Yr Adran Iechyd a Gwasanaethau Cymdeithasol
Cyfarwyddwr Cyffredinol a Prif Weithredwr, GIG Cymru

Department for Health and Social Services
Director General and Chief Executive, NHS Wales

Llywodraeth Cymru
Welsh Government

Darren Millar AM
Chair
Public Accounts Committee
Cardiff Bay
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Our Ref: AG/KH

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Dear Darren

Health Finances 2013-14

Further to my evidence session at the Public Accounts Committee on 11th November regarding Health Finances 2013-14, please find below a response to the additional information requested during the session.

The Cochrane Centre for meta analysis (2012) conclusion that the treatment in the borderline range of blood pressure is more likely to harm patients than help them except in the case of diabetes and is one of the quality and outcome framework contracts for GPs

Hypertension is recognised as a risk factor for many disabling conditions including stroke, heart attack, heart failure, chronic kidney disease and cognitive decline. Raised blood pressure is one of the three main modifiable risk factors for cardiovascular disease, (along with high cholesterol and smoking) which remains a leading cause of morbidity and mortality in Wales, with a particular impact in areas of socio economic deprivation.

The 2012 Cochrane paper referenced at PAC considered the risks and benefits for patients with mildly elevated blood pressures and concluded that;

'Individuals with mildly elevated blood pressures, but no previous cardiovascular events, make up the majority of those considered for and receiving antihypertensive therapy. The decision to treat this population has important consequences for both the patients (e.g. adverse drug effects, lifetime of drug therapy, cost of treatment, etc.) and any third party payer (e.g. high cost of drugs, physician services, laboratory tests, etc.). In this review, existing evidence comparing the health outcomes between treated and untreated individuals are summarized. Available data from the limited number of available trials and

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participants showed no difference between treated and untreated individuals in heart attack, stroke, and death. About 9% of patients treated with drugs discontinued treatment due to adverse effects. Therefore, the benefits and harms of antihypertensive drug therapy in this population need to be investigated by further research'.

Comments on the review noted the small number of patients and relatively short timescale studied, supporting the proposal for further research to provide stronger evidence.

NICE clinical guidance for the management of hypertension emphasises that 'a person-centred approach is fundamental in delivering high-quality care to adults with the condition'. The aim is to ensure that hypertension of any degree is identified and assessed to ensure that patients are advised of the risks and are aware of the potential benefits of both behaviour change and medical management options.

Clinicians consider the level of individual risk- for example the absolute measurement (i.e. the level of raised blood pressure) and whether the hypertension is an isolated condition or is associated with other conditions or evidence of target organ damage.

For patients described in the Cochrane review, with mildly elevated blood pressure and no previous cardiovascular events, NICE guidance advises that medication is offered only when there is evidence of target organ damage, renal disease, diabetes or a 10-year cardiovascular risk equivalent to 20% or greater.

For people aged under 40 years with stage 1 hypertension and no evidence of target organ damage, cardiovascular disease, renal disease or diabetes, clinicians are further advised to:
'Consider seeking specialist evaluation of secondary causes of hypertension and a more detailed assessment of potential target organ damage. This is because 10-year cardiovascular risk assessments can underestimate the lifetime risk of cardiovascular events in these people'

Through shared decision making, doctor and patient agree a management plan that is appropriate for the individual, taking into account the estimated individual risk and informed by relevant evidence such as the Cochrane review.

Guidance also recommends that patients are provided with; -
'Appropriate guidance and materials about the benefits of drugs and the unwanted side effects sometimes experienced in order to help people make informed choices.'

The Quality and Outcomes Framework is a series of financial incentives to ensure that GP practices deliver high quality services for their patients, based on evidence based clinical guidance. The incentives apply at a population level and do not determine the management of individual patients.

Achievement thresholds for the population are set below 100% to acknowledge that there are degrees of risk influenced by the severity of each condition and combination with other health problems. (For hypertension the upper threshold for achievement is set at 80%). Practitioners are also able to exclude individual cases from measurement against QOF performance measures where they judge that the intervention would not be appropriate or where treatment has been discussed but declined by the patient.

We believe that current guidance does support a patient centred approach, offering treatment in the context of a shared understanding of risks and benefits. The prudent health care approach is further strengthening the emphasis on informed patient choice.

The QOF indicator relates to the management of hypertension at the population level and does not incentivise clinical management for all patients.

We continue to work closely with the National Institute for Health and Clinical Excellence to review QOF indicators as further clinical evidence emerges.

How rurality is being catered for in any future allocation of resources

As stated at the recent committee the intention is to issue any additional monies where appropriate based on the Direct Needs formula. The Direct Needs Allocation Formula is constructed as follows:

LHB allocation share = population share x health need index (as measured by a range of health needs indicators x cost of meeting those needs) x additional cost indices

The original work on the Direct Needs Allocation Formula in 2001 was supported by a Task Group that looked specifically at Rurality/Remoteness by reviewing the additional costs of delivering health care services to rural/remote locations. Their work and that of the research team was reflected in the Targeting Poor Health Report (2001), the Targeting Poor Health - Review of rural and urban factors Report (2004) and the recommended Direct Needs Allocation Formula outlined above.

The formula is complex and the relative rural heath needs are reflected in all factors e.g. Cancer data sets where these are based on prevalence.

However within the formula there are also some specific components that add to the relative health needs factors e.g. one factor applies to the proportion of community services expenditure likely to be affected by extra staff travelling costs. Additionally as rural population tend to be older than urban areas the age costs index is another factor that benefits rural areas.

While the formula construction has not changed the needs and cost datasets are being updated so that the direct needs formula reflects the latest available validated datasets. Accordingly the formula, which will inform the distribution of the additional 2015/16 funding announced in the draft budget, has been updated and continues to reflect the cost of providing services in rural areas.

In addition to the significant work that has been undertaken to date, further work has been agreed to completely review all aspects of the formula in line with PAC recommendations and the agreed December 2015 deadline.

How the Welsh Government holds health boards to account in delivery against the prudent healthcare objective

Prudent Healthcare provides the central organising principles for health in Wales. It is not a single objective, rather a strategic intent for how the NHS in Wales can organise services differently in the future. It reflects similar approaches being developed in many countries.

Over the past ten months a sustained discussion has taken place in Wales about prudent healthcare and the potential benefit for the Welsh NHS and its patients. That conversation has been enthusiastically embraced by people working within the health service and other public services in Wales and many examples of prudent healthcare in practice have come to the fore.

In July, the next steps to advance prudent healthcare and ensure Wales remains at the vanguard of this emerging global movement were set out. This included the development of an interactive online resource www.prudenthealthcare.org.uk to capture some of the perspectives of those working in or using health and social care services about what prudent healthcare means to them and its potential for Wales. The online resource also includes case studies which demonstrate how prudent healthcare is already happening in the work of the renal services team at Morriston Hospital, in Swansea, which put the co-production principle at the heart of their service redesign and has improved service quality and in the improvement of lymphoedema services across Wales, which embodies the principles of prudent healthcare and is leading the way in Europe.

But prudent healthcare has to be more than an idea and more than a set of principles. It has to change the way health services are used and provided. It has to make a real, practical difference to the millions of encounters which take place every year between the Welsh people and their health service. Alongside this online resource, Welsh Government, NHS Wales and key partners are taking forward action by organising their work around prudent healthcare principles. Key aspects include:

- Build on the recent strengthening of the NHS Wales planning system. The planning requirements and outcomes framework have been refreshed to embody the prudent healthcare principles to ensure they are embedded within health boards and NHS trusts;
- Draw on international best practice including the Choosing Wisely work, which has been developed in the US and Canada. The Choosing Wisely campaigns help clinicians and patients make smart and effective choices about tests, treatments and procedures;
- National guidelines for interventions not normally undertaken and National Institute for Health and Care Excellence “do not do” guidance are being refreshed, alongside the introduction of enhanced compliance at health board and NHS trust level. This is being led by the planned care work programme, which is developing prudent surgical and medical pathways;
- The re-vamped Bevan Commission will improve the evidence base for, and advice around, prudent healthcare as well as championing the agenda;
- Continuing to work with the Department of Economy, Science and Transport on initiatives which will drive healthcare improvement and economic development. This will develop a more systematic approach to product and process innovation, including for example applied research to address clinical needs and challenges, coordinated adoption of new technology into practice and more engagement with industry.

Prudent healthcare will not suddenly happen overnight. We are at the start of a journey which will ensure that public value is at the heart of our healthcare system; there is always a culture of putting people first and there is an expectation of constant measurable improvement in the delivery of health and better care for all. Prudent healthcare will also not happen by the Welsh Government acting alone. For the NHS to embrace prudent healthcare and for people across Wales to realise its benefits, leaders, managers, clinicians and the public need to think about what the principles mean for them and their interactions with health services and to act accordingly.

In the New Year NISCHR will be issuing a research call to underpin prudent healthcare, aiming to answer three key questions:-

1) How is it best to engage the public in owning their health and health service?

2) How is it best to engage clinicians in adopting prudent healthcare principles into routine practice?

3) What does operational modelling of prudent healthcare inform us of the impact of prudent healthcare in terms of quality, clinical and economic outcomes?

Working with workforce directors in Wales, outline their approach to disciplinary policies and how the process can be speeded up

The All Wales Disciplinary Policy has recently been reviewed in partnership with Trade Unions and was ratified by the Welsh Partnership Forum in July 2014. The policy confirms that it seeks to ensure that fair and effective arrangements exist for dealing with disciplinary issues and to ensure that expected standards of conduct and behaviour are observed. One of the principal aims of the policy is to provide a mechanism for dealing with disciplinary issues in a way that is fair, consistent and without discrimination as soon as possible.

The issue of disciplinary cases has been raised by the Welsh Government's DHSS' Director of Workforce and OD with Directors of Workforce & OD for Health Boards and NHS Trusts at their September meeting. It was emphasised that such cases need to be managed efficiently and concluded as expeditiously as possible mindful that due process has been observed. This issue will remain an item for discussion at this forum and NHS organisations will be expected to highlight any protracted cases as and when they arise and how they are being addressed as well as sharing best practice.'

Medicines management

I have requested that our prescribing analytical unit compile the data required to respond to the point raised at the meeting of the committee. I do not wish to delay my response to you on any of the other matters and so I will write to you again with this information at a later date.

I hope the information provided is of assistance.

Yours sincerely

Dr Andrew Goodall