



Llywodraeth Cymru
Welsh Government

National Clinical Framework:

A Learning Health and Care System

Welsh Government 2021

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FOREWORD

The year 2020 was undoubtedly the most challenging the NHS in Wales has faced since its creation in 1948. The COVID-19 pandemic meant services had to adapt rapidly to reduce the risk of transmitting the disease and meet the needs of those who became seriously unwell from contracting the disease. At the same time, essential services had to be maintained and difficult decisions made about the provision of more routine services in order to cope with the demands caused by the pandemic. In doing so, we witnessed the sheer determination of our workforce to continue to deliver care and do the best for the population and one another.

Despite all the challenges, the pandemic also acted as a powerful stimulus to transform healthcare delivery. We saw examples of innovation delivered at scale and pace that was unprecedented. Notable examples include the roll out of digital platforms to support virtual consultations, the reorganisation of primary care services in clusters to provide COVID 'hot' and 'cold' sites, cross-sector partnership working that allowed the extremely clinically vulnerable to be supported in their homes, and the beginning of the biggest vaccination programme in the NHS's history.

As the vaccination programme gives us hope of more normal times, our thoughts will begin to turn to the recovery of all clinical services and the ongoing needs of our population. This will be a long and complex process, with a workforce that is tired and which also needs a chance to recover. However, there is also an opportunity to come back stronger and we cannot afford to miss it. It is an opportunity to build an NHS that is able to address some of the long-standing challenges it faces and to ensure it can meet the needs of future generations.

This National Clinical Framework sets out how we can begin to realise that ambition through the development of our clinical services. It is a vital part of a much broader effort that was described in *A Healthier Wales*. This Framework is about how clinical services in our NHS fit into that wider picture. Although the work to develop this Framework began before the pandemic, the experiences of the past year have helped us to see what it is possible to achieve with the right impetus, leadership and engagement. This is something for us all to build on and through this Framework I hope we can capture some of that spirit for the longer term.

As a nation we have made a distinctive choice that planning, not the market, drives our healthcare system. This Framework will build on that choice and puts planning for our population's needs above the organisational interest and beyond the constraints of their boundaries. It seeks to unleash the revolution from within that is needed to deliver prudent and value based healthcare. It recognises that greater central direction is needed to make that behaviour and philosophy a reality. The Framework sets out a health system that is co-ordinated nationally and delivered locally. One that is managed through collaborations, between health organisations and partners, by those directly responsible for their respective populations. This will ensure local ownership and a thriving innovation agenda.

This new way of organising and delivering care is more vital than ever. The pandemic has had a devastating effect on thousands of people and their families in Wales. It has also shone a light on the appalling impact that health inequality has on our population, particularly for vulnerable groups, deprived communities and Black, Asian and Ethnic Minority populations. We have arrived at an important crossroads in our history and the decisions we take at this juncture will determine the health and wellbeing of current and future generations of the Welsh population. I am pleased to be able to endorse this Framework as a means of helping us all make the right decisions about how clinical services should be delivered in the 21st century.

Vaughan Gething
Minister for Health and Social Services

EXECUTIVE SUMMARY

I would like to offer my heartfelt thanks to the team that developed this important Framework. Particular thanks go to Dr Allan Wardhaugh, Dr Alastair Reeves and Sian Passey RN/RM who led the clinical engagement to inform and shape the drafting of this Framework, as well as all those who participated in the extensive engagement to influence its development.

It has been a significant challenge to write such a Framework in the context of the historic challenges facing the NHS, while the UK was in the midst having to cope with a destructive and destabilising pandemic. I am confident that this Framework offers the NHS in Wales a sound basis for the modernisation and transformation of the clinical services that will now emerge.

It is of course part of a much broader set of actions that are set out in *A Healthier Wales* designed to move us to a fit for purpose and sustainable health and care system. How we design and deliver our NHS clinical services is an absolutely fundamental aspect of how we can achieve that aim. The NHS has already changed significantly and has balanced the challenges of increased demand and cost, within the context of the constrained and finite resources that we see all publically funded health services struggle with. The reason it has been able to do this so far has largely been down to the dedication and hard work of its staff - staff in its broadest sense and not just our vital healthcare professionals.

More significant change in the way we plan to deliver clinical services will make things easier for our workforce trying to do their best, will make our service more resilient in meeting the needs of our population, and make it more responsive to the priorities set through our democratic processes. *A Healthier Wales* called for the development of “a national clinical plan for specialist health services setting out our strategic approach to delivering safe and high quality health services which meet the needs of people across Wales”. Therefore, I welcome this Framework and the opportunity to make this a reality for people working in our health system.

In doing so, I recognise that our health and wellbeing are affected by wide ranging socio-economic impacts. So I am pleased this Framework is grounded in a life-course approach and that it requires NHS organisations to act upon areas of cross-cutting priority with partners, to maximise the contribution our healthcare system can make. It means the NHS will be able to make the most of its contribution to keeping people well in childhood and adolescence, throughout their education and employment, and supporting people to stay well and independent for as long as possible.

This document acts as a Framework for the NHS's planning and delivery of clinical services in the context of the strategic approaches set out by the Welsh Government. This includes the approach to digital health services, NHS workforce development and the shift of focus to primary and community services. It encompasses outpatient reform,

improving disease outcomes and the challenges of unscheduled care. It brings these challenges and solutions together into a coherent vision for clinical services.

Early cross cutting opportunities have been identified in this Framework and I expect to see progress in these areas. I also look forward to seeing how other areas not specifically mentioned are being reviewed to utilise the principles set out in this Framework. It will ensure we are able to offer our patients better experiences and improved outcomes.

If we have learnt anything over the last year, it is that our workforce is our greatest asset and good health and healthcare are our community's most valued commodities. This Framework looks to set the ambition for how these will be nurtured as NHS Wales sets out on the path to recovery and to a brighter future.

Dr Frank Atherton
Chief Medical Officer for Wales

1. INTRODUCTION

This National Clinical Framework sets out a coherent vision for the strategic and local development of NHS clinical services. It is grounded in the life course approach to service delivery and aligned to the burden of disease facing the population. Its intent is to improve patient outcomes and support the planning and delivery of resilient clinical services. It builds upon the findings of the Parliamentary Review and the direction set in *A Healthier Wales* and has benefited from looking at international experience and engagement with NHS colleagues. The Framework will sit at the centre of our system of planning.



Background

In 2015, the Organisation for Economic Cooperation and Development (OECD) reviewed the strengths and weaknesses of how Wales meets the health and wellbeing need of its population. It called for a 'stronger central guiding hand' for the NHS. This was followed by a Parliamentary Review of the Long Term Future of Health and Social Care, led by a former chief medical officer for Wales, Dr Ruth Hussey. It called for a 'revolution from within' to drive the changes we need to see in our health system. The Welsh Government's response, *A Healthier Wales*, was published in June 2018 and among its

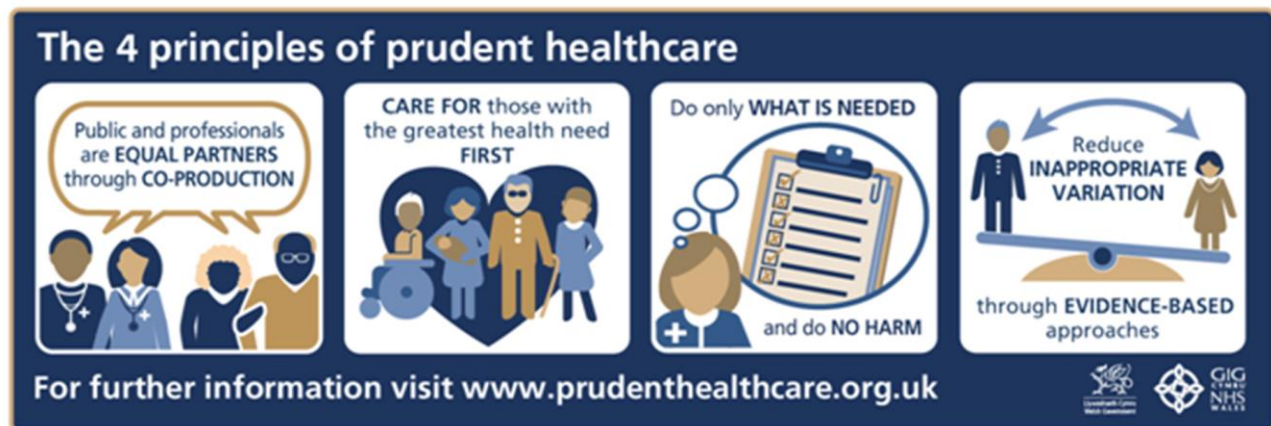
actions was a national clinical plan. The clinical plan was intended to set out our strategic approach to delivering high quality healthcare services, which meet the needs of people across Wales. This was to include consideration of how specialist services and hospital-based services should be provided, and the skills and technologies needed to support them, as part of the broader health and social care offer.

In recognition of the scale of the national challenge and the complexity of operationalising this locally, it was decided to develop a National Clinical Framework. This Framework attempts to set the parameters for a wider set of clinical changes required through our national, regional and local NHS planning processes. The Framework sits between *A Healthier Wales* as the overarching strategy and the clinical aspect of local plans that reflect the realities of their geography, population and workforce.

The definition of specialist care that has been applied derives from the prudent healthcare principle of a practitioner doing what only they can do. Therefore it is not limited to hospital-based care or medical specialties. It recognises the importance of greater integration of primary and secondary care services, and also of the vital role played different health professionals clinical staff. This Framework therefore attempts to

describe the role that all clinicians should play in the delivery of more integrated, seamless clinical pathways.

The Framework describes how clinical services should be planned and developed in Wales based on an application of prudent and value based healthcare principles, which we refer to as 'prudent in practice'. In doing so, it recognises the need to continue to shift focus from hospital based care to person centred, community based care. Care that can support people to stay well, self-manage their condition and when necessary provides seamless and appropriate specialist support. Central to this is the creation nationally and local adoption of higher value pathways that focus on the patient rather than the setting in which the service is delivered.



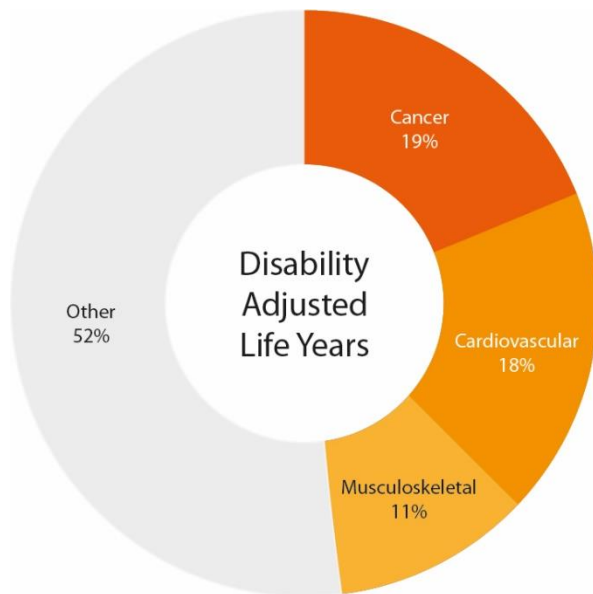
2. THE CURRENT CLINICAL MODEL

The NHS in Wales is still largely a ‘planned care’ system driven by statutory organisations and underpinned by professional, specialty and delivery silos. This can create organisational and professional boundaries that can inhibit patient experience and outcome, as well as being wasteful in terms of making the most of scarce resource. Like many other modern healthcare systems, we find that the complexity of patient needs and healthcare delivery is a significant challenge for person-centred healthcare delivery. In order to overcome this complexity and avoid fragmentation of delivery, there has been a focus on developing disease specific pathways that bring clarity and consistency to the patient journey.

However, these clinical pathways are often in reality only a snapshot of the patient’s lived experience, or short parts of the full clinical pathway and tend to have been built around specialist interventions. They tend to focus on referral to secondary care and stop at first definitive treatment. Therefore, the current pathway approach is still not as seamless or complete as it needs to be. It can create sub-optimal patient experience, with patients being seen by many different teams that focus on only one aspect of their health need. These models of care were developed in response to population needs some decades ago, but now need to evolve to meet the changing needs of our ageing population, many of whom have multi-morbidities.

It can also mean that within each individual disease pathway, there are dedicated interventions that could be more effectively delivered once for multiple pathways. Examples include primary and secondary prevention, rehabilitation and end of life care. These services would benefit from a more centralised approach and provision for the benefit of many disease pathways. There is also a need for greater recognition of the role of supported self-care and the more systematic use of non-NHS services and social prescribing in pathways. Therefore, there are many opportunities to design more person-centred, holistic and efficient pathways.

The report *Health and Its Determinants in Wales* (2018) shows that the leading causes of disease burden are cancers, cardiovascular disease, musculoskeletal conditions, mental health and substance misuse. Much of this disease burden is preventable and further effort is needed to reduce the burden of avoidable ill health on people and the NHS. The *Tobacco Control Delivery Plan* and *Healthy Weight, Healthy Wales* strategy are two important strategic examples of how we will support a shift in amenable population risk factors; with Making Every Contact Count a consistent model for all healthcare professionals to engage with patients on reducing their personal risk. Nonetheless, the NHS should be more focused on meeting the population’s burden of disease and its existing networks and programmes are not well aligned to this burden.



A number of national clinical networks and forums are developing pathways of care for some of these conditions. These pathways aim to reduce unwarranted variation in quality and outcomes. However, the current balance of representation on these clinical networks tends to lean more towards very specialist clinicians and the pathways tend to only cover referral to first definitive treatment. Few clinical networks currently have significant primary care and broad multi-professional input. There is increasing recognition of the need to develop these pathway in a way that includes broader professional and patient input to deliver higher value interventions.

Clinical networks often struggle to access data on pathways and what is available tends to be process data. Some are starting to use Patient Reported Outcome Measures (PROMs) to understand and refine how pathways are delivered but this is still not widely used and embedded across Wales. There is also a broader challenge related to understanding what matters to the patient, in that treatment pathways can be recommended without fully comprehending what matters to the patient by a process of co-producing their care. This can have the unfortunate effect of using scarce resources to achieve the wrong outcome for the individual concerned and also clogging up pathways with lower value work that results in long patient waiting lists that cause harm and distress.

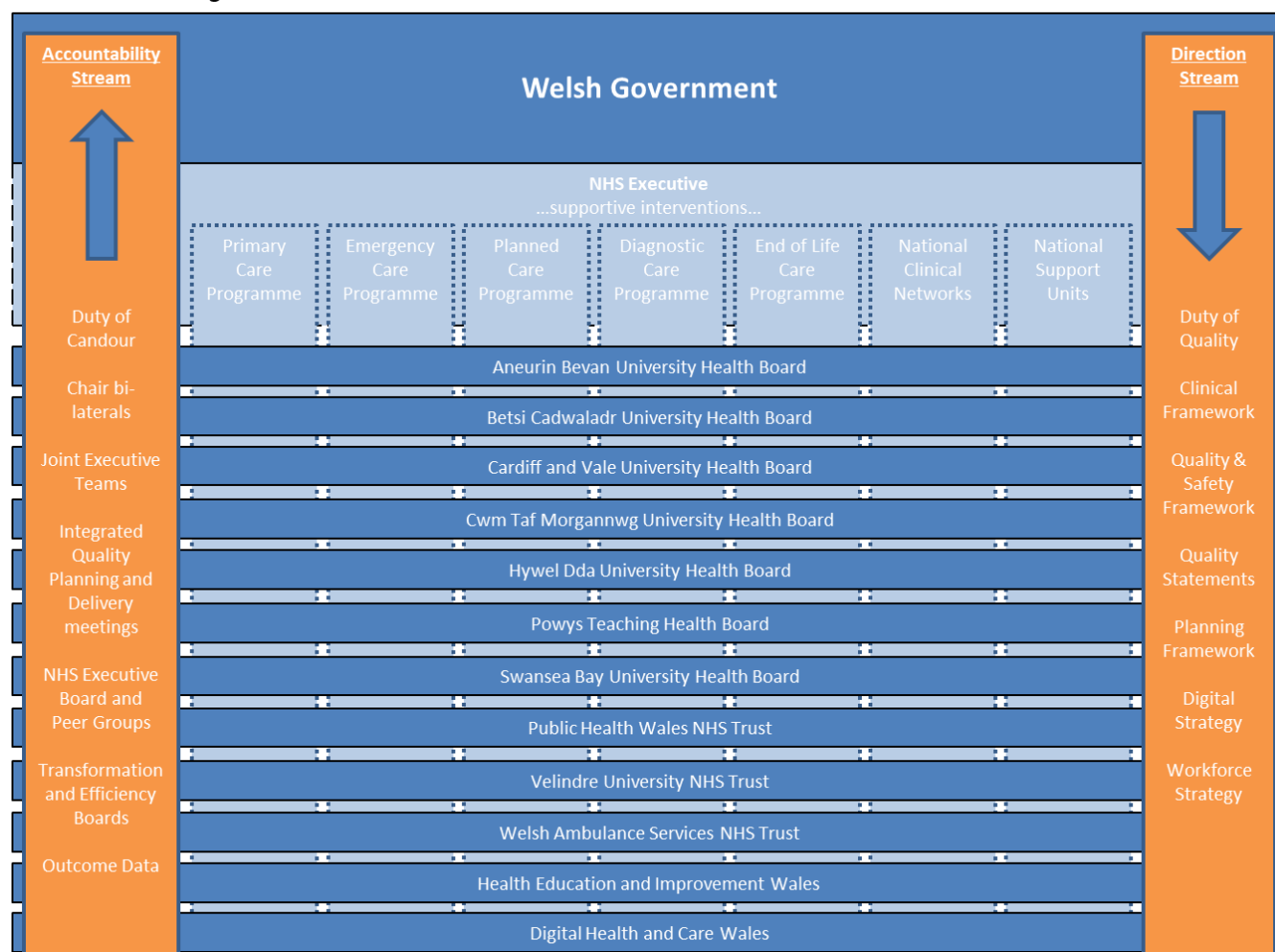
There is also a pressing need to embrace innovation and to scale up those initiatives that have demonstrated an impact on patient care, experience, service quality or sustainability, and achieve better value for the wider system. Clinical networks and national programmes can often experience significant barriers to trying to support large scale changes in clinical practice or service models, even where there is clinical consensus on the solution. The accelerated pace of innovation we have seen during the pandemic needs to be sustained in the years ahead by empowering clinical communities to act.

In terms of the important interface with social care, local authority, third sector and independent providers face significant challenges in delivering personalised care within tight financial limits. For service users, it can sometimes result in falling between the gaps between organisations when being referred across organisational boundaries. The user experience can sometimes be disjointed and close working between sectors difficult to achieve. The interfaces between clinical or medical care and social care need to become smoother, particularly as age and frailty increase. This will require more treatments or care options which favour increased prevention and pre-emptive social support that enables and protects independent living.

3. THE FUTURE CLINICAL MODEL

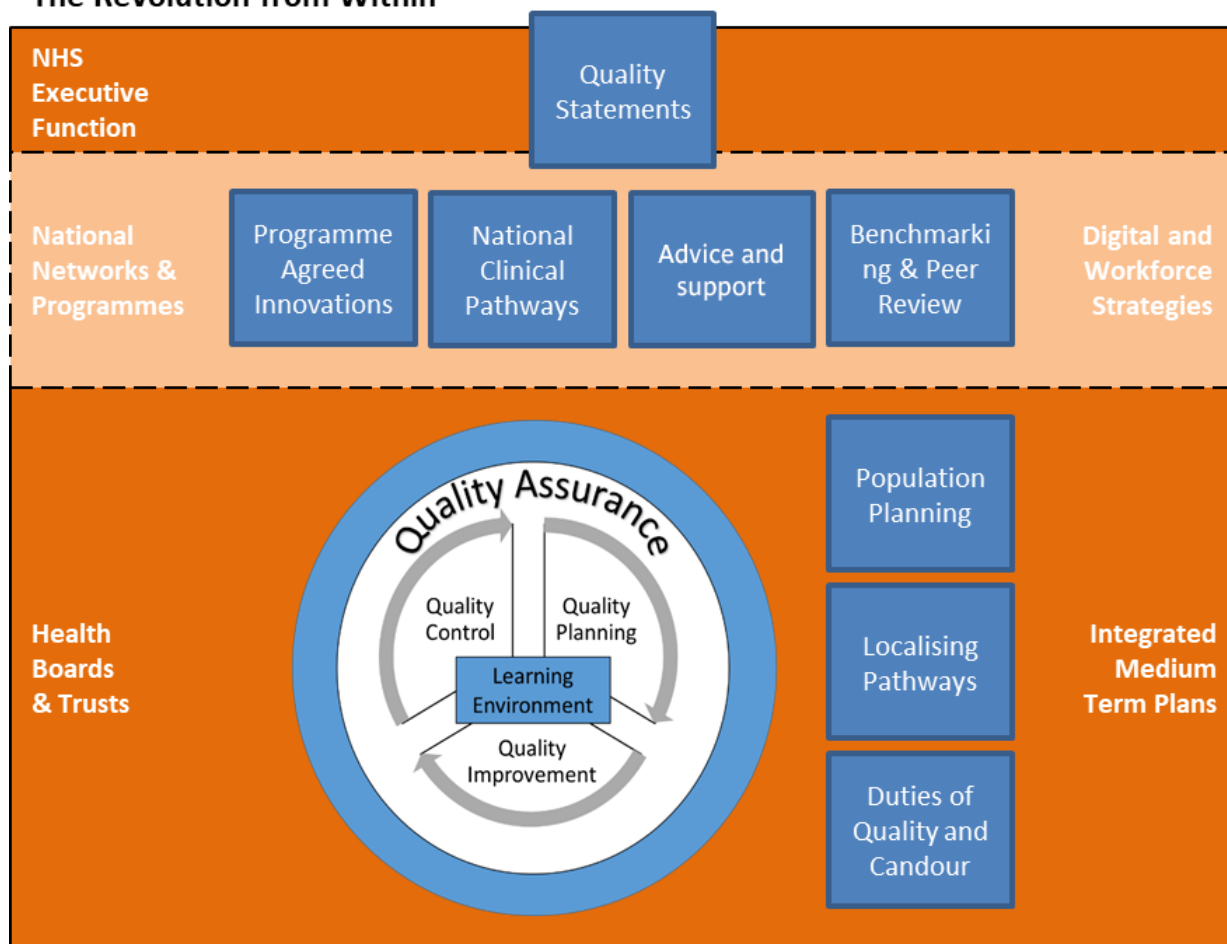
This National Clinical Framework sets out a new model of planning and delivery for clinical services. It sets out how the NHS Executive will emerge as the central guiding hand called for by the OECD and Parliamentary Review. Over time the Executive will incorporate the existing national networks, programmes and support units. It will use these components to direct, support and enable the NHS in Wales to transform clinical services in line with national priorities. It will have a significant focus on ensuring that nationally agreed service innovations and holistic pathways of care that have been developed through the collaboration of NHS bodies are then implemented. The National Clinical Framework links the Executive to other NHS bodies through its national programmes and networks. The Framework confirms the introduction of a new suite of documents to guide the development of clinical services called 'quality statements'. These quality statements will set out the vision for specific clinical services and be underpinned by more detailed service specifications. The Executive will then use data to benchmark services to support accountability discussions with the Welsh Government and support public transparency of service delivery.

The Central Guiding Hand



The National Clinical Framework also sets out how to stimulate the revolution from within called for by the Parliamentary Review. It envisages that health boards and trusts take a population health approach to planning services, grounded in the life course approach. It sets out how health boards and trusts should adopt service innovations and higher value clinical pathways in a way that fits their local context. It emphasises the importance of local organisations applying quality system methodology and the duties of quality and candour. It reinforces the need for clinical teams to embed quality assurance cycles and clinicians to adopt prudent in practice behaviours. Finally it highlights the importance of using data on what matters to patients and how the integrated healthcare system is working to guide service development.

The Revolution from Within

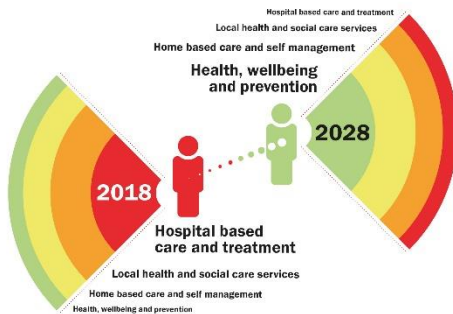


NATIONAL ACTION	LOCAL SYSTEM ACTION	PROFESSIONAL ACTION
The NHS Executive will oversee the implementation of the Framework and provide supportive interventions through its national	Local and regional plans will respond to the Framework and ensure alignment with RPBs and PSBs.	Take part in agreeing national innovations and pathways; as well as implementing them according to local context.

programmes and networks.		
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Population Health

Health boards are responsible for meeting the healthcare needs of their resident population. It is important that organisations plan their services with the principle of the life course firmly in mind. Services need to meet need across this life course, from pre-conception, maternal health and birth, through to adolescence and adulthood, as well as staying independent in older age and providing end of life care. The vast majority of a person's health and wellbeing is not determined by healthcare but wider determinants, such as housing, environment, education and employment. In taking a life course approach, the NHS can play its part via Public Services Boards in the wider partnership agenda to tackle the socio-economic determinants of health and health inequality. It must also respond to inequity of access and outcomes. Health boards may wish to consider how their clinical board structure can change to support a more holistic approach to delivering services.



A key aspect of the vision for healthcare delivery must be the shift of focus from hospital to primary and community care, a shift which makes the best use of all the professionals, providers and sectors. Primary care clusters provide a locality population footprint to better plan the integration of local community services and deliver more care closer to home. Regional Partnership Boards can bridge the gap with other community services. For care to

be delivered closer to home effectively, there must be a significant rebalancing of resources (human and financial) across the system to ensure that more can be delivered by all the agencies working in the community. The trigger for rebalancing resources should always be where it is identified that an intervention or service can be delivered in primary care with higher value than delivery elsewhere along a pathway. The resource includes funding transferred from points along a pathway, clinicians who will move out of an acute setting and the use of third sector partners. We should aim strategically for our hospital footprint to become smaller and more purposeful.

Population health is relevant to the entire clinical team - whether on a hospital, community or practice footprint - because planning how clinical services are delivered has an implication for the population waiting to access the service or needing to access it at a later date. Managing individual patient clinical risk and population clinical risk must then be balanced. We must not lose sight of meeting the clinical need of our population and not exhaust our capacity on a small portion of demand. This means when faced with the situation where demand for treatment exceeds capacity to deliver it, access needs to be prioritised according to the clinical need and service models may need to change to meet different levels of need in different ways. This should help to manage risk among those waiting but ultimately, completely new models are required to

eradicate waits and the inherent risk of harm that waiting lists tolerate. For instance, outpatient service models need to transform to risk stratify and meet that stratified risk through triage investigations, list validation, providing advice to primary care, virtual consultation, and remote follow up. Ultimately it means not doing low value work.

Some clinical services delivered by health boards can be considered fragile due to the more specialised nature of the procedure that means there are limited numbers of trained people able to deliver it all of the time and some services can only meet evolving professional standards with a larger population catchments. Health boards will need to willingly collaborate where there is a robust case for delivering services across their boundaries in the interests of the population of Wales. Some objective criteria have been set out that will support planners and clinicians to identify and make the case for service changes.

One of more of the following criteria can be demonstrated:

Criteria 1: There is evidence that the outcomes for people are significantly below comparator providers or there are significant patient safety concerns.

Criteria 2: There is no viable prospect of the service meeting professional standards and/or recommended minimum volumes of activity to maintain high standards of care.

Criteria 3: The workforce required to safely and sustainably deliver the service is not available because it cannot be recruited, developed or retained - or can only be delivered by a dependency on agency or locum staff.

Criteria 4: There is professional consensus on the merits of reconfiguring services to deliver an enhanced pathway or a new service model.

Criteria 5: There is significant public support or democratic mandate to change a service model.

In these scenarios, health boards will need to embrace service change and engage their populations in conversations about reconfiguring services. Health boards should not shy away from centralising more specialist services where this is in the interests of patient safety and outcomes. This includes moving beyond the standard district general hospital offer and not sticking rigidly to delivering elective and acute streams on each site. The centralisation of more specialised and unscheduled care services facilitated by the development of the Grange University Hospital is an example of a clinical service delivery model that has broader application among other health boards. Clinical leadership, regional health planning beyond traditional organisational boundaries, and stakeholder engagement will be fundamental to shaping sustainable service reconfiguration.

NATIONAL ACTION	LOCAL SYSTEM ACTION	PROFESSIONAL ACTION
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More robust collaborations should be enabled to plan fragile services on regional and super-regional footprints.	Health boards will plan across sector boundaries via regional health planning mechanisms and RPBs to meet population need.	Prioritise capacity and adjust delivery models to meet population need rather than demand.
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Quality and Safety

A Healthier Wales raised the profile of quality by committing to put quality above all else and committed to the development of the system approach to quality and a statutory duty for quality on NHS bodies. Through a new Quality and Safety Framework we will set out how we must address the six domains of quality: safe, effective, person-centred, timely, efficient and equitable. In order to deliver this, healthcare organisations must adopt a quality management system that is underpinned by the quality assurance cycle of quality planning, quality improvement and quality control.



A Healthier Wales also called for the introduction of Quality Statements to describe the outcomes and standards we expect to see in high quality, patient focussed services. They will set out ambitions to be delivered consistently across Wales and will inform national oversight of delivery through the planning framework and the performance management system. They will be produced by the national programmes and networks and replace strategies and delivery plans. They provide a guide to what quality attributes key clinical services should aspire to and will therefore help guide and inform the local Quality Assurance Cycle.

Quality Improvement is a local activity, supported by national standards, data and the expertise of Improvement Cymru. Once we have the relevant data to determine where care quality is suboptimal compared to peers, we are in a position to apply quality improvement approaches as part of the ongoing quality management system. By understanding our clinical pathways, we can plan changes, implement them and follow their effect. These change can then be refined further to create a cycle of ongoing learning and improvement. This has been defined as the basis for a learning health and care system.

Most healthcare harm derives from how health services are organised rather than from individual clinical practice. Practice that may seem the safest for an individual, such as a consultant seeing all patients referred from primary care, can perversely create risk for the majority by creating delay. Interfaces within complex pathways can also cause and hide harm. Therefore, having the right data on what the health system does is integral to

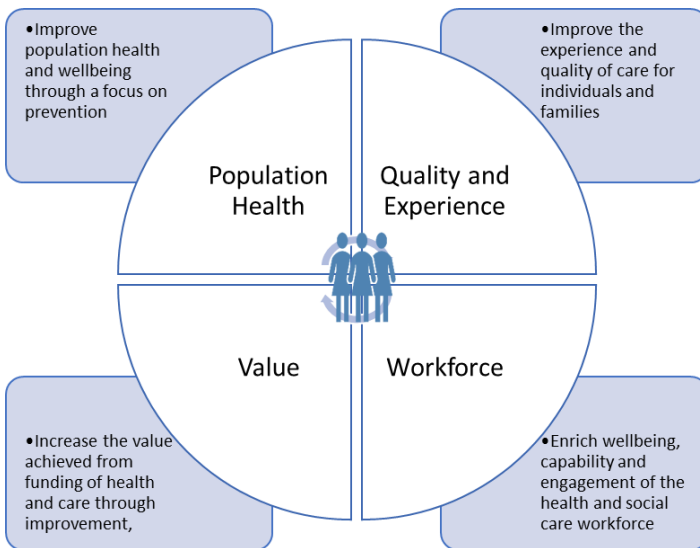
minimising the potential for harm and understanding where it is happening. Through the routine collection of clinical pathway data that work across professional and organisational boundaries we can better understand the impact of healthcare processes on whole groups of patients - such as racial or deprivation driven inequity. We can use that data to benchmark against others and to provide quality assurance or to intervene quickly when required. Robust and standard processes must then be used to identify, report and act on patient safety concerns; as well as ultimately learn and improve how our healthcare system functions. The focus on quality must be a clear Executive Board focus and this will be strengthened by the reporting requirements of the Quality and Safety Framework.

Another important aspect of quality is patient experience. Patient reported experience measures (PREMs) are an important aspect of outcomes and can act as an early alarm when something is going wrong in healthcare delivery. It is important to triangulate reported experience with quality and safety intelligence to get a more rounded picture of services. It should be possible to start benchmarking services based on patient experience.

NATIONAL ACTION	LOCAL SYSTEM ACTION	PROFESSIONAL ACTION
The development of a new quality and safety framework, and quality statements, to improve the system focus on quality of healthcare delivery.	All organisations will adopt a quality improvement system and provide annual reports on quality.	All clinical teams will implement quality improvement projects using the quality assurance cycle.

Pathways

The term 'pathway' is widely used but can have slightly different meanings. Pathways can provide a high level description of a disease process from a state of pre-disease and risk-factor development, through investigation diagnosis and treatment, towards recovery, management or end of life. The scope can also extend from community settings, encompassing self-care and independently provided high street services, to local clinics and hospitals, and through to larger centralised hospital services. These 'integrated care pathways' have been suggested in recent years as the appropriate mechanism for achieving the Institute of Health Improvement triple (now quadruple) aim. They can work as a shared understanding of what each party is aiming to deliver for the patient and thereby help to better integrate the various providers into a seamless model of delivery.



National pathways may describe health and care journeys experienced by cohorts and groups of patients based on a particular defined condition or perhaps group of conditions. As recognition of multi-morbidity increases, there will be more need to develop these broadly based approaches. Such high-level pathways encourage a system wide view starting with prevention before considering the details of diagnosis and treatment. The priority areas for

pathway development flow from the population’s burden of disease. They can be grouped under the following broad headings: cancer, cardiovascular disease and diabetes, musculoskeletal conditions, mental health, substance misuse, multi-morbidity and frailty, and infectious disease.

At this level the pathways are not specific to organisation or professional groups. This produces the opportunity for evidence based, standard approaches across Wales in ensuring equity of experience and producing equity in outcomes. By remaining agnostic of these delivery considerations, the local organisations who will then implement these national pathways will have flexibility to respond to local need and to innovate but within evidence-based parameters. Local health boards and their primary care clusters, working with regional partnership boards have the opportunity to determine how to deliver the national pathways according to their knowledge of their own area. Local organisations will understand their geography, the demographics of their population, their workforce and other factors in a much more informed way than would be possible nationally. Importantly the standards remain the same.

At an individual patient level, healthcare pathways become more detailed process maps showing how an individual patient may move through different parts of the system for the investigation, management and treatment of a condition. The ability to describe and record and publish such pathways is important in allowing both patients and clinical practitioners to understand the organisational route or possible routes ahead for management. A learning healthcare system can use continuous data collection and analysis to determine which models work best or where service need to improve. It can identify bottlenecks but also where it is possible to switch investment from low to high value interventions. At local level these pathways should be held to account based on vital clinical standards and their outcomes rather than their activity or uniformity of approach.

NATIONAL ACTION	LOCAL SYSTEM ACTION	PROFESSIONAL ACTION
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National pathways will be developed, based on evidence, with broad professional and patient input.	Health boards will localise national pathways in a way which reflects the needs of their populations and the characteristics of their workforce.	Implement and continuously improve how local pathways are delivered.
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Prudent and Value Based Healthcare

Prudent healthcare is becoming increasingly well-known and used at national and health board level but more needs to be done to embed it in clinical decision making. The individual day-to-day clinical decisions made across Wales will ultimately determine the overall outcomes for patients but they also have a significant impact on the sustainability of the NHS. Healthcare delivery costs are being driven upwards by the ongoing development of new technology and advances in treatment options. Healthcare can do more and more but funding cannot keep pace with these developments and resources always appear insufficient to meet need.



The healthcare system needs to learn to live within the available funding by reorienting its resource towards the interventions that offer the highest value. The emphasis should be on quality of life and what matters to the patient. It is not about rationing care but providing the best care possible to the population with the resources available to the system. In future, we need to foster more opportunities to understand what matters to the patient and to regularly check the patient's wishes have not changed. It is also important that this co-production of care is whole pathway, and not confined to very specialist parts of the pathway. There is increasing recognition of

the place for rehabilitation, early therapeutic intervention and self-management, group consultations and interventions, as well as other options such as social prescribing and community support groups. Local organisations will need to allocate resources across the life course and within pathways to achieve value based healthcare.



There is a body of research showing that overtreatment and over diagnosis produces real harm to patients. It is important that our focus on pathways does not drive patients into interventions that are not in their interests or are unlikely to deliver the outcomes

they want. It is not uncommon for patients to experience decision regret or in the benefit of hindsight have preferred an alternative treatment response. It is an approach which is gaining traction internationally, through approaches such as Slow Medicine in Italy or Realistic Medicine in Scotland and by professional bodies such as the BMA's Too Much Medicine and the American Medical Association's Less is More. A variant of this in Wales is the Choosing Wisely campaign, which encourages clinicians to have meaningful conversations about the benefits, risks and alternatives of treatment decisions, including doing nothing. All these types of endeavors are covered by the principles set out in Prudent and Value Based Healthcare. In order to make this a reality for our patients, clinicians need to be supported nationally and locally to deliver care that is prudent in practice.

NATIONAL ACTION	LOCAL SYSTEM ACTION	PROFESSIONAL ACTION
National programmes and clinical networks design higher value interventions.	Local organisations re-allocate resources to higher value interventions.	Change clinical practice to deliver higher value interventions.

Outcome measures

Relatively little clinical outcome data is routinely collected and used to inform service delivery. Most NHS services are planned and held accountable according to process measures, such as activity and waiting times. A major reason why outcome measures have not been used more comprehensively in the past is because defining them and collecting them has been incredibly difficult. In recent years, there has been increased interest and work in this area linked to International Collaboration of Health Outcome Monitoring (ICHOM).

The development of Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) are important opportunities to understand the patient's perception of symptoms, treatment, rehabilitation and its outcomes compared to their priorities and experience. It can be used directly as part of the patient's care to guide decision making or more generally as aggregated data to support service improvement. PROMs may even be able to support a more individualised service that can better triage referrals, deliver remote follow up or guide when to intervene in those patients who are not able to self-manage their chronic condition. PROMs can also be used more broadly at population level to understand differences in health between groups, monitor general health over time and changes in response to population level interventions, as well as to assess the burden of disease and provide a basis to plan and develop services to meet population need.

Providing timely access and high levels of service productivity will always be important in healthcare delivery but this new approach attempts to adjust the balance away from activity and toward outcomes that matter to patients. It is also an important means of combating the bias in patient selection involved in trials that often does not extrapolate well to the population more broadly. Considerable work is required to ensure that through PROMs we are collecting the correct outcomes, are able to collect them routinely and at scale, and to embed their use in health service planning and

benchmarking. The early development of PROMs in Wales has identified significant technological and behavioural barriers to collecting and using the data. Substantially more time and resource will be required to resolve these and broaden the use of PROMs throughout the health system and then embed their use. Nonetheless, the early adopters have benefited from the aggregated data collected and used this to inform service improvement in the cataract surgery and joint surgery pathways. Experience in the Netherlands and some Scandinavian countries is also starting to show significant benefit. The utilisation of PROMs is a vital tool of delivering prudent in practice healthcare.

NATIONAL ACTION	LOCAL SYSTEM ACTION	PROFESSIONAL ACTION
Enable the development of PROMs capability and capacity.	Make greater use of PROMs in planning and managing pathways	Use PROMs where available to guide patient management.

4. THE ENABLERS

Clinical Networks

Clinical networks can have a variety of formats, ranging from informal ad hoc meeting of a particular specialty through to managed networks that commission services. The role of clinical networks in this Framework is the facilitated bringing together of all the clinical communities, NHS partners and our patients to set out the high level, national pathway for the relevant service or condition. This model will build upon the work of the NHS Collaborative's existing clinical networks; although these presently only cover a small number of conditions and tend to focus on more specialist end of the disease specific treatment pathway. The participation, remit and number of clinical networks will be different in the years ahead and enable the development of comprehensive national pathways. At present, the existing cancer and heart disease networks are an important basis from which to build in line with this Framework's focus on the main burdens of disease facing the population.

Guided by a suite of Quality Statements, clinical networks will create consensus on high value, comprehensive clinical pathways based on evidence-based practice and co-production. The networks will not duplicate the specific highly specialised standards set by professional bodies apply them and fused them together with the wider requirements of the pathway. The network will play a vital part in monitoring the pathway and outcome data to support local benchmarking and accountability arrangements. This will be necessary to ensure that local delivery meets the standard and outcome expectations set in the national pathways and also to encourage innovation, quality improvement and spread of good practice.

The development of clinical networks with broad health and care professional representation will require strong representation and a recognition in job descriptions of those professionals. Significant time will need to be allowed for important work in relation to service planning and improvement. Although consultant medical staff have

some time allocated in their job plans to undertake such activity it is not the case for many of the other professional groups. This will need to change, initially through paid leadership roles but in the longer term as part of contractual professional development for all clinical staff.

NATIONAL ACTION	LOCAL SYSTEM ACTION	PROFESSIONAL ACTION
Clinical networks will reform and align to the population's burden of disease, using standards and data to develop and monitor national clinical pathways.	Provide the local pathway data and engagement with the pathway setting process.	Participate in the clinical networks

National Programmes

There are several national programmes that have been established to provide greater central direction and to support the local transformation of services. These programmes serve a vital national requirement for investigating systemic service challenges, developing solutions at scale, supporting service transformation, and providing assurance of equity of service offer across Wales. These national programmes have a vital role to play in making this Framework a reality. The Programmes are there to support equity of service offer and local change with additional resource and expertise.

The strategic programme for primary care is focusing on supporting health boards to develop sustainable and more integrated primary and community care models. It includes six work streams: prevention and wellbeing, a 24/7 model, data and technology, workforce and organisational development, communication and engagement, and transformation and the vision for clusters. In addition, the planned care programme has been developed to help hospital based services to achieve a better balance of capacity and demand. It includes programmes to transform outpatient services and also the redevelopment of service models in very large volume specialist services such as orthopaedics, ophthalmology and urology. Similarly, the national programme of unscheduled care supports health boards to agree what good looks like when accessing emergency departments. This will include work to agree care standards and a nationally agreed model of care to enable optimisation of clinical outcomes and patient and staff experience.

There are also a number of national approaches built around diagnostic care, such as the imaging, pathology and endoscopy programmes. The programmes exist in recognition of the challenges facing these services and the need to work together to deliver transformational change in how these services are delivered. Precision Medicine is an increasingly important capability that will support multiple clinical pathways but requires strategic direction to keep pace with innovation. Some other vital services may emerge as Ministerial priorities that require strategic direction and support, such as rehabilitation, maternity and neonatal care, and critical care.

Finally, the End of Life Care Programme exists in recognition that while everyone dies, not everyone gets a good death. It is human nature to want to do all that is possible to prolong life and to avoid difficult discussions of what people really value in the context of their death. A sensitive but more realistic approach to dying is required and the health system needs to enable these discussions with families. Most people would prefer not to spend their remaining time having aggressive and sometimes futile healthcare interventions, attending hospital appointments or being in hospital when they die. Indeed, it has been shown that good palliative medicine may actually prolong survival. It is important to support people to have a dignified death and that people's wishes are understood in advance to avoid inappropriate escalations of care in the heat of the moment. It is also important to support people's spiritual needs, both faith-based and non-faith based. Involvement of palliative medicine in the treatment of patients happens often but ultimately this is the business of almost all clinicians. It is important that they are much more familiar and comfortable with the language around the end of life conversations.

NATIONAL ACTION	LOCAL SYSTEM ACTION	PROFESSIONAL ACTION
The national programmes will realign to support the Framework described.	Local health organisations will engage in the national programmes.	Inform and deliver outputs of the national programmes.

Workforce Strategy

A core element of the Parliamentary Review and *A Healthier Wales*' Quadruple Aim is to deliver an inclusive, engaged, sustainable, flexible and responsive workforce. It is in recognition that the healthcare workforce is the NHS's most precious resource. The NHS needs to recruit, train and retain the right staff to be able to meet the future burden of need. Several clinical workforce challenges stand out: finding and funding sufficient workforce to deliver our clinical pathways, the consequences of ever greater specialisation and the risk of over medicalising the response to patient need.

All public sector services have staffing challenges. These challenges can be felt quite acutely in healthcare, where standards of professional input and rota cover provide objective means of demonstrating any deficiency. Yet the NHS workforce has increased significantly in recent decades. With the ability to do more and greater expectations of service quality, comes an inexorable need for more staff capacity. Although the workforce is likely to continue to grow, it will not always do so in a way that can keep pace with demand. This challenge is complex and the system response has been set out in the Health and Care Workforce Strategy.

Some key aspects in relation to the development of clinical services are the need to fill essential gaps and vacancies. Health Education and Improvement Wales is developing its workforce intelligence to support NHS bodies with their workforce planning, to identify the specialty groups that are most pressurised and to deliver targeted programmes to develop staff. GP recruitment campaigns, targeted uplifts in specialty training places and novel interventions such as the Imaging Academy are helping to create a more sustainable workforce in key areas. Some of this specialist need can also

be met and capacity created by staffing groups focusing on only doing only what they can do (i.e. working at the top of their license) and through the development of advanced practice among key allied staffing groups (e.g. advanced practice nurses, paramedics and health scientists).

Alongside the uplifts in capacity and the targeted interventions will be a need to consider the impact of specialisation and the importance of multi-disciplinary working. Specialisation improves outcomes for very specific interventions and this will be an important part of future healthcare delivery. But it reduces the pool of staff that can meet the growing need for multi-morbidity management and in particular the burden of frailty resulting from our ageing population. The correct balance and institutional value needs to be placed on providing general practice and general medicine based services. Related to this is the issue of over-medicalising need and the potential to meet need in different, more appropriate ways. That can be done by better integration of non-medical professionals through multi-disciplinary approaches and services led by nurses, midwives, pharmacists or Allied Health Professional; as well as forging closer working relationship with social services and third sector partners. When developing clinical pathways, networks need to ensure they are making the most of all the available capacity and all the available skills to meet the growing and complex needs of the population. Job planning and roles will need to become more flexible to support different modes of healthcare delivery, work across internal boundaries, and recognise the need to provide advice to colleagues and share responsibility for managing patients in other settings.

Running alongside all this work to create the right capacity, in the right place, is the need to stimulate clinical leadership. Clinicians are often powerful advocates for improving service models and outcomes. This can come from their professional insight and passion for improvement. We need to harness and support this, helping to channel it into the right internal processes and external collaborations to achieve meaningful change through the quality assurance cycle. It will always be important to make this a shared endeavor between patient, clinician and manager to ensure innovation achieves system benefit (i.e. higher value) and does not just exacerbate the system's challenges.

NATIONAL ACTION	LOCAL SYSTEM ACTION	PROFESSIONAL ACTION
Strategic targeting of training to meet future burden of disease.	Make the most of all clinical disciplines to deliver more sustainable workforce models.	Local pathways will be implemented in a way that supports clinicians to work at the top of their license.

Digital Strategy

Individual and population level healthcare outcomes are the result of complex systems of care, involving multiple teams and specialties, delivered across multiple levels of care and across organisational boundaries. In order for healthcare to be seamless, safe and efficient it needs to be supported by integrated digital systems. The NHS is going through a prolonged, expensive and complex digital transformation as set out in the Informing Healthcare and Informed Health and Care strategies. Ultimately the goal is to

develop an interface of systems that constitutes a digital health record for the patient. The development of common underpinning systems and the adoption of common standards that permit inter-operability are supporting the healthcare system to move in this direction. This is demonstrated by the ability to access all clinical documentation and test results across the primary and secondary care system, anywhere in Wales. However, there is still much further to go to enable healthcare pathways to become fully digital in both processes and record. The ability for clinicians to more quickly find, understand and add to the clinical record before them will enable better decision making, reduce harms and avoid wasted resources. Digital approaches will also support transformative models care, from virtual consultation, to patient activation and remote follow up.

Given the complexity of modern healthcare systems, it is not just the ability to achieve one version of the truth for that patient that determines outcomes. It is also the aggregated or cumulative sum of the healthcare interactions that counts. Healthcare leaders need to understand how their healthcare system is functioning in order to guide service improvement and avoid systemic harms emerging. In order to do this we need standardised, high quality data. The improved system-wide availability of clinical records captured as documents is an important enabler of integrated care but it does not solve the difficulty of accessing data to monitor and plan services because documents are not data. The development of existing clinical data sets used to understand care quality and outcomes is often achieved by expensive, slow and limited capacity to re-enter data from written records into spreadsheets for one-off uses. The future will be about data captured once at the point of care in a format that can be re-used endlessly across the healthcare system to support quality improvement. The development of the National Data Resource (NDR) heralds a step change in the NHS's ability to automate collection, provide timely and comparable data, link organisational data sets, and represent them to any part of the system that legitimately needs it to guide service improvement. An analytic capability is required to turn the data into knowledge and academic partners will help enable the shift from counting activity to understanding meaningful outcomes.

The NDR can bring together the data needed to better plan and monitor services. It will also allow risk-stratification of patient populations to better target interventions and to shift resource in the pathway to higher value interventions. It provides the means to populate service dashboards that can be used at network level to benchmark services and inform planning and accountability discussions. For each patient it has the potential to fuse their healthcare data and make it accessible to them and for them to add to it directly through patient devices and apps.

Digital systems need significant investment and a new approach to their implementation as highlighted by the Welsh audit office and the Public Accounts Committee. The digital architecture review of 2019 describes a way forward under the leadership of the new body Digital Health and Care Wales.

NATIONAL ACTION	LOCAL SYSTEM ACTION	PROFESSIONAL ACTION
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Establish Digital Health and Care Wales and publish a revised Digital Health and Care Strategy.	Development of the national data resource and service specific dashboards, fusing together data on delivery to support service change.	Use service dashboards and other digital tools to plan and deliver services that can better meet need.
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5. FRAMEWORK SUMMARY AND IMPLEMENTATION

The Framework must now be brought to life through the behaviours that we exhibit at national and local levels. It will guide our approach to the recovery of NHS services in the context of the pandemic and help to ensure we do not return to business as usual. We can capitalise on the strengths of our small, integrated health system to make the most of the opportunity before us to transform clinical services.

We already have many of the tools to guide us, including our prudent and value based principles, and our national enablers, such as the approach to networks and our national programmes, all orientated towards delivering higher value pathways and interventions.

Through our planned healthcare system we can move the delivery of our clinical services in a more sustainable direction. With one long term vision for clinical services we can pull in the same direction and harness our collective efforts.

This Framework has a number of system behaviours set out that will be taken forward through the next layer of approaches, such as the planning framework and approach to quality. But it also speaks directly to the clinician, to the service manager, and to everyone else involved in the planning and delivery of clinical services.

Its message is don't wait to be told. This Framework is your permission to act.