Bevan Commission

...promoting health and health services improvement in Wales

Prudent Healthcare one year on

Overview

The following paper presents a qualitative assessment of what has happened in respect of the adoption of prudent healthcare one year on from its inception in January 2014. This assessment was undertaken to not only help the Bevan Commission determine where it may be able to add value in the future, but to act as a stock take on the adoption of the prudent approach.

A brief survey was conducted in December 2014. Twenty one organisations were contacted and asked four simple questions about what actions had been taken in response to the Prudent Healthcare agenda. Thirteen responses were received and a basic thematic analysis of the responses was undertaken.

The analysis suggested the importance of the prudent approach was recognised and the early work around this, such as pathway redesign and the efficient use of staff was evidence of this. There was some degree of retro-fitting of previous projects as being prudent, which could lead to an overestimation of the adoption of the prudent approach. The scale of change was varied and fragmented. However, this is understandable at this point in the implementation of the prudent approach and may also be an artefact of the way in which the research was conducted. There was some suggestion of a misinterpretation of the prudent principles, specifically around the area of co-production. For example the engagement of patients was put forward as evidence of co-production, when co-production is actually much more than this.

Although the initial signs are encouraging, it is clear that much more needs to be done across organisations and at a national level, to ensure that the support and structures are there to mainstream and activate a more prudent approach to health in practice. Overall there does appear to be acknowledgment of the importance of this approach, however it has yet to be fully translated into action. What is needed now is a wholehearted drive towards the comprehensive and consistent implementation of the prudent approach.

Background

The concept of Prudent Healthcare was first articulated by the Bevan Commission in a paper published in December 2013 entitled Simply Prudent Healthcare[1]. In that paper prudent healthcare was described as "...*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*". It was not devised for the sole purpose of saving money. It was about making the most of what finite resources the NHS in Wales had, while ensuring that the healthcare provided fitted the needs and circumstances of the individual and that money was not being wasted on ineffective practice or that which provided marginal gain or even caused harm.

In January of 2014 the concept was adopted wholeheartedly by the Minister for Health and Social Services in Wales and a set of six provisional 'prudent principles' were developed by the Bevan Commission. These principles were used as the framework to support a conversation within Wales around prudent healthcare. Throughout 2014 various workshops and events were held and supplemented by the development of a website focused on making prudent healthcare happen. In addition, various forms of the provisional prudent principles were articulated by a range of individuals and organisations. The principles were both contracted and expanded with various forms being published in a range of documents. This continual modification of the provisional principles occurred as a result of the open nature of the conversation around the principles. However, in the background to all of this the concept was being actively taken up and applied by a range of organisations delivering health services to the population of Wales.

Following a request by the Minister for Health and Social Services the Bevan Commission, taking all of the above feedback into account, developed recommendations on a final set of Prudent Health Principles[2] which are:

- Achieve health and well being with the public, patients and professionals as equal partners through co-production.

[1] Bevan Commission (2013) Simply Prudent Healthcare (www.bevancommission.org)
[2] Bevan Commission (2015) A Prudent Approach to Health: Prudent Health Principles (www.bevancommission.org)

- 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

One year on from adopting the concept of prudent healthcare the Minister for Health and Social Services accepted the principles recommended by the Bevan Commission as the final version of the prudent principles upon which the model of a Prudent Approach to health would now be based.

Aim

The aim of this preliminary piece of work was to gain a high level overview of the work that had evolved and been initiated through 2014, within the NHS in Wales and its partner organisations, in response to the prudent healthcare agenda. This information was to help inform the Bevan Commission in its future work and to provide an overview of the current degree and nature of adoption.

Methodology

In order to gather an initial overview within the short timescale available an email based survey was conducted. The following four questions were asked:

1. Has your organisation initiated any work/developments in light of the prudent healthcare agenda?
2. If so could you provide a brief overview of the work and highlight how it links with the provisional prudent principles?
3. Are you aware of any other external initiatives linked to prudent healthcare?
4. If so do you know who is carrying out the work and what the focus of the initiative is?

To try and ensure a relatively high level of response no set format was given for the provision of feedback. The aim was not to make the task too onerous for those organisations with limited time available to them to respond

A total of 89 individuals at various levels of seniority within 21 different organisations were emailed on the 5th of December 2014. Recipients were given until the 19th of December 2014 to respond. However, due to the restricted window within which feedback was requested a number of late responses were accepted.

A basic thematic analysis was conducted upon the responses received and the various themes were placed under the following headings for ease of consideration:

- General
- Methods of application
- Prudent Principles

Although the final prudent principles were not articulated until January 2015, the final four have been used as the basis for analysing the feedback. The rationale for this is that while there were initially six prudent principles, the concepts underpinning those are all contained within the final four principles. This therefore provides a useful framework from which to examine the emerging themes.

Results

Response

In total 13 of the 21 organisations contacted (62%) submitted a response, with only one of these being outside of the health sector. In the majority of cases each organisation submitted a co-ordinated response despite numerous individuals being contacted within each organisation.

The type and depth of responses received was mixed, ranging from a brief email overview to detailed tables and documentation. This range was not surprising considering the time available to respond. As such it is reasonable to assume that if given additional time to respond most organisations would have been able to provide more in depth feedback.

The time available to respond is also likely to have limited the variety of initiatives that each organisation will have been able to highlight. Therefore it is reasonable to assume that the initiatives highlighted are a flavour of the range that may be ongoing. However, by examining the themes across the respondents it has been possible to determine initial patterns in the initiatives that have evolved or been started in response to the prudent healthcare agenda.

Findings

General

While no specific question was asked about their understanding of the prudent principles there were indications within the responses that there was some misinterpretation of the principles. For example, engaging with the public was something that several respondents were doing. However. simply engaging with the public is very different to co-production, which is one of the key aspects of the prudent approach.

Some of this may be due to the format by which the survey was conducted. However, it is also likely that over the course of 2014 there was a lack of a clear message as to what prudent healthcare meant and what it consisted of. As a result of the open nature of the conversation around the principles there were many different forms of the prudent principles available during 2014. In some instances there were as little as 3 principles while in others there were up to 7. There were also instances where centrally published documents contained varying numbers of principles. This suggested either a misinterpretation or misunderstanding by some of the concept of prudent healthcare confounded by the variety and number of principles in circulation at that time. This apparent confusion is also supported by the feedback. One respondent believed that there were only 4 key areas to prudent healthcare. This was at a time when the ‘making prudent healthcare happen’ website was emphasising that there were 5 principles of prudent healthcare. .

Nearly half of the respondents claimed that prudent healthcare was already present to an extent in previous projects that had been undertaken or in the work they were currently undertaking. There appears to have been some retro-analysis of previous projects to determine whether they were prudent or not. One respondent felt that much of their work was already prudent and the prudent healthcare agenda endorsed their work rather than directing or driving it. It is true to say that some of the principles are not entirely new to certain areas of practice. In other words, it may well be that it was considered that the reflection of some elements of the prudent approach in on-going initiatives was being interpreted as demonstrating the full application of prudent healthcare. This may also suggest that in certain instances the

principles were being considered at an individual level and not as an interconnected set. It has been emphasised by the Minister for Health and Social Services, and endorsed by the Bevan Commission, that all of the principles needed to be taken into account in any piece of work that could describe itself as truly reflecting the proper application of the prudent approach. Caution should be exercised in categorising an intervention or initiative as a representative example of prudent healthcare unless all the five provisional principles extant at the time were being considered. It could be argued that this is a rather rigid and inflexible approach, However, this avoids drift and emphasises that for maximum effect and to ensure that the prudent approach is mainstreamed and that the concept and its principles must be applied in total. In some organisations the principles were now being applied to projects that were already in the pipeline, which is encouraging as it suggests recognition of the importance of the prudent approach being properly applied.

Respondents were clear that in going forward the prudent approach was a driver for change in their organisations and that it was part of their strategic development at the highest level. While one respondent was confident that it was now embedded within their development approaches and underpinned everything they did, it was apparent that across all respondents many of the examples provided were at an individual project or clinical area level. Whilst at this juncture in the implementation phase it is not unreasonable to expect this, it would be expected that more holistic examples of the application of prudent healthcare would be the norm in the not too distant future.

Further advancement of the prudent approach is likely to benefit through a better understanding of the concept and its principles both within and between organisations and at a societal level. A system wide sign-up by organisations and their staff as well as the development and dissemination of good prudent practices across Wales is strongly advocated. Several respondents made a clear request that this set of actions was needed. Others gave welcome examples of how this was being done already within their organisations. These included the setting up of more formal networks and simply encouraging their staff to engage with others outside of their organisation. This was encouraging as it suggested a push towards making prudent healthcare conversations routine in practice.

It was suggested by some respondents however that the move to a prudent approach would need the levers within system as a whole to facilitate that move. For example, it was commented that a fundamental shift to prevention was challenging when there were still existing pressures on the system that needed to be dealt with. In addition, it was held by some that current metrics and targets were not helping that move by inadvertently suggesting inefficient practice where in fact the opposite was true and prudent healthcare was being practised.

At a national level there are streams of work being undertaken which are linked to Prudent Healthcare. These streams include workforce, quality, primary care, unscheduled care etc What is not clear at the moment is the degree of interconnection between these areas of work or the clarity, depth or consistency by which prudent principles are being applied and their validity. As patients tend to flow throughout the system, it is important that in order for the prudent approach to be successful that these national programmes are connected and complimentary. There has been a degree of awareness raising through conferences and workshops and the development of a making prudent healthcare happen website. The website has been through two phases of production with articles being developed by a range of external contributors. These articles have been focussed on what the authors' thoughts and perceptions were in respect of what prudent healthcare meant for their area, such as precision medicine or demand management.

Methods of application

As suggested previously the prudent approach appears to be viewed as a substantial policy shift. This can be seen in how respondents were viewing its importance and how they were using it to frame their Integrated Medium Term Plans (IMTPs) and their organisational and service strategies.

Frameworks came through in a few of the responses as methodologies by which the prudent approach was being applied. Encouragingly, evaluation is part of some of these frameworks and in some areas the outcome measures are co-produced with patients. While some of these frameworks would have been developed prior to the articulation of the prudent approach, it is not to say that they are inappropriate methods of application. However, it is important that they are fully re-considered in

light of the prudent approach, which must include the means by which indicators are formulated to assess progress against set outcomes and goals and that robust methods of evaluation are relentlessly employed to document progress.

Prudent principles

During 2014 there were several different articulations of the prudent principles. While the final four principles, provided below, were only finalised in January 2015 they do provide a most useful framework by which to describe the work that has been ongoing within Wales.

The four final prudent principles 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

This section describes the feedback received from all of respondents in a narrative that will endeavour to follow the layout of the final four principles.

It was clear from the responses that the involvement of patients and others was important for the successful application of the prudent approach. Many appreciated that this was about putting the patient at the centre and that individuals needed to be more in control of their own health. However, whether respondents were all correctly interpreting what co-producing health meant was not clear. Putting people at the centre and engaging with them was mentioned frequently, but it was not obvious if this was true co-production or not. Self management was clearly an important area for respondents and it is one element of achieving health with everyone acting as equal partners. However, it is not co-production in its entirety. There were actions being undertaken at an undergraduate level to teach students about putting the patient at the centre. In addition, there was some clear work being undertaken to educate staff in certain clinical areas on how to co-produce health. This is

encouraging and should be welcomed as it acknowledges the need to shift and develop the relationship with the patient.

The designing of services together is an important part of co-production and it is clear from the responses that pathway redesign is at the forefront of respondents' work. Various clinical areas are being looked at through a prudent lens to determine how the pathway may be altered. In some instances patients are being involved in this shift however it is not clear whether this is universal. There are moves towards direct referral schemes thereby reducing the pressure on primary care and moves to bypass hospital referrals for those needing percutaneous coronary intervention (PCI). The biggest drive, which is not surprising following the most recent government policy announcement on Primary and Community Care, is the shift towards providing more care in the community.

Across the respondents there is work ongoing to shift care to the community, building upon the 'locality' infrastructures. There are developments around the management of specific conditions and the initial assessment of individuals. The aim of which is to prevent unnecessary attendance at secondary care. In order to achieve this there is acknowledgement by some respondents of the need to work across agencies to make this happen. While this links with a previous point around the need to share good practice, it is subtly different. The cross working appears to be at a variety of levels. For example, traditional boundaries between hospitals within a health board have been broken down and professionals are acting as a co-ordinated group at a health board level. There is also collaboration across respondents, for example where some may not have the specialist expertise necessary others are providing that expertise. Finally there are examples of collaboration at a national level where benefits can be realised by acting as a co-ordinated group.

The need for a shift to prevention was noted but only by a small number of respondents and in the main this was still very much in the traditional paradigm of prevention. There was little acknowledgement of the social model of health and the need to work at a population health level. This may be a reflection of the respondents that were surveyed and the relative newness of this approach to health. However, depending upon one's interpretation of the word prevention, there was work being undertaken that aims to support people at home thereby reducing

unnecessary admissions and the need for secondary care. While this is clearly an example of shifting care into the community it also links to secondary or tertiary prevention. It does however differ from primary prevention, which is directed at the population level to bring about a change in attitudes, behaviours and life-style modifications, etc.

Linked to the shift towards prevention is the need to focus care on those who need it most. Some work does appear to be ongoing around this with work being conducted around decision support for professionals to not only reduce surgical rates but to ensure that those who need surgery urgently get it sooner. There was also an acknowledgment that people needed to be added to waiting lists in order of clinical priority. However, in some submissions there was some misunderstanding and confusion between the principles of equality and equity. This is not surprising as it frequently happens, but going forward there is a need for there to be clarity on this area as it is a potentially difficult message to get across to the general public.

There was some encouraging work being undertaken around making the most of all of the available skills and up skilling staff to take on new responsibilities. There was a shift to using pharmacists to a greater extent and using staff in audiology to take more from ENT clinics. This use of all of the available skills is also being applied by moving staff to undertake work in clinics and wards in which they may not have usually been active. The intent is to aid the decision making process, thereby making better decisions at an appropriate time and appropriate level thereby improving outcomes for both the patient and the system itself.

In terms of evidence based care, research in its truest sense is being conducted in areas such as patient centred care and the use of medicines. Work is also being undertaken to ensure that evidence is being applied appropriately. There were also examples of innovative practice. This innovative practice was not only focused on the potential of areas such as telemedicine, but also in maximising the skills of the all of the staff available. However, it is not clear from the submissions whether these innovations are being appropriately evaluated. It is important to ensure that if there is a desire to share new ways of working across organisations, thereby helping the advancement of the prudent approach, that there is appropriate evaluation of these approaches. While the traditional level of evidence of effectiveness may not be possible, due to aspects such as sample size, there is a need for some form of

evaluation at this juncture. To not do this runs the risk of ineffective practice being spread throughout the system, which does not benefit the NHS in Wales or the public.

There is work being conducted by respondents around the list of interventions not normally undertaken (INNUs) and the NICE “do not dos”. Much of this work is around the auditing of compliance against these and the need to reduce their activity. Some are also looking at using refined lists, which would be the top 5 within each area. While this chimes with the Choosing Wisely approach, it was not clear how these truncated lists are being determined. It is also not clear if this is linked to the Choosing Wisely initiatives being considered within Welsh Government.

Conclusion

While limited in its depth and scope this exercise has unearthed some interesting themes in this first year of prudent healthcare.

- From the responses received there is recognition by organisations of recognise the importance of the prudent approach and its timeliness. Reference to the use of the prudent approach in the development of strategies and business plans is welcome.
- Some of the work being undertaken around pathway redesign, the shift of care to the community and people taking more responsibility for their own health and the intelligent use of professionals, are encouraging and should be acknowledged as a shift in the right direction. However, the t clinical area by clinical area approach adopted now needs to be more fully extended across and between organisations to ensure more uniform and transparent application across Wales. This may however be an artefact of the way in which the survey was conducted and the lack of time for organisations to provide a truly comprehensive picture.
- It is widely acknowledged that the prudent approach needs to be adopted at both pace and scale across the NHS in Wales. Therefore a clear, consistent and systematic up scaling of the application of this approach across all areas during 2015 would be welcome. This may occur following the incorporation of the prudent approach into organisations’ IMTP plans, through the

development of networks spreading good practice and/or through the adoption of the approach by patients and the public. However it occurs, it needs to happen and happen quickly.

- It is important to ensure that while some areas may be partially prudent in their approach, that the retrofitting of previous work as being prudent does not become the means to overinflating the scale of adoption. There is a risk that the true level of application of the prudent approach may be masked by a labelling of non-prudent practice as being prudent. This is a danger as there is a risk that areas of practice may be deemed prudent as they meet 3 of the 4 principles. It is important to note that the principles are not criteria by which 3 out of 4 will do. They are a set of interconnected principles that provide a framework by which services can be designed and delivered.
- The analysis suggests that there has been some misunderstanding of the principles over the course of 2014. This is to be expected as various forms of the principles were in circulation, which will not have helped a uniform application of them. In addition, aspects such as co-production are relatively new and therefore organisations are getting to grips as to what this may actually mean in practice.
- While some areas of the prudent approach sit traditionally within the clinical field, such as the application of evidence based practice, co-production does not. It is a significant shift for the NHS in Wales and as such the responses received did not suggest a universal understanding of what this meant or how it should be applied. There were some clear pockets of understanding and a drive to helping professionals truly co-produce services with individuals. However, in order for the prudent approach to be applied correctly there is a need for this to be done across the board. That should not be read as a criticism of the NHS in Wales, instead it should be read as a need for support to be provided to help organisations make that fundamental shift of remodelling that relationship with the citizen.
- There were some suggestions that it will be difficult to make this shift when one is still required to do the day job. Unfortunately, unlike the refurbishment of a shop it is not possible to temporarily close the store while the work is carried out. The NHS is being required to make this change while still

providing care. Against this backdrop there is a risk that previous performance metrics may actually distort the real picture or hinder change.

Overall this preliminary survey has indicated that the prudent approach is starting to be embedded within Wales and there is some excellent work being undertaken. However, there is a risk of misinterpretation and inappropriate application especially in those areas that are new to the health service. Therefore it is important that those providing services are supported with appropriate advice and practical resources in order to ensure the prudent approach to health is comprehensively adopted.

Next Steps

- Full engagement and sign up is needed with the NHS in Wales, at various levels throughout the organisations, using all levers and drivers within the system to facilitate that move
- Take all steps to ensure that prudent healthcare is fully understood and included in all NHS staff key work objectives
- Action and commitment by all is needed with accountability by Health Boards and Trusts to validate how the implementation of the prudent approach may be facilitated at both pace and scale.
- Work should not be categorised as prudent heath care unless all 4 principles are being addressed. This avoids drift and ensures that the principles are mainstreamed and applied in total.
- Urgent consideration should be given to propagating the concept of the prudent approach by means of generating an all inclusive social movement for change.
- Establish a mechanism to support the development and dissemination of good prudent practice
- It is essential that the concept and practice of co production in its entirety is applied in accordance with the principles
- Prudent healthcare should be embedded in teaching, training and CPD
- Work needs to be undertaken to determine how best the implementation of prudent healthcare may be monitored and evaluated. Once determined, any assessment needs to be undertaken at periodic intervals to ensure the approach is being adopted widely and at a suitable pace.
- Advice and support needs to be provided on remodelling the relationship between the citizen and the NHS to help aid the move towards co-production.
- Systems and initiatives are needed to help support the spread of innovative practice across the health boards.