SUMMARY

PRUDENT HEALTHCARE: A RADICAL AND COMPREHENSIVE REDESIGN OF HEALTHCARE IN WALES?

A study supported by the Health Foundation

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This Summary should be read in conjunction with the full report

Prudent Healthcare

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. The Principles, which still govern health policy in Wales, are:

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

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.

Method

This report summarises the findings of a year-long study, supported by the Health Foundation. More than 100 healthcare professionals from across Wales contributed to a series of interviews and workshops for Phase 1 of the work in the early part of 2016, 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. It informed the models of future financial impact on healthcare in Wales reported elsewhere[1]. Phase 2, which began in August 2016 looked at the system-wide impact of the four Prudent

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

Principles. 45 people were interviewed in depth, including the Minister responsible for its introduction, Mark Drakeford AM, senior civil servants in Welsh Government, many NHS Chief Executives and Executive Directors, senior clinical leaders and middle managers, as well as external stakeholders. Others took part in three workshops, and provided the team with extensive documentary evidence on the impact of Prudent Healthcare.

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.

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 a 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?

PHC 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 policy silo of its own. There are many examples 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.

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.

Progress is clearly being made in the prudent remodelling of the workforce. This 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?

The interpretations and definitions of co-production (Principle 1) 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 which will be required 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. 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 pragmatic. There are many examples quoted in the report 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 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 has been 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 of the full report explores this in more depth. 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 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 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:

Principles in order of progress made in their implementation:

What has determined its success?

It is possible to discern various factors which have helped and which have hindered progress towards greater prudence. *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 – and which typify many such initiatives - 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. 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 of the full report. 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.

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 the full 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.

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