is also vitally important.

David Hughes, Podiatry Manager & Clinical Lead and Carol Hesford, Podiatrist

IMPLEMENTING ICHOM'S STANDARD SETS OF OUTCOMES:
PARKINSON'S DISEASE AT ANEURIN BEVAN UNIVERSITY HEALTH BOARD IN SOUTH WALES, UK

Background

In 2014, the Welsh Minister for Health and Social Services laid down a set of Principles to achieve more efficient health care across the country. This new set of Principles , referred to as Prudent Healthcare, involved a greater emphasis on the co-production of health care between professionals and the public, caring for patients with the greatest health needs first, doing no harm, and reducing inappropriate variation through evidence-based approaches. Each of Wales' seven health boards would be tasked with defining a local strategy to achieve this over the coming years.

Dr Sally Lewis, Assistant Medical Director and Dr Paul Buss, Medical Director, at Aneurin Bevan University Health Board (ABUHB), welcomed the new National Policy but felt there was a missing vehicle for the delivery of these new principles. Increasing financial pressures facing the Board and the repeated cost cutting exercises leaving staff feeling deflated across the organisation. There was a lack of visibility of both clinical and patient reported outcomes and detailed costing of patient pathways across the whole system, proving difficult to assess the value of healthcare provision to patients throughout the organisation.

Incidentally, Sally and Paul's colleague and Finance Director at ABUHB, Alan Brace, had just returned from a course at Harvard Business School on Value-Based Health Care (VBHC). Both Alan and Sally saw VBHC as the ideal vehicle for achieving ABUHB's goals. This would be an opportunity to engage in a dual focus on both of ABUHB's targets - outcomes and cost - with the potential to create a common language between clinicians, managers and financiers within the organisation whilst leveraging resources more efficiently. Thus, the senior leadership of ABUHB agreed to use VBHC as a vehicle to achieving Prudent Healthcare's Principles in the coming years.

GETTING STARTED
It was important to identify a department in which to pilot an ICHOM Standard Set on a small scale. This was essential to ensure feasibility and impact before scaling across the organisation. ICHOM's Parkinson's disease Standard Set was identified as a relatively simple model to begin with.

1. Process-mapping
ABUHB subsequently process-mapped the pilot implementation clinics from patient, clinician and informatics perspectives. They produced a gap analysis of what, where and how each metric was measured. This allowed them to create a plan for any missing outcome metrics. Through process-mapping all three perspectives, the timing and manner of data capture was designed from concept to execution to cause minimal disruption to normal patient and clinician flow.

2. IT/Informatics restructuring

A data mapping and gap analysis exercise was undertaken in order to identify the data gaps between the ICHOM Standard Set for Parkinson's Disease and what the clinic was already collecting. This involved an investigation into where and how the various types of data were stored, and how these could all be pulled together. The biggest gaps in the Parkinson's Disease clinic between current data collection and the Standard Set were the use of patient-reported outcome measures (PROMs).

ABUHB developed a home-grown electronic data capture platform that allowed for the accurate capture of PROMs by the patient through the use of a tablet computer in the waiting room. The process mapping exercise had already identified that there was capacity within the role of the Health Care Assistant to help with this, and therefore, the additional resource cost to deploy this was minimal. The system was created with the Parkinson's patient population in mind, and the user interface designed to make data entry as easy as possible at every step. On deployment of the tool, weekly PDSA (plan, do, study, act) cycles and Project Team meetings to review the results of these cycles were held, until the process was perfected.

EARLY RESULTS

The early benefits were clear to all involved – patient information collated via PROMs was immediately available at the clinician's fingertips, streamlining history-taking and focussing the consultation on what matters most to the patient. There were limited delays within the clinic, as patient data collection occurred outside of physician-facing time, and remaining data items were pulled from pre-existing clinical and administrative data sources. In particular, the PROMs tool comprised an early question that re-ordered the subsequent PROMs questions based on what had been bothering the patient most in the recent past. Getting patients to complete PROMs questions on iPads in the waiting room was stimulating patient-patient conversation and helping them structure their thinking prior to their appointments. Other key pieces of information – such as drug adverse reactions and allergies - became more readily available and understandable due to a common data entry format across domains.

Through the process mapping exercise, ABUHB also decided to divide clinics by patient cohort. This will lead to the allocation of more specialised teams with a better understanding of patient cohort clinic needs (e.g. new diagnosis versus complex established diagnosis), and will mitigate the distress for new patients attending clinic with patients with visibly more complicated, severe diagnoses.

As of February 2016 – 9 months into the implementation process - administrative data capture of basic demographic information was 100%. Patient-reported data capture was very high, with 88% of Parkinson's PROMs questions completed across all fields and 73% of baseline patient variable factors completed across all fields. Clinician-reported data capture initially had the lowest completion rate at 23% due to 'crashing' of the e-forms. Once this was resolved, clinician-reported data capture was 100%, emphasising the importance of an enabling IT system. Coding accuracy was satisfactory at 66% overall, indicating the need for further training of data abstractors. Fields simply need to be cleaned in order to render the data compliant for external benchmarking. For example, instead of listing gender as M or F,

it needs to be listed as '1' or '2' as indicated in the Standard Set Reference Guide. Coding was, however, high quality for the majority of the patient reported data items.

Lessons learnt

1. **The IT team need to be on the Front line** In order to better understand and iterate the user interface, the IT team need to visit the clinic on a regular basis and see the technology in practice from both clinician and patient perspectives.

2. **Front-load support systems and manage expectations, especially IT** Support systems need to be front-loaded to facilitate early troubleshooting to give both clinicians and patients confidence. These systems can then slowly be dialled down as the process becomes more efficient and free of errors. As part of this, empower and enable front-line teams so that they continue to feel ownership.

3. **'Out of the box' IT solutions are less burdensome** The ABUHB IT team decided to build their own e-forms for data collection. Complexities can arise (e.g. system-wide upgrades leading to 'bugs' in the e-forms) unexpectedly, which increases the burden on the IT team. The ideal solution is an affordable 'out of the box' solution that integrates with the hospitals IT system.

4. **Provide real-time data that clinicians can use immediately** Maintain the support and engagement of clinicians by providing them with actionable data, ideally in real-time. Frequently, clinicians are asked to support data collection for mandatory audits and other initiatives that may never get fed back to them, reducing their interest and support.

5. **Top-level commitment to both arms of the value equation** This sends a very powerful message to the organisation and acts as a 'call to arms' to all teams – not just clinicians – to modify their thinking. These must not just be stated as organisational priorities, but also operationalized to ensure action.

6. **There is no 'team' for this - it should transcend all teams** Don't over-define the team responsible for outcomes measurement and VBHC, because this may detract from it being core business across all teams. It is important for teams and individuals to be aware of their responsibilities, with matrix ownership allocation across domains. The VBHC Project Team and Steering Committee should act to support pre-existing teams until this becomes woven into routine practice.

7. **Small, incremental improvements rather than mass overhauling** In order to change the way people work, it is important to take small steps. This reduces the risk of destabilising the organisation or departments, and facilitates incremental learning at every unit level – from individual to organisation.

8. **Frame the initiative in the right way** Use of common language from the management played a big role in engaging clinicians, finance and managers, which is far more meaningful for teams and aligns interests across domains.

9. **Make it user-friendly** If the clinician and patient-facing elements of the data collection system are not easy to use, they will not be used and data collection will be deprioritised. It is worth investing significant time and effort in, for example, the user interface.

10. **TAKE A LONG-TERM VIEW** Even though no single team 'owns' an outcomes measurement initiative, it is important for individuals and teams to be brought in with a long-term view. Short-term projects often fail to significantly shift culture.

Adapted from:

Arora J, Lewis S, Cahill A. Implementing ICHOM's Standard Sets of Outcomes: Parkinson's Disease at Aneurin Bevan University Health Board in South Wales, UK. London, UK: International Consortium for Health Outcomes Measurement (ICHOM), March 2017 (available at www.ichom.org).

Development of the Medical Technical Assistant (MTA) role – Cwm Taf University Health Board (hospital)

'There is huge potential for making our services/ NHS more prudent through workforce development – the thinking is not new, but Prudent Healthcare helps to provide a focus'. The purpose of the MTA role was to bring patients through the A&E system more efficiently, and to reduce overall time spent waiting for minor medical procedures, that could be done competently by well trained lower grade staff.

The starting point for designing the MTA role was focussing on what patients needed at each point in the pathway, and then looking at the skills necessary to meet those needs. Staff who were previously at band two were then trained up to band three level, with a focus on developing competencies that were essential for treating patients at each point along the pathway. This included learning to cannulate, take bloods and catheterise. There are now 9 band 3 staff who have been trained to deliver the MTA since inception in October 2015.

The development of the Medical Technical Assistant role has drawn on four of the Prudent Healthcare Principles but there has been a particular focus on part of Principle 2; 'making the most effective use of all skills and resources'. The role has also encouraged communication and a co-productive approach between professionals, particularly across bands, from MTA assistants to consultant level. There has been a very enthusiastic embracing of the new roles by staff, as they are now working to 'the top of their licence' and

have good job satisfaction. A facilitator for this work was identified as picking roles where staff are 'ripe for development'.

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