NHS Wales
Annual Quality Framework
2011/2012
Introduction

The NHS Reforms were the start of a journey towards service transformation. The first stage of this work is now completed with the removal of the internal market, the development of integrated Local Health Boards and placing public health centre stage. This has led not only to a reduction in bureaucracy, streamlining the NHS from 32 to 10 organisations and reducing unnecessary and expensive transaction costs, but has heralded a new set of behaviours where competition is being replaced by collaboration, joint working, whole systems thinking and greater emphasis on quality and patient outcomes.

As we move to a period of austerity, we need to get smarter about what we do. Sustainable improvement can only be brought about by significantly increasing the number of clinical leaders, and engaging the whole workforce in generating lasting improvements and innovation.

We need to challenge the mindset on what is important. Chasing targets to a point is fine, providing this is seen as part of an improvement process. However, too much time and effort has gone into seeking to deliver specific targets for their own sake without understanding the objective behind why they were set, which is to improve the service for patients.

It may be counterintuitive, but I believe we need less command and control and centrally driven targets and more freedom for staff to innovate and improve services. This cannot however be seen as an excuse to slacken our commitment to service improvement and waiting times. We must therefore continue to sustain and build upon what has already been achieved to date and any recurring deficits must quickly be driven down.

I therefore want the emphasis in the future to be on a set of common values and on systems thinking which releases the potential of the organisation rather than chasing the target. I want to see continuous improvement integrated into everyday working and a new set of metrics developed which focus more on outcomes and quality.

Setting goals which underpin and promote health improvement, integrated health and social care, sustained improvement in quality and better outcomes for citizens in Wales will be the key drivers for the future. We must shift the balance towards local services that tackle problems before they occur or become serious, and that cross traditional organisational boundaries.

I want to see far greater transparency about patients’ outcomes, and a more meaningful engagement between clinical teams, managers, citizens and stakeholders about the issues which must be tackled if we are to make real advances in patient safety and quality of care, using the resources at our disposal. The 1000 Lives campaign has shown how we can make changes and I would congratulate all who took part in it on their extraordinary achievements. Indeed, such is the importance of the 1000 Lives campaign and driving the reduction in waste, harm and variation that I have made 1000 Lives Plus one of our National Programmes to give it the weight and prominence it requires to drive this work forward.
These elements may not be the complete answer, but I do consider them to be some of the essential building blocks which will place us on the path of transformation. Above all, you must have the ambition and belief that you can be part of this journey. We have indeed come a long way in a short time but this is the beginning.

Paul Williams
Chief Executive, NHS Wales
Director General, Health & Social Services
Welsh Assembly Government
Towards Transformation

Current position

The change in NHS structures was not an end in itself, but the essential basis for a transformation in our approach to health in Wales. The establishment of new integrated Local Health Boards creates an unparalleled opportunity to create integrated health services. We must think in terms of whole system working, of creating well designed care pathways where patients receive joined up services at the right pace and the right time. For many people much of this care can be in or close to their own homes.

To seize this opportunity, LHBs, Public Health Wales and Trusts must change. Collectively, we must now ensure that operational effectiveness is a given, and we must also demonstrate a relentless drive for cost control and cost improvement whilst improving the clinical care to patients.

Our focus should also shift to increasingly measure performance in terms of delivery of high quality services, providing improved patient experience and better health outcomes. More recently the NHS has itself picked up this challenge, and has been giving clinical staff more freedom to design services around the best available evidence. The 1,000 Lives campaign (now the 1000 Lives Plus programme) exceeded expectations, and has transformed thinking about what can be changed and how. It is a living example of getting the balance right between national policy and local ownership of improvement.

But improvement has not been at the same pace everywhere, and our collective expectations that we will adopt the lessons of the best, and quicken the pace of change needs to be delivered.

The 5-year vision
The key aims for NHS Wales over the next five years will be to:

- **do more to protect and improve health for all**: within 5 years, there must be a significant, measurable improvement in reducing health problems in all the priority areas in Our Healthy Future (OHF), and concentrating efforts on the specific key outcomes identified from the Prevention and Promotion National Programme;

- **create integrated services**: there must be a significant, measurable improvement in joint working in primary, community and social care services, evidenced in the annual primary care reports and delivery against the priorities identified within Setting the Direction;

- **modernise what the NHS does so that it has systems that delivers and sustains excellent services to meet the needs of patients and maximises clinical outcomes**: there will be a significant, measurable improvement against all the health specialty indicators defined for clinical service areas in Wales.

We are already taking significant steps in delivering this vision, and all organisations are developing new integrated planning and delivery systems.
which look to assess the health needs of its local population and explain how its resources will be managed to have the greatest impact on those needs.

**What is Transformation?**

It means better systems, with improved outcomes and new, innovative ways of working. The visible, tangible signs for patients and clinicians should include a significant shift in the balance of care, with individuals accepting more personal responsibility for their own health and better use of new technology.

The outcomes for Wales will be:

- better health for all, because the system will do more to protect and improve health and tackle inequality;
- better results and experiences for those using our services because integrated, clinically led services will increasingly meet their needs.

The immediate steps that will move us in this direction will include:

- acceptance throughout organisations that delivering and self-monitoring operational effectiveness is a given, allowing us the opportunity to significantly reduce central targets;
- a shift to systems thinking as a means of driving improvement, and continuous improvement embedded into everyday working;
- clinical leads and managers working together to inject pace into service improvement and innovation. GPs will also have greater involvement in the planning and management of local services;
- better use of information;
- development of integrated health and social teams, with more joint appointments and pooled budgets with partner bodies.

These will be the signs of a new way of working. Another will be evident in how the NHS engages with staff and promotes clinical leadership. Behaviour must be based on values that guide and motivate everyday action. These have been discussed with, and accepted by the trade unions as a solid basis for working together:

<table>
<thead>
<tr>
<th>Welsh NHS Values</th>
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<tbody>
<tr>
<td>1. <strong>Putting quality and safety above all else</strong>: providing high value, evidence based care for our patients at all times;</td>
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<tr>
<td>2. <strong>Integrating improvement into everyday working</strong> and eliminating harm, variation and waste;</td>
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<tr>
<td>3. <strong>Focusing on prevention, health improvement and inequality</strong> as key to sustainable development, wellness and wellbeing for future generations of the people of Wales;</td>
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<tr>
<td>4. <strong>Working in true partnership</strong> with partner organisations and with staff;</td>
</tr>
<tr>
<td>5. <strong>Investing in our staff</strong> through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively.</td>
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Fewer targets, more engagement

In recent years, government targets have helped bring about a number of improvements in reducing waiting times for treatment for example, and ambulance performance. However, using national targets has been shown to have only a limited success, and can themselves cause problems. It is far better that local organisations measure and manage themselves to make service excellence their prime aim, whilst adopting a policy of full transparency to their communities.

Full engagement of clinicians, and strong clinical leadership, continues to be vital to our success. Clinicians, managers and boards will need support in building the confidence and capability to manage differently. A step change in the culture and focus of the NHS will depend on staff who are empowered, engaged and well supported to provide better patient care, and a national development programme will move this forward. Responsibility for care rests with every individual working in the NHS, whatever level or area they work in.

We should recognise the work of the new National Programme Boards, and the role that they are taking in shaping this agenda. These programme boards should increasingly be seen as an integral support for the NHS to deliver.

Integrated services

Our vision for integrated health care is one where the different groups involved in patient and social care are brought together, so that services are more consistent, cost-effective and co-ordinated. Care must be patient-centred, and delivered seamlessly, despite organisational boundaries. Care settings will be co-ordinated through shared access to knowledge and shared processes. Health population analysis, derived from individual patients’ information will be used to inform system decisions (e.g. workforce allocation)

Full engagement with local partners needs to also form part of planning and delivery. This should include statutory bodies, third sector and voluntary organisations. All opportunities and options for development of true integrated services need to demonstrate this level of engagement.
Key Actions for 2011 /12
The requirements fall into the following categories:

### Protecting and Improving Health for all in 2011 /12

It is a primary responsibility of the boards of LHBs to identify inequities in health outcomes across their LHB area, to identify actions to close the gap - and to deliver and report on those actions. This links clearly to the emphasis on achievement of the Child Poverty Targets - and the ongoing political imperative to reduce the gap in health outcomes.

By the end of 2011 /12, each LHB must:

- Deliver against the targets for which the organisation is responsible for within its local Children and Young Persons Plan, and especially those relating to child health, health inequalities and child poverty. More specifically, there should be demonstrable local progress with achieving the child poverty targets relating to infant mortality, low birth weight and teenage conceptions (LHBs to agree milestones by March 2011);

- Set and deliver against the key targets identified within ‘Our Healthy Future’ through the development of a Local Public Health Strategic Framework. This should be integrated with operational service planning and include the high impact areas identified by the National Preventions and Promotion Programme Board. The key interventions with the greatest impact on preventable disease are as follows:
  - Implementing best practice on smoking cessation;
  - Preventing falls in older people;
  - Reducing the burden of alcohol misuse;
  - Improved health at work;
  - Effective management of vascular risk.

### Integrating Services in 2011 /12

By the end of March 2011, organisations must have agreed and set local targets for implementing the following in 2011 /12:

- improve primary care services based on the outcomes and variations identified within the first primary care annual report (detailed guidance on completion of this was issued in December 2010). Senior clinical leadership within each LHB must put sufficient resource locally into reviewing QOF data, and thus engaging with primary care colleagues as a result;

- put in place the core elements to support Setting the Direction including:
  - establish local management teams which deliver effective GP locality working;
  - communication hubs;
- common all-Wales information and computing technology (ICT) systems that support the safe and efficient delivery of integrated care;
- joint health and social care multi disciplinary teams to support the frail elderly;
- pilot at least one local management team operating with an indicative budget.

- Each LHB should demonstrate a direct shift of clinical care into community services; specific measures can be agreed locally, but should include an overall reduction in bed days, reduced unplanned emergency admissions /readmissions, particularly in the key chronic conditions (chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), diabetes, stroke, epilepsy and end of life care);
- Specifically for end of life care, the LHBs need to demonstrate an increase in the number of patients who receive care in their preferred place of care as agreed in their dynamic end of life plan;
- An increase in the number of people living independently at home or usual place of residence in their area, in particular, patients with a mental health illness and anyone over 75 years.

Specific deliverables (evidence) for reporting to your LHB /Trust Board are included within Appendix A.

**Deliver and sustain excellent services that meet the needs of patients and maximise clinical outcomes**

All NHS bodies should review local reporting arrangements, ensuring that all clinical and operational services move towards regular and consistent quality reviews, irrespective of the existence of precise national or local targets.

In relation to the minimum requirements required for improving and reporting on patients’ experience, Boards should now be satisfying themselves that they have answers to four key questions:

- Do we treat patients well?
- Did we help them with their problem?
- Do we deliver safe, high quality services?
- Do patients experience timely access to our services?

Nationally, there will be an agreed approach to engage service users and a mechanism for establishing levels of patient satisfaction. In addition, the Board must have a process for annual patient audits and evidence of reports with agreed actions which are published and presented at board level.

In high priority specialty areas, there will be an expectation that organisations will continue to deliver against the nationally recognised standards identified within the 2010 /11 Annual Operating Framework (AOF). There will, however, be the opportunity for each LHB to establish and begin publishing their own local targets in the following areas:
- **Stroke** - increase in the number of patients discharged home or other place of residence following a stroke. Ongoing compliance will still be required against the stroke acute care intelligent targets and the planned intelligent targets for Transient Ischemic Attack (TIA) and rehabilitation in 2011/12;
- **Cancer** - increase in the survival rates at 1 and 5 years, and ongoing achievement of the cancer access targets;
- **Cardiac services** - reduce admission and readmission rates for specific cardiac conditions, including access compliance (see appendix A);
- **Major trauma and acute illness** - improved treatment times through unscheduled care with improved survival rates;
- **End of life care** - Decrease in symptom burden in patients approaching the end of life, improved access to specialist palliative care support and improved outcomes as assessed by patients/families;
- **Mortality rates (30 days post event)** reduce rates for these four conditions – stroke, cancer, cardiac disease, major trauma;
- **Mental Health** - full compliance with Care Programme Approach (CPA) across all age groups, and implementation of intelligent targets for dementia and depression.

**National Audits:** To reduce confusion, and the administrative burden on organisations, it is proposed that the number of national audits be reduced. This will be led by the National Audit Steering Group. However, at a minimum, the NHS should all play a full part in the following audits; MinaP, Tarn, RCP stroke audit and confidential enquiry into patient outcome and death audit (CEPOD). They also need to be able to demonstrate that action has been taken to secure improvement in response to the findings. Where appropriate, assurance will be taken from internal audits.

**Clinical Leadership:** Quality and continuous improvement will be a key priority for 2011/12, and we will develop nationally sponsored programmes to enhance clinical leadership. This will give clinicians the tools and techniques to ensure local ownership for the delivery of change. The programme must also involve middle managers who are critical in terms of operational delivery.

The NHS must also play its part in the local delivery of the programmes and enable their staff to act on their new learning. This will encourage every LHB to engage fully with, and apply the lessons of, 1,000 Lives Plus across their organisation, and secure the gains in better patient health outcomes, better patient experience and better resource use.

**Reduce harm and variation:** It is unacceptable that the health care system should cause harm to patients, and as such, some basic quality deliverables have been set for delivery in 2011/12, namely:

- eliminate pressure sores;
- adopt an explicit policy of zero tolerance for healthcare associated infections;
- Implementation of the blood borne viral hepatitis action plan through local delivery plans,
- Deliver the nationally agreed patient outcomes in relation to fractured neck of femur (“Focus On” pathway), in particular, demonstrating
evidence of, effective pain control, time to theatre and discharge to home following treatment;
- Timely access to services; Deliver 95% of patients receiving treatment within a maximum of 26 weeks and reduced waits within Unscheduled Care Services (refer to Appendix A).
- Implement and sustain the 9 nationally agreed “Focus On” pathways which will include the enhanced recovery programme under 1000 Lives plus.

**System change specific for transforming services in 2011/12**

Besides the specific service-related requirements noted above, there must be changes that reflect how the NHS is beginning to transform its internal workings. We will expect all LHBs to demonstrate that they are implementing local ‘system changing’ targets which will drive the integration and transformation agenda. This will encourage NHS bodies to move away from traditional thinking /behaving, and make a quantum shift in performance that will generate learning that can then be applied to other areas.

Research suggests that success in creating such systems relies on:

- **self-care** - patients have specific support to manage their own care;
- **proactive community orientated care** – care teams have responsibility for a list of patients, and there are triggers in place for direct interventions /treatments which prevent hospital admission;
- **transparent information** – care teams receive regular updates about “their” patients;
- **clinical leadership** - clinicians step up to lead care in the system;
- **governance and incentives** - the right systems and structures are in place to ensure individuals and organisations are aligned.

**Corporate requirements for all NHS bodies in 2011/12:**

NHS bodies must be able to demonstrate clearly how they plan to change systems in the following areas:

**Workforce**

- Workforce redesign, including improved productivity and efficiency to support the development of the required service redesign such as enhanced community services;
- Investment in staff in line with the value statement;
- Engagement of the workforce, clinical leadership and empowerment of frontline staff to deliver patient expectations and clinical outcomes that are nationally driven, locally owned;
- Focus on the development of intelligence and information related to the workforce to support more effective deployment of staff to meet the changing needs of the service, such as e-rostering;
- Continue to deliver the local sickness and absenteeism trajectories which include back-to-work initiatives;
• Continue to work towards achieving the Platinum Corporate Health Standard by 2013;
• Agree health and safety intervention plans with the Health and Safety Executive by September 2011;
• Improve the Health and Safety competence at board level;
• Respond to Health and Safety audits within agreed timescales.

Finance
• Unless previously authorised, no NHS body may overspend in 2011/12, and every NHS body must, by April 2012, be balancing income and expenditure;
• Focus on service level reporting and locality mapping and monitoring of resources;
• Ensure that clinical leaders are involved in designing and managing budgets and budget systems;
• Boards will be required to undertake a thorough and radical review of all their estate to ensure maximum utilisation. It will be expected that all opportunities/options are explored for building functions to improve access and convenience for citizens. Evidence of inclusion of the wider Public Sector in this work will also be expected.

ICT
Organisations should pool resources and work collectively to deliver the shared implementation plan for the following common all-Wales information services:
• Enterprise patient master index (EMPI) - to identify the right patient at every contact and their information;
• National directory and email service (NADEX) - to identify each member of staff uniquely on the electronic information systems and provide them with the information services they individually need;
• Individual Health Record (IHR) - to see the key parts of the GP record in an emergency;
• Welsh Clinical Portal (WCP) - to order a pathology or radiology investigation and see the results and to manage medicines in the hospital;
• My Health On Line (MHOL) - to enable patients to order repeat prescriptions, book an appointment, and later, with appropriate safeguards, use their own record to self-manage their own care;
• Welsh Clinical Communications Gateway (WCCG) - to enable electronic referrals and discharges to be delivered to any location in health and social care.

Responsibility for data quality rests with the provider of the information and the objectives must be to make sure that all information is fit to be used both internally and externally. Additionally, organisations should contribute to the development and use of national standard reporting tools and systems for efficient collection and reporting.
• Organisations should also work with clinical teams to make sure that: common ICT systems are used to improve delivery of high quality clinical services and the benefits to patients and staff are identified, realised and reported.

Too much money is being used to collect data that in future may not be needed. **A new information regime** will be developed, to help us move to an information-driven NHS. Work will commence to identify two sets of indicators of national importance:

a. **National system indicators** – these will show the overall health of the population and the health system, such as disability-free life expectancy.

b. **Health specialty indicators** – these will be agreed by health professionals as key performance indicators in relation to particular services, such as stroke care.

These indicators will be used to assess the performance of the system and of individual organisations.

**Responding to this document**

Guidance and/or policy documentation previously provided to the NHS in the form of the 5 year Service and Financial Framework, National Service Frameworks, Quality Standards and 2010 /11 AOF, should continue to inform organisations on how best to deliver services. There are however two outputs which organisations will be expected to produce in regards the 2011 /12 AQF.

1. An updated five year plan setting out key in-year objectives /measurables to reflect progress along the 5 year pathway. This should include:

   • Demonstrating greater integration of services, workforce, financial planning;
   • Exactly how they will take forward Setting the Direction and the Rural Health Plan;
   • Setting out commitments related to their Health, Social Care and Wellbeing Strategies (HSCWBS), Children’s and Young Peoples partnerships (CYPP) etc.;
   • Actions relating to existing government commitments and requirements in relation to maternity, neonatal, paediatrics, Child and Adolescent Mental Health Services (CAMHS);
   • Any recommendations from the national programmes;
   • How they propose to change their internal processes to support the new direction of focus.

2. The second is an abstract for 2011 /12 which captures what is proposed to be delivered against each of the key headings identified (pages 6 - 11). **Appendix A** provides a summary of the key evidence areas that the NHS bodies would be expected to demonstrate improvements in through locally
agreed targets as part of their plans. These targets/plans will be used to measure progress throughout the year.

Where performance falls short of expectations (against agreed local plans), additional evidence will be required to demonstrate the organisations drive and commitment to deliver. Organisations will be expected to routinely have this data/evidence available through their own internal monitoring processes, and where appropriate, will also be published in an open and transparent manner for their local population.

An initial set of **publicly available indicators/outcomes** will be developed over the first quarter of 2011/12 for reporting by the NHS. This could be web enabled, publically accessible, and based on the principle of reporting once and freely available to all.

Work will continue within the Welsh Assembly Government to agree the format and level of published data in line with the national requirements. This will be an area of development in collaboration with the NHS to agree the final outputs.

**Timescale**

Overall AQF responses are required from:

- All LHBs
- Welsh Ambulance Services NHS Trust (WAST)
- Public Health Wales; and
- Velindre NHS Trust

An organisation’s final AQF response, updated five year plan, and the annual abstract for 2011/12, must be submitted to the Director of Operations, Welsh Assembly Government, by Monday 7 March 2011. The Final Plans will be assessed and jointly agreed.
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<th>Targeted areas</th>
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<tr>
<td>Protecting and improving Health</td>
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<td><strong>Improved quality and length of life, with fairer outcomes for All</strong></td>
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<td>• Deliver against the targets for which the organisation is responsible for</td>
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<td>within its local Children and Young Persons Plan and especially those</td>
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<tr>
<td>relating to child health, health inequalities and child poverty. More</td>
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<td>specifically there should be demonstrable local progress with achieving</td>
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<td>the child poverty targets relating to infant mortality, low birth weight</td>
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<tr>
<td>and teenage conceptions (LHBs to agree milestones by March 2011).</td>
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<tr>
<td>• Demonstrate clear progress with achieving the child poverty targets</td>
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<td>relating to infant mortality, low birth weight and teenage conceptions;</td>
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<tr>
<td>• LHBs will work with all its local partners to identify local target areas</td>
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<td>to ensure inequalities are identified and addressed within plans and local</td>
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<td>actions;</td>
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<td>• Annual Public Health Directors report.</td>
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<th>Evidence areas</th>
<th>National board to support NHS</th>
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<td></td>
<td>Prevention and Health Promotion Board</td>
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- Set and deliver against the key targets identified within ‘Our Healthy Future’ through the development of a Local Public Health Strategic Framework. This should be integrated with operational service planning and include the high impact areas identified by the National Prevention and Promotion Programme Board. The key interventions with the greatest impact on preventable disease are as follows:
  - Implementing best practice on smoking cessation;
  - Preventing falls in older people;
  - Reducing the burden of alcohol misuse;
  - Improved health at work;
  - Effective management of vascular risk.

- An agreed Local Public Health Strategic Framework which demonstrates the agreed Public Health activity and planning within the LHBs and Public Health Wales. These should be used to evidence:
  - Action on the ten priorities of public health as set out in Our Healthy Future and directional statements for the national programme targets;
  - Achievement of vaccination and immunisation requirements;
  - Achievement of the requirements in the National Screening Programmes.
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<tr>
<td><strong>Integration within health and with partners</strong></td>
<td><strong>Outcome:</strong> <em>To deliver community-based services that are reliable, accessible and support even the most vulnerable to live independent lives</em></td>
<td></td>
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</table>
| - Improve primary care services based on the outcomes and variations identified within the first annual report. | **Primary Care**  
- Produce an annual Primary Care Report as a minimum based on the national framework areas 2010/11;  
- Develop and manage Primary Care Plans consistently across localities;  
- Share and benchmark good practice within local areas and across Wales;  
- Engage GPs in improving access and quality of services;  
- Use data and information to manage and support improved care;  
- Ensure core contract commitments are met;  
- Review and refocus enhanced services to improve quality and consistency of services;  
- Establish and communicate out-of-hours access for local populations;  
- Increase Patient Participation Groups and self-care;  
- Develop clear plans for reporting performance of Dental, Pharmacy and Optometry services.  
- Develop a further annual report for March 2012 | Primary Care Board  
- Continuing Care (CHC) Board  
- Unscheduled Care Board  
- ICT Board  
- Workforce |
| - put in place the core elements to support *Setting the Direction* including:  
  - establishing local management teams which deliver effective GP locality working;  
  - communication hubs;  
  - common all-Wales ICT systems that support the safe and efficient delivery | **Supporting redesign of community services for setting the Direction**  
- Build locality-based multi-disciplinary teams with identifiable clinical leaders, delegated budgets, developing increasingly integrated services and/o posts with Local Authorities;  
- Create Clinical Resource Teams to provide multi-disciplinary/agency specialist support to the localities, the interface with hospital services being agreed in terms of | Primary Care Board  
- CHC Board  
- Unscheduled Care Board  
- ICT Board |
of integrated care;
- joint health and social care multi disciplinary teams to support the frail elderly;
- pilot at least one local management team operating with an indicative budget.

- An increase in the number of people living independently at home or in their usual place of residence, in particular those with a mental health illness or who are over 75 years.

- Each Board should demonstrate a direct shift of clinical care into community services; specific measures can be agreed locally but should include an overall reduction in bed days, reduced admission for unplanned emergency admissions /readmissions in the key chronic conditions (COPD, CHD, Diabetes, stroke, epilepsy, end of life care).

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<th>Workforce</th>
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<tr>
<td>‘pull’ mechanisms, to be developed from ‘in-hours’ to 7 day service;</td>
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<td>Introduce Communications Hubs to streamline patient and staff access to services by co-locating the contact routes to a range of services within a single, physical or virtual telecommunications centre; these services to include a comprehensive directory of services, call handling and signposting functions and, increasingly, coordinating and scheduling services for the target groups on a 24/7 basis;</td>
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<tr>
<td>Identify and implement opportunities to transfer resources and expertise from hospital to community settings, establishing integrated primary and secondary teams in critical interface areas;</td>
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<tr>
<td>Ensure developed and trained multidisciplinary teams to support in particular the frail elderly.</td>
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<th>CCM and medical conditions</th>
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<tr>
<td>Introduction of alternative care services in the community - linked to CCM agenda;</td>
</tr>
<tr>
<td>Development of a locality model which supports financial management of care, to support this move of caring for patients within community;</td>
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<td>Reducing the bed days for patients (time in hospital per episode of care) in excess of 20 and 60 days;</td>
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<td>Patients having discharge plan within 48 hours of admission;</td>
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<tr>
<td>Achieve and sustain the three year Delayed Transfers of Care (DTOC) targets;</td>
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<td>Continue to use Maturity Matrix assessments.</td>
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<th>Primary Care Board</th>
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<td>Workforce</td>
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<td>Targeted areas</td>
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<tr>
<td><strong>Clinical quality improvements</strong></td>
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<tr>
<td><strong>Outcome:</strong> High quality clinical practice needs to drive service redesign to ensure effective patient outcomes</td>
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<tr>
<td>• Boards must have a process for annual patient audits and evidence of reports and agreed actions which are published and presented at board level.</td>
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In high priority specialty areas, there will be an expectation that organisations will continue to deliver against the nationally recognised standards identified within this year’s AOF (2010 /11). There will, however, be the opportunity for each LHB to establish and begin publishing their own local targets in the following areas:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>National board to support NHS</th>
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<tr>
<td><strong>Stroke</strong></td>
<td>Stroke Delivery Group 1000 lives Programme Board</td>
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<tr>
<td>• Increase in the number of patients discharged home following a stroke. Ongoing compliance will still be required against the acute care intelligent targets and the planned intelligent targets for TIA and rehabilitation 2011 /12.</td>
<td>• Implement Stroke (acute, TIA and rehab) care bundle outcomes.</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td>National Cancer Networks</td>
</tr>
<tr>
<td>• Increase in survival rates at 1 and 5 years and ongoing achievement of the cancer access targets.</td>
<td>• Deliver cancer access requirements (31 and 62 days); • Improve MDT working particularly pre treatment stage; • Ensure compliance with NICE referral criteria with GPs through audit where appropriate.</td>
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<tr>
<td><strong>Cardiac</strong></td>
<td>Local and National Cardiac Networks</td>
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<tr>
<td>• Reduction in readmission rates for specific</td>
<td>• Implement and deliver Cardiac specific care bundles;</td>
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<tr>
<td>Major trauma and acute illness -</td>
<td>• Decrease inappropriate advice to attend Emergency Department (ED) by out-of-hours services;</td>
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<td>• Improved treatment times through unscheduled care with improved survival rates.</td>
<td>• Reduce maximum waits within ED departments for treatment;</td>
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<td>• Patient questionnaires for unscheduled care (potential development of fundamentals of care audit);</td>
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<td></td>
<td>• Focus on audit of outcomes for MI, stroke, trauma, fracture neck of femur and sepsis in ED;</td>
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<td>• Timely assessment;</td>
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<td></td>
<td>• Reduction in emergency admissions and readmissions to ED;</td>
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<td></td>
<td>• WAST Cat A compliance together with other WAST supportive measures.</td>
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</tbody>
</table>
### End of life care -
- For those with chronic conditions cared for in the community and approaching the end of life, the LHBs need to demonstrate an increase in the number of patients who receive care in their preferred place of care, as agreed in their dynamic end of life plan;
- Decrease in symptom burden in patients approaching the end of life, improved access to specialist palliative care support and improved outcomes as assessed by patients / families.
- Increase the number of patients supported to live and die at home;
- Audit that a minimum of 40% of all deaths of patients registered with a GP are included in the palliative care register of that GP;
- Timely access to specialist palliative care advice for those with complex needs, as demonstrated from CANISC referral data and 7-day working data;
- Increased end of life care pathway use, as demonstrated by variance sheet returns to the Welsh End of Life Care Pathway variance sheet audit (WCP);
- Good patient evaluations of the service through iWantGreatCare.

### Mortality rates -
- (30 days post event) for the above four conditions, demonstrate a reduction in mortality for stroke, cancer, cardiac disease, major trauma
- The medical director will be responsible for summarising this area of work in to a public annual report which demonstrate the organisations performance and progress in year.

### Mental Health -
- **Full** compliance with the agreed CPA process across all ages-its currently just adults. This reinforces the NHS Measure and consolidates current requirements.
- **Delivery of Dementia-and Depression care bundles based on clinical and patient outcomes.**
- Implementation of a planned patient questionnaire cycle that captures and influences design of services;
- Implementation of the stages of the pathway specified within the dementia and depression intelligent targets;
- Reduction in the use of inpatient bed days and number of admissions- as a minimum achieve and sustain the requirements against the 2010/11 Crisis Home Treatment services.

<table>
<thead>
<tr>
<th>Palliative Care Strategy Implementation Board</th>
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<tr>
<td>NSAGs National Medical Directors Group</td>
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<td>1000 lives Programme</td>
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<tr>
<th>Mental health Programme Board</th>
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<tr>
<td>1000 lives programme</td>
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</table>
**National Audits:**
It is proposed that the number of national audits is reduced to lessen administrative burden on organisations. This will be led by the National Audit Steering Group. However, as a minimum services should all play a full part in MinaP, Tarn, the RCP stroke audit, CEPOD and WCP and be able to demonstrate that action has been taken to secure improvement in response to the findings relevant to the organisation. Where appropriate, evidence will be accepted from internal clinical audits.

- All LHB and NHS organisation will participate in all relevant national audits agreed across Wales and linked to agreed R&D programmes where relevant;
- The Organisations will agree an internal governance link to demonstrate how the results and information from the audits are used to improve services.

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<tr>
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<th>National Medical Directors Group</th>
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**Quality of care clinical and citizen focus**

**Outcome: Reduce Harm and Variation**

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<tr>
<th>To be measured by:</th>
<th>Implement skin bundles - 1000 lives plus</th>
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<tbody>
<tr>
<td>- Elimination of pressure sores.</td>
<td>- Assessment of high risk patients, in A&amp;E and theatre particularly</td>
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<td>- Elimination of preventable healthcare associated infections through the adoption of an explicit policy of zero tolerance.</td>
<td>- Hand Hygiene;</td>
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<td>- Isolation and cohort facilities;</td>
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<td>- Antimicrobial prescribing;</td>
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<td>- 1000 lives plus;</td>
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<td>- Root cause analysis of patients with Clostridium Difficile infection.</td>
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<td>- National implementation of the Blood Borne Viral Hepatitis Action Plan through local delivery plans.</td>
<td>- Demonstrate through an agreed action plan with clear clinical leadership systems in place a reduction in the transmission of hepatitis infection, a reduction in the pool of undiagnosed infections and improvement in the provision of treatment and support to individuals infected with hep B and C.</td>
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<tr>
<td>- Deliver the nationally agreed patient outcomes in relation to fractured neck of femur focus on pathway in particular evidence of effective pain</td>
<td>- Implementation of the Focus on fractured neck of femur pathway capturing key deliverables:</td>
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<td>- Effective pain control;</td>
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</tbody>
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| 1000 Lives Programme | 1000 Lives Programme | Health Prevention and Promotion | Acute Productivity Board |
| **Control, time to theatre and discharge to home following treatment.** | **Ensure timely access to planned services 95% within maximum of 26 weeks;**  
**Implement and sustain the 9 nationally agreed “Focus On” pathways which will include the enhanced recovery programme under 1000 lives plus.** | **Outpatient productivity measure - being developed;**  
**Sustainable volume reduction by stage of pathway - local targets to deliver sustainable solutions within 2011/12;**  
**Admission on day of surgery - unless clinically required to pre-admit;**  
**Increase in day case and procedures not requiring admission - to set local targets to achieve as minimum 75% of all planned surgical interventions;**  
**Theatre turn around times - building on productive theatre work;**  
**Pre op assessment for all planned surgery;**  
**Use of predicted date of discharge for all planned events (as part of pre-op assessment) to also look at emergency admissions as part of assessment for discharge within 24 hrs post admission;**  
**Limitation of Procedures with a low effective outcome - against locally agreed targets to address variance and local needs;**  
**Self referral should be explored as a suitable entry point into therapy services to improve patient experience and improved access.** | **Acute Productivity Board**  
1000 Lives |