Bevan Commission

...promoting health and health services improvement in Wales

Notes

Bevan Commission
Meeting 10

Date of meeting: 5 September 2013
Version: 1

Members attending:
Prof Sir Mansel Aylward
Prof Bim Bhowmick
Dr Tony Calland
Prof Marcus Longley
Prof Ewan Macdonald
Prof Donna Mead
Prof Sir Anthony Newman Taylor
Prof Ceri Phillips
Prof Jennie Popay

In attendance:
Helen Howson, Public Health Wales
Julie Lake, Public Health Wales
Jon Matthias, Public Health Wales
Leighton Phillips, Welsh Government

Apologies
Sir Ian Carruthers
Dr Jo Farrar
Lt-Gen Louis Lillywhite
Prof Allyson Pollock

1	**Welcome and apologies** The Chair welcomed the attending members of the Bevan Commission and support staff. Apologies as listed above were noted.
2	**Declarations of Interest** There were no declarations of interest.
3	**Notes from last meeting held on 6 June 2013** The Chair advised that the notes from the last meeting had been shared confidentially and informally with the CEO NHS Wales,Welsh Government. Sharing the notes had

	led to two issues requiring action by the Commission: a) The CEO of NHS Wales had thanked the Commission for raising the issues of Data and Information and had committed to a programme of change which would robustly address the concerns raised by the Commission. b) There was a discrepancy identified regarding comments made by one person who had been invited to present at the meeting. The Commission discussed the notes of the meeting and it was agreed that for future meetings comments would be anonymised. The Commission's role is to listen to presentations and then make an informed view. Presenters must feel able to discuss issues under the Chatham House Rule with the Commission. The notes should then record the deliberations of the Commission and any conclusions reached. **ACTION: It was agreed that the draft notes would be distributed to other participants at the last meeting who would be asked to check and approve the accuracy of their contributions to the meeting.**
4	**Update from Chair** The Chair updated the Commission on the following: • The Transforming Health Improvement Review will be circulated to Commission members. It will be published at the end of September. This is a major piece of work analysing the effectiveness of public health improvement initiatives in Wales and making recommendations for transforming health improvement programmes. • The Health and Wellbeing Board is being wound up following the appointment of its Chair to head the Police Complaints Commission in Wales. • Papers produced by the Bevan Commission on Integrated Care and the Francis report have been well received and used in recent publications issued by the Health Minister. The origins of the paper, i.e. the authorship of the Commission, had not been fully recognised in the Ministerial publications. • The Bevan Commission had been invited to the Public Services Commission conference 'Brave New Wales' on 26 September. The Chair invited members to consider attending. The Chair and three Commission members have presented evidence to the Commission on Public Services Governance and Delivery and provided all the papers published by the Bevan Commission. • The Minister has cited occupational health as an important issue and the Chair will be leading a small group to take forward recommendations made in earlier submissions to Ministers.
5	**Data and Information** Professor Ceri Phillips presented his revised paper on data and information that drew on the previous work of the Commission and the presentations at the meeting in June 2013. It was noted that in 2009 a Bevan Commission paper described information as the 'glue that holds the system together'. It recommended establishing an Information

Requirements Board. The previous Bevan Commission meeting (June 2013) revealed that whilst this had been established and an Information Strategy produced by Welsh Government in 2012 little progress had been made in improving data and information use.

It was noted that whilst there are some examples of good practice, overall there appear to be a plethora of unconnected organisations collecting data with duplication, limited analysis and powerbases 'guarding' information and not enabling its use. Decision-making and strategy is not being fully informed by information. There is considerable wastage as opportunities to help people are being missed.

£240m has been given to NHS England to improve information systems and get an individual patient record system in place by 2015. It seems likely that NHS Wales will fall behind England if information issues are not addressed

There have been some improvements in data quality in Wales. In the 1980s, approx. 80% of patients were not classified according to need. The figure now is between 50%-60%. This is important because if people are not classified by need it is not possible to accurately assess costs.

In England there are financial incentives to classify (with the attendant risks of people gaming the system) however, there are variations in levels of data-gathering in England.

Part of the issue is limitations on being able to classify needs. The system does not allow for enough detail when cases are 'coded'. Alternatively, there are some conditions that could be coded in several ways e.g. 'chest pain'. However, as many of 35% of cases are vague symptoms or non-identifiable diagnosis which are compounded by difficulty in recording multiple conditions. Other issues regarding coding are:

- It is time-consuming, especially verifying the accuracy of coding
- There is a time-lag in coding, so real-time performance is hard to judge
- Coding is an undervalued skill that needs to be invested in properly
- There is very little coding in community healthcare, so organisations don't know what money is being spent on
- Coding can be subjective

Currently there is confusion. Clinicians are unsure whether they can trust the data they are presented with. Services can't be assessed because different departments collect different information. Some departments in Welsh Government and NHS Wales refuse to share data.

Suggestions for improving data quality included:

- NHS Wales needs to identify what data it actually needs and stop collecting data it doesn't need or use
- Staff need to be trained to enter data correctly
- A 'clubcard' system for patients that is scanned at every point. Journeys through the system can then be mapped
- The use of tablet devices to enable real-time coding at the bedside (although wi-fi limitations have been an issue in hospitals outside Wales that started using tablets)
- Welsh Government needs to control the volume of regulatory demands for data being placed on NHS Wales from many different bodies (e.g. Fundamentals of

	Care, Older People's Commissioner). The Commission also noted that the patients' views are important when data is being collected. Decisions on data should include the patient. **ACTION: The Commission requested information on patients listed in the "bucket category" i.e. unclassifiable illnesses** **ACTION: The Commission will finalise the paper and submit to the Minister with clear recommendations**
6	**Primary Care** The Commission was updated on progress by the sub-group, which has met twice and is arranging two workshops with GPs and wider stakeholders to gain further feedback and input. These will be held in September to consider; current challenges; opportunities and new approaches or models to best fit the needs of Wales. The Commission heard that GPs are frustrated with their workloads, lack of staff and criticism over out of hours services. The workshops are planned to identify specific problems and discuss possible new models of providing care. Patients have been invited to present at the workshops. It was noticed that often discussions on primary care focus on GP services, but it was recognised that this is not the entirety of primary care. There are a number of issues with the current general practice model, and other models are evolving and being shown to be effective elsewhere. The Commission were invited to note the King's Fund paper, 'Securing the future of general practice' and a BMJ article 'Where will the GPs of the future come from?'. Further consideration of the future model for primary care in Wales will be given at the workshops. The Commission is also aware that there are other people looking at primary care, and so it needs to know what is being discussed elsewhere. Social enterprise models or community interest cooperatives could provide an alternative way to run GP services, particularly in more deprived areas. There is a case for greater integration in GP services. A practice could include a social worker, care coordinator/manager, pharmacy advisor, public health, consultant-led outpatient clinics and provide locality out of hours cover. Recruitment and retention of GPs is also an issue. This is partly because the Wales Deanery does not guarantee rotations will stay in the same part of Wales. Instead it operates a clearing house system with no choice for the doctors. Recruitment is difficult in North Wales and the hospitals there are not allowed to work with Liverpool University.
7	**Commission on Public Services Governance and Delivery** The Chair gave an update on the attendance of Bevan Commission representatives at the above Commission on 8 August and outlined what was covered in the presentation. He had subsequently received positive feedback from the Chair of the Public Services Commission.

8	**Prudent Healthcare** The Chair led a discussion on the topic of 'prudent healthcare' based on the discussion paper presented to the Commission. Further to the paper the question was raised whether the financial challenge may mean that NHS Wales could no longer adhere to the principles of free, universal health care available at the point of need, the 'Bevan Principles'. Existing work to improve efficiencies in the system will not address the funding shortfall. The financial situation is not about the mid to near future – next year is going to be very difficult. 'Tinkering at the margins' is not the solution. Driving the quality agenda alone will not release enough resource to cover the shortfall. There is a danger of finance becoming a political issue. There needs to be cross-party political support for prudent healthcare, based on the facts of increased demand coupled with a financial squeeze on the system. The Chair told the Commission that he had asked a colleague to prepare a paper on 'Prudent Prescribing' and this would be circulated when published. The Chair also explained that the Minister wants to hear radical options for 'plugging the gap' in funding. The Chair asked the Commission to consider the question: 'What is the unthinkable?' The following points were raised in the discussion: • Health inequalities deepen the issue • The focus needs to be on quality, equity and safety • There should also be a focus on the positive – the stories of excellent care need to be shared • There needs to be a genuine conversation with the people of Wales to address the issue. There have been consultations on changes, but there is a need for sustained dialogue. Although, whether the public fully understand the issues at stake is difficult to ascertain • Predictive risk tools may help identify people who will develop ill health and enable preventative intervention • The 'cheapest solution' is not always the least expensive. NHS Direct has not reduced costs. The computer may default to the least risky option and refers people to attend at A&E departments. (It was noted there are some examples of successful nurse-led triage systems.) • The problem is not the ageing population, but people living longer with illness • There is no system to rationalise what pathways NHS Wales should take or which clearly identify areas for potential disinvestment. • Care can often be improved on the frontline within current resources, as evidenced by the work on primary care geriatrician consultants led by Prof Bhowmick • Who is responsible for the financial drains on the system? Locum costs in one health board are £50m per year • 78% of NHS Wales costs are staffing. Where should savings come from? • There is no mandatory quality process in NHS Wales, hence high error rates and wastage in the system are not adequately addressed • Clinicians also need to own and be involved in the process of change

	• Remedies for issues around ill-health like obesity and smoking are not necessarily in the reach of NHS Wales. The determinants of health are often outside the healthcare dimension. There needs to be controls on food/obesity, cigarettes and alcohol as they account for 10% of NHS Wales expenditure (at a conservative estimate).
9	**Bevan Commission Public Meeting** The Chair asked the Commission for opinions on holding a public meeting. It was agreed that the theme of the meeting will be the financial pressures facing NHS Wales and that there will be electronic voting to help engage with the audience and measure the response of attendees. The Commission agreed to hold the public meeting on Wednesday 11 December in Swansea and invite the Minister
10	**Priorities for Ministerial consideration** The Commission used its final session to discuss future priorities for the Minister to consider. Suggestions for priorities included: • An external benchmark of quality for NHS Wales services, preferably ISO. • Shared, assured information and anonymised aggregate information that is freely available. • Sustainable engagement - structures to create authentic, sustainable engagement and insist that organisations do it. • Centreing healthcare delivery in the community, not in hospitals. • Review free prescription charges – are they necessary? • Question the over-medicalisation of the population – move to 'prudent prescribing'. • Mandating certain treatments based on evidence. • Promoting and protecting health and managing ill health – the role of professionals and the public. Addressing the social determinants, particularly child poverty. • Make rehabilitation to maximum function after illness a key aim. • Remove the 'tyranny of targets' – stop the collection of unnecessary data and make sure all demands for measures are appropriate and are actually used. • Analyse productivity. Theatre usage appears to be inefficient in some quarters. The Commission also highlighted the impact of severe cuts in local authorities and how they will have an impact on health. Non-statutory services (e.g. leisure centres) are particularly at risk.
11	The date of next meeting was agreed as 12 December 2013.