GIG CYMRU NHS WALES

Llywodraeth Cymru
Welsh Government

www.cymru.gov.uk

NHS Wales

Delivery Framework 2013-14 and Future Plans






ISBN 978 0 7504 9296 6

WG18462

Delivery Framework 2013/14

1. Background

1.1. This Framework provides clarity about the delivery priorities for 2013/14. These are aligned with Ministerial policy and the need to drive up standards and outcomes. It sets out the processes which will be in place to monitor progress and provide support and intervention as necessary.

1.2. Five quality 'domains' have been identified to help provide a more integrated view of NHS delivery. These are:

- **Need and prevention**- Are we meeting need? Are we managing demand? Is prevention improving? Is our focus balanced?
- **Experience and access**- Are services accessible and are users satisfied?
- **Quality and Safety** – Are services safe? Are standards improving?
- **Integration & partnerships** – Is integration improving?
- **Allocation and use of resources (staff and finance)** – Are services efficient and affordable? Is the workforce engaged? Are we managing supply?

1.3. The 2012/13 Tier 1 standards, and those added for 2013/14, have been mapped against these domains.

1.4. In general the changes to the standards are in line with the requirement to focus more on prevention, integration and outcomes.

2. Introduction

2.1. The 2013/14 Delivery Framework is a development of the previous Framework, but includes a step towards a more integrated approach.

2.2. The new updated Tier 1 standards are attached at Appendix A. Whilst this is largely unchanged from the previous version of Tier 1 standards, a limited number of adjustments have been made to ensure a necessary focus on prevention, integration and quality. The principle of 'Quality Triggers' have also been added so they can be accommodated into the delivery framework

2.3. Delivery assurance will be provided via Quality and Delivery Meetings (QDM) with all NHS organisations that cover Tier 1 and statutory delivery requirements. Additionally, these meetings will periodically review other key areas, highlighted through other external bodies reports such as Community Health Council and outstanding Welsh Audit Office national audit recommendations.

2.4. Quality and Delivery meetings will be supplemented by various Performance, Quality, Finance, Capital and other meetings as required. Information from these meetings will be used to support Quality and Delivery meetings when required.

2.5. The objectives of these meetings will include:

- Discussing and assessing NHS non compliance and seeking assurance on plans to mitigate risks and improve delivery.
- Agreeing and communicating any necessary further assurance or action.
- Monitoring progress against agreed actions and assess if additional intervention is required.

2.6. Monthly Quality and Delivery meetings will cover the following:

- Delivery & Performance;
- Finance;
- Delivery Support Unit Work Plan;
- Quality/Patient Safety;
- HR/Workforce;
- Nursing;
- Primary Care;

2.7. Individual NHS organisations will need to ensure appropriate representation at the meetings and the agenda papers will primarily be based on the papers presented to their respective Board and/or Committee and minutes/actions approved by Board/Committee.

2.8. These Quality and Delivery meetings will be within a framework of:

- Welsh Government's Integrated Delivery Board (IDB);
- Monthly CEO meetings;
- Bi-annual Joint Executive Team meetings (JET);
- Regular meetings between Minister and LHB /Trust Chairs.

2.9. Quality and Delivery meetings will complement the NHS's internal Board and Committee arrangements, whether through their Performance or Finance Committee, for performance managing and ensuring delivery in line with plans. The responsibility for delivery is with the Board and it will be a matter of Board governance to ensure delivery.

2.10. The role of the QDMs will be to monitor progress and assurance that delivery is on plan and/or that Boards have taken the necessary rectifying actions to ensure delivery. Where assurance is not provided on delivery or Board approved rectifying actions, escalation arrangements will be instigated.

Accountability and ownership of the delivery and improvement of services remains the responsibility of Health Boards.

2.11. Health Boards/Trusts are responsible for remedial action in response to areas of failure at each escalation level. This responsibility is a matter of Board and organisational governance and accountability. Where escalation comes into play Health Boards/Trusts are expected, and are required to, identify and implement the proposed escalation action. Monitoring and assurance arrangements will be embedded into the escalation plans.

2. Escalation within the Delivery Framework

Escalation Level	Performance trigger	Escalation Action	Monitoring	De-escalation
0.	Local delivery of all targets and/ or within trajectory.	None required – earned autonomy (including potential for reducing the frequency of Q&DM) and minimal monitoring beyond that required for national returns. Proactive assurance mechanisms.		
1.	Health Boards/Trusts fail to achieve/ maintain one deliverables.	Health Boards/Trusts are responsible for remedial action in response to areas of failure. WG indicates the additional monitoring requirements. Plans brought forward to redress the position with immediate effect.	WG, in conjunction when necessary with DSU (or other intervention mechanism identified by WG), assures and monitors implementation of plans and effectiveness of solutions. Executive highlight report. Support from other agencies if required.	Immediate removal of escalation action upon achievement of plan and return to improving KPIs.
2.	Continued failure to achieve/ maintain one or more key deliverables.	WG instigates DSU and/or other intervention. WG and DSU (or other intervention mechanism identified by WG) will be actively involved in determining the necessary changes within the HB/Trust to deliver required outcomes through regular meetings/calls.	WG Representatives to join regular meetings/calls and monitor effectiveness of organisational response with DSU and &/or other intervention mechanisms.	Sustained improvement of KPIs causes removal of escalation actions.
3	Continued failure and/or a failure to maintain an agreed improvement trajectory following intervention.	Issues raised with Chief Executive NHS Wales. Meeting required between HB Chief Executive, NHS CEO and/or NHS Deputy Chief Executive to determine future requirements and actions.	Regular reporting established between CEO NHS Wales and HB Chief Executives until improving trajectory established.	Maintenance of agreed improvement trajectories causes return to escalation level 2.
4.	Continued failure to improve performance or failure to engage with the national process despite level 3 escalation.	Actions to be determined by NHS Chief Executive which may include the following: • Meeting required with Chair, Vice Chair, CEO, Board Secretary and relevant Executives. • Introduction of `special measure' arrangements. • Review of executive effectiveness. • Review of Board effectiveness. • Removal of appropriate funding streams.		

3. Attachments

- Appendix A – Tier 1.

4. Context

4.1. The framework for intervention by Welsh Government was introduced because of concerns in respect of performance and finance as summarised in WHC (2007) 049 “Statutory Financial Duties of NHS Trusts and Local Health Boards”. This circular primarily focused on the statutory financial duties, where for LHBs there is currently no flexibility with regards to this absolute target, and set out the intervention framework as follows:

(i) Formal Intervention Powers – NHS (Wales) Act 2006

Very wide intervention powers are available to the Welsh Government through the NHS (Wales) Act 2006, S26-28. These powers can be utilised if a NHS organisation is considered to be failing to perform one or more of its functions and can, in certain circumstances, be applied to suspend or remove powers and functions from organisations and individuals.

(ii) Accountable Officer Appointment Letter and Memorandum

The Accountable Officer Memorandum, which each Chief Executive receives on appointment together with a letter from the Chief Executive, NHS Wales, defines the responsibility of the Accountable Officer in each NHS organisation for financial management/performance.

The Memorandum clearly states that the Accountable Officer of each NHS organisation is directly accountable, for all financial performance issues (and all other performance issues) delegated to the organisation, to the Chief Executive, NHS Wales as Sub Accounting officer for Health and Social Care at the Welsh Government.

The Accountable Officer’s powers can be removed by the Chief Executive, NHS Wales where the Accountable Officer is not performing the delegated responsibilities.

(iii) WHC (2007) 049 - Statutory Financial Duties of NHS Trusts and Local Health Boards

This circular provides details of the requirement of Trusts and Local Health Boards to achieve the statutory duty to meet their respective financial targets, including the Welsh Government’s requirement for all NHS organisations to achieve financial balance each year. The circular clearly states that the Accountable Officer of each NHS organisation is accountable for the achievement of those duties for his/her organisation.

The circular states that failure to achieve statutory targets will be viewed as a serious matter by the Welsh Government and that under the Accountable Officer arrangements, the Chief Executive, NHS Wales will determine the sanctions to be applied to an organisation and its Accountable Officer under these circumstances.

Appendix A

Tier 1

The following have been dropped from Tier 1:

- Efficiency & Productivity standards: Considered now to be core business for the NHS to deliver.
    - Short Stay surgery;
    - Reduced bed days/improved length of stay – Elective.

- Achievement of 24/7 access to stroke thrombolysis. This is being achieved and now needs to be maintained.

- The specific separate monitoring of orthopaedic RTT delivery. This will be monitored within overall RTT monitoring.

The following have been elevated from Tier 2 to Tier 1:

- Health prevention and promotion
    - Immunisation - Children under four years of age 95% target rate;
    - Improved uptake of smoking cessation services;
    - Influenza vaccine rate - staff and high risk groups.

- Mental health Target
    - Implementation of all areas of the Mental Health Measure.

- Delayed transfers of care targets - annual reduction.

- GP access - % of appointments available after 5pm.

- Workforce
    - Staff survey;
    - Staff appraisal;
    - Improved Clinical engagement.

The following will be elevated to Tier 1 once data sources, intervention processes, etc. have been confirmed and in the meantime will be discussed as '**Quality Triggers'**

- Reduction in Hospital Acquired Thrombosis (HAT).
- Sepsis rate two areas:-
    - Sepsis mortality rate for Intensive Care Units; and
    - implementation of the Sepsis bundle.
- Completeness and timeliness of discharge letters.
- The % of people over 65 who are discharged from hospital and referred to a nursing or residential home (new address).

Tier 2

There are no proposed Tier 2 standards for 2013/14, however through the Integrated Delivery Group and Ministerial priorities, areas of concern may be raised for assurance through out the year.

Data requirements or reports may be required to support this type of ad hoc assurance, but this will be kept to a minimum and discussed with the NHS through the Quality and Delivery process.

Data Definition and data flows

As indicated, the 2013-14 Tier 1 standards are in the main established defined areas with agreed definitions and data flows. There are however a number of areas which are new and more work is required to develop and agree the definitions and the data flows.

A separate process and proposed action plan is being developed to support these areas. This will be shared and discussed with information leads and taken through the Data Definitions Group linked with the Welsh Information Standards Board (WISB).

Quality Questions	• Are we meeting need? • Are we managing demand? • Is prevention improving? • Is our focus balanced?				
Domain	**Deliverable**	**Lead or Owner**	**Data Source**	**Frequency**	**Escalation Process / Support Resources**
Need and Prevention	**Standards** 75% uptake of influenza vaccination among: • 65 years and over • Under 65s in at risk groups • Pregnant women 50% uptake of influenza vaccine among: • Health care workers. *(Baseline – 2012/13 data available in the summer of 2013)*	Ruth Hussey	Audit+ (LHB returns collated by PHW)	Weekly (during flu season Sep - Mar) Monthly (during flu season Sep - Mar)	Communication from Health Protection Division to Immunization Co-ordinators. If required, CMO communication to Directors of Public Health.
	95% vaccination of all children to age 4 with all scheduled vaccines.	Ruth Hussey	PHW COVER statistics	Quarterly	As above.
	5% of smokers make a quit attempt via smoking cessation services, with at least a 40% CO validated quit rate at 4 weeks.	Ruth Hussey	Stop Smoking Wales, LHB Pharmacy Scheme, Hospital Cessation Services	Quarterly	Report to Tobacco Control Delivery Board. If required, CMO communication to Directors of Public Health.

Quality Questions	• Are services accessible? • Are users satisfied?				
Domain	**Deliverable Indicators**	**Lead or Owner**	**Data Source**	**Frequency**	**Escalation Process / Support Resources**
Experience and Access	**Standards – Satisfaction with Services** Patient experience and dignity in care monitored though: • "Fundamentals of Care" audit; • Progress against Older Peoples Commissioners action plan; • Patient experience surveys; • HIW dignity spot checks; and • National survey e.g. CHC Patient Hospital Environment Survey.	Jean White	Fundamental of Care Audit Board reports on patients experience HIW Dignity Spot Check report CHC patient hospital experience survey.	Annual Bi-monthly As per programme Annual	
	Compliance with response rates for complaints and SI reviews against agreed standards	Janet Davies (lead)	"Putting Things Right" reporting	Quarterly	

Quality Questions	• Are services accessible? • Are users satisfied?				
Domain	**Deliverable Indicators**	**Lead or Owner**	**Data Source**	**Frequency**	**Escalation Process / Support Resources**
Experience and Access	**Standards - Scheduled Care Acute Access Times** • 95% of patients will be waiting less than 26 weeks for treatment with a maximum wait of 36 weeks. • % of procedures cancelled on more than one occasion by the hospital with less than eight days notice that are subsequently carried out within 14 days or at the patient's earliest convenience.	Kevin Flynn / Lesley Law (lead)	NWIS - RTT	Monthly	Covered via escalation process. If performance is not delivering against standards then discussed at IDB to agree escalation and intervention.
	Efficiency & Productivity Support Measures • Theatre turn-around times. • Uptake of ERAS across whole HB.		DSU 1,000 lives	Monthly	
	Standards - Unscheduled Care Access Times • 95% of patients spend less than 4 hours in all hospital emergency care facilities from arrival until admission, transfer or discharge. • Eradication of over12 hour waits within all hospital emergency care facilities. • Deliver the 65% Cat A response times (with an internal stretch target of 70%[1]).	Kevin Flynn / Roger Perks & Trish Harper (leads)	NWIS - EDDS	Monthly	Covered via escalation process. If performance is not delivering against standards then discussed at IDB to agree escalation and intervention.

[1] Subject to recommendations in Strategic Review of Welsh Ambulance Service.

Quality Questions	• Are services accessible? • Are users satisfied?				
Domain	**Deliverable Indicators**	**Lead or Owner**	**Data Source**	**Frequency**	**Escalation Process / Support Resources**
	Standards – Mental Health Access Each Local Authority to: • 80% of assessment by the LPMHSS undertaken within 56 days from the date of referral. • 90% of therapeutic interventions started within 56 days following an assessment by the LPMHSS. For all ages. • *(Part 1 of Mental Health Measure).* • 90% of LHB residents (all ages) to have a valid CTP completed at the end of each month. • *(Part 2 of Mental Health Measure)* Ensure that: • individuals are re assessed in a timely manner; and • a copy of a report to that individual is provided no later than 10 working days following the conclusion of that assessment in 100% of cases. • *(Part 3 of Mental Health Measure).* • 100% of hospitals within each LHB to have arrangements in place to ensure advocacy is available to qualifying patients. *(Part 4 of Mental Health Measure).*	Jo Jordan / Sarah Watkins & Andrea Gray (leads)	Delivery Division, WG Delivery Division, WG	Monthly 6 monthly	

Quality Questions	• Are services accessible? • Are users satisfied?				
	Ensure that: • individuals are re assessed in a timely manner; and • a copy of a report to that individual is provided no later than 10 working days following the conclusion of that assessment in 100% of cases. (Part 3 of Mental Health Measure). 100% of hospitals within each LHB to have arrangements in place to ensure advocacy is available to qualifying patients. (Part 4 of Mental Health Measure).		Delivery Division, WG	6 monthly	

Quality Questions	• Are services safe? • Are standards and outcomes improving?				
Domain	**Deliverable**	**Lead or Owner**	**Data Source**	**Frequency**	**Escalation Process / Support Resources**
Quality and Safety	**Indicator** Cancer Mortality rate under 75 years per 100,000. **Standards** • Delivery of the 31 (98%). • And 62 day (95%) standard referral to treatment. • Each organisations will have a rolling action plan and will publish an annual progress report against the Cancer Delivery Plan.	Dr Chris Jones Kevin Flynn / Olivia Shorrocks (lead)	ONS KAS, WG WG returns	Annual Monthly Annual	Covered via escalation process. If performance not delivering against standards then discussed at IDB to agree escalation and intervention.
	Indicator Reduction in circulatory disease mortality rate under 75 years per 100,000. • Sustained compliance against four acute stroke bundles. • Participation improvements within RCP Snap clinical audit- to start July 2013.	Dr Chris Jones Kevin Flynn / Olivia Shorrocks (lead)	ONS DSU SNAP data	Annual Monthly Quarterly	

Quality Questions	• Are services safe? • Are standards and outcomes improving?				
Domain	**Deliverable**	**Lead or Owner**	**Data Source**	**Frequency**	**Escalation Process / Support Resources**
Quality & Safety	**Indicator** Eradication of Healthcare Acquired Infections. **Standards** • Reduction in C. Difficile and Staphylococcus Aureus Bacteraemia (MRSA & MSSA).	Jean White / Tracey Gauci (lead)	PHW	Monthly	
	Indicator Elimination of pressure sores. **Standards** • Reduction in the number of healthcare acquired pressure ulcers. • % compliance with Hand Hygiene (WHO 5 moments).	Jean White / Tracey Gauci (lead)	Nursing dashboard	Monthly	
	Indicator Reduce mortality from acute illness. **Standards** • Demonstrable reduction in the mortality rate for stroke, heart attack and fractured neck of femur patients (30 day post event). • Crude and Risk adjusted scores together with HB mortality review process.	Ruth Hussey	CHKS	Monthly	

Quality Questions	• Are services safe? • Are standards and outcomes improving?				
Domain	**Deliverable**	**Lead or Owner**	**Data Source**	**Frequency**	**Escalation Process / Support Resources**
	Standards – Data Quality • Ensure that the data completeness standards are adhered to within 3 months of episode end date (95% on a monthly basis and 98% for any given rolling 12 month period). *Ensure that both standards are applied across all episodes of admitted care at specialty, admission method (elective and emergency) and patient class (inpatient or day case) levels.*	Kevin Flynn / Roger Perks (lead)	NWIS	Monthly	

Quality Questions	• Is integration improving?				
Domain	**Deliverable**	**Lead or Owner**	**Data Source**	**Frequency**	**Escalation Process / Support Resources**
Integration & Partnership	**Standards** • Reduction in the number of emergency hospital admissions for basket of 9 chronic conditions. • Reduction in the number of emergency hospital readmissions within a year for basket of 9 chronic conditions.	Abi Harris/ Kevin Flynn / Ruth Hussey / Albert Heaney	NWIS To be developed.	Monthly	
	• Improvement in DTOC delivery per 10,000 of Local Authority population – mental health (all ages) and non mental health (75 years and over).	Lisa Dunsford/ Steve Milsom / Roger Perks / Grant Duncan (leads)	NWIS	Monthly – rolling 12 months	
	Indicators • Percentage of GP practices offering appointments between 17:00 and 18:30 on at least two nights per week. • Percentage of GP practices open during daily core hours, or within one hour of the daily core hours. **Standards** • % GP practices offering appointments after 5 pm.	Abi Harris / Lisa Dunsford (lead)	Primary Care Policy Team & KAS, WG	Quarterly	

Quality Questions	• Are services efficient and affordable? • Is the workforce engaged? • Are we managing supply?				
Domain	**Deliverable**	**Lead or Owner**	**Data Source**	**Frequency**	**Escalation Process / Support Resources**
Allocation & Use of Resources	**Standards - Workforce** All staff to have an annual appraisal or performance appraisal development review (PADR). • Percentage of staff (excluding medical) undertaking. PADR (Performance Appraisal Development Review) • Medical Staff – percentage of staff undertaking. Performance Appraisal. • Experience of appraisal. *Percentage of headcount - staff undertaking PADR in previous rolling 12 month period (excluding staff with zero hour's contract*). A staff survey is undertaken that provides a baseline for organisational climate, employee engagement and well-being. • % of staff completing staff survey in the organisation. • Overall measure for organisational climate / engagement. • Narrative comment on action plans. • Achieve annual local sickness and absence workforce target.	Neil Wooding	ESR & Health Board /Trust workforce data NHS staff survey results Health Board ESR	Quarterly	
	Standards – Finance • Financial balance. • Remain within resource limits and within capital resource limits. • Show reductions in annual total pay spend.	Kevin Flynn / Martin Sollis (lead)	LHB finance returns to WG	Monthly	

Developmental areas to be included in Tier 1 when data source and data collection is fully validated

Domain	Deliverable	Lead or Owner	Data Source	Frequency	Escalation Process / Support Resources
Quality & Safety	• Reduction in % of patients who have a Hospital acquired Thrombosis (DVT/PE) up to 90 days post discharge. *Developmental of HAT score process*	Ruth Hussey	To be developed	To be developed	
	• Annual rolling reduction in the Sepsis mortality rate for ICU units. • Implementation of the Sepsis Bundle.	Ruth Hussey	ICNAC 1,000 lives	To be developed	
Integration & Partnership	• % of Discharge letters meeting agreed standards.	Ruth Hussey	To be developed	To be developed	
	• % of people over 65 who are discharged from hospital and referred to a nursing or residential home and not their usual place of residence.	Abi Harris / Kevin Flynn / Ruth Hussey / Albert Heaney	To be developed	To be developed	