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Transforming unscheduled care and chronic conditions management

Abertawe Bro Morgannwg University Health Board

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Status of report

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Context

1. It is widely recognised that many parts of the Welsh health and social care system are under considerable pressure. The current situation is unsustainable because these services continue to face excessive levels of demand against a background of constrained financial resources and there is now an urgent need for service transformation and whole system change.

2. The need for change has been apparent for some time. In 2003, the Review of Health and Social Care Services in Wales identified the need for radical redesign for health and social care services and for greater capacity of services outside the hospital setting. A number of subsequent Welsh Government policies, alongside the 2009 reconfiguration of the NHS, provide the building blocks to achieve this change. Setting the Direction sets out a strategic delivery programme for primary and community services in NHS Wales. It describes the pressures that Welsh hospitals experience, which include the large number of emergency admissions and delays in discharging patients who are ready to leave hospital. The programme states that one of the causes of elevated pressures in hospital is that, historically, the health service has gravitated services and patients towards hospital, thus restricting the sustainability and effectiveness of community services.

3. The programme argues for a need to rebalance the whole system of care away from an over-reliance on acute hospitals and towards greater use of primary and community services and an increased focus on preventive approaches. Such a change would have the benefit of reducing the demand on acute hospitals but importantly, it would benefit patients. Currently, too many patients are treated in hospital when they would be better cared for in the community.

4. If health boards are to succeed in implementing these more sustainable models of care, two of the vital and interrelated service areas that must be transformed are chronic conditions management and unscheduled care[1]. It is vital to transform these two areas because:

- **The impact of chronic conditions is growing in Wales.** One-third of the adult population in Wales, an estimated 800,000 people, report having at least one chronic condition, such as diabetes, emphysema or heart disease.
  This proportion is higher in Wales than the other constituent countries of the United Kingdom. The prevalence of chronic conditions increases with age and given that Wales's population of over 65s is projected to increase by 33 per cent by 2020, the burden of chronic conditions on the system is likely to grow.

[1] The Wales Audit Office defines unscheduled care as any unplanned health or social care. This can be in the form of help, treatment or advice that is provided in an urgent or emergency situation.

- **Unscheduled care services are some of the most pressurised parts of the health and social care system.** The Welsh Government's 2008 *Delivering Emergency Care Services* strategy stated that unscheduled care services face ever-increasing demand. We estimate that there are more than eight million contacts[2] with unscheduled care services in Wales every year, with associated use of resources implications.
- **The areas of chronic conditions management and unscheduled care are crucially interrelated**. People with chronic conditions tend to be frequent users of the unscheduled care system because when their conditions exacerbate, they often need to access services in an urgent and unplanned way.
  Moreover, people with chronic conditions are twice as likely to be admitted to hospital than patients without such conditions. Transforming chronic conditions services and helping more individuals to self care has huge potential benefits for unscheduled care services.

5. The Wales Audit Office has previously carried out a large body of work on chronic conditions and unscheduled care. In December 2008, the Auditor General published *The Management of Chronic Conditions by NHS Wales,* which concluded that too many patients with chronic conditions were treated in an unplanned way in acute hospitals, community services were fragmented and poorly co-ordinated and service planning and development were insufficiently integrated.

6. In December 2009, the Auditor General published *Unscheduled Care: Developing a Whole Systems Approach*. The report highlighted a range of problems resulting in a lack of coherence in the operation of the unscheduled care system. The report also concluded that against the backdrop of the severe pressures on public funding, there would have to be radically new ways of delivering unscheduled care services and support.

7. More than two years since the publication of this body of work, the Wales Audit Office undertook follow-up audit work on chronic conditions and unscheduled care in NHS bodies across Wales. This work, considered progress against our previous recommendations but also aimed to provide insight into the barriers and enablers affecting progress. As there are a number of key interrelationships between chronic conditions and unscheduled care, the work has been delivered as a single integrated review. One of the key enablers that we have focused on is clinical engagement, given its crucial importance in delivering the service transformation that is required. Fieldwork at the Health Board was undertaken in 2012.

[2] This number of contacts includes approximately 285,000 calls received by the Welsh Ambulance Services NHS Trust, approximately 790,000 contacts with NHS Direct Wales, approximately 980,000 attendances at hospital emergency departments, approximately 530,000 calls answered by primary care out-of-hours services, and approximately 5.5 million urgent primary care appointments during normal working hours.

8. Abertawe Bro Morgannwg University Health Board (the Health Board) covers three local authority areas: Swansea, Neath Port Talbot and Bridgend. Over a quarter (27 per cent) of lower supra output areas are among the most deprived fifth in Wales and lifestyle indicators reported in the Welsh Health Survey are generally worse than, or similar to, the Wales average. Almost one in four adults smokes, less than a third of people meet recommended physical activity levels, more than half than population is overweight and alcohol and drug use is more common than for Wales as a whole[3].

9. In addition to these factors, which affect the general health of the population, the prevalence of chronic conditions increases with age. Over the next 20 years the number of people of pensionable age in the Health Board area is expected to increase by around a quarter. In the current economic climate, the projected increase in the economically and care-dependent population poses particular challenges for the Health Board, which faces continued cost pressures and the need to make year-on-year savings in the order of six per cent over the next five years.

10. The Health Board's five-year strategy 'Changing for the Better' recognises the importance of rebalancing care so more can be delivered nearer to people's homes, closer working between primary care and hospitals, and less reliance on hospitals unless patients really need to be there. These principles are reflected in the Health Board's aims for developing unscheduled care and chronic (or long-term) conditions services:

- To develop a 24/7 healthcare system to increase the amount of unscheduled care taking place in the community and primary care settings, while providing good-quality, timely care to patients who need to attend an emergency department.
- To integrate the development of community networks, specialist community resource teams and signposting of services to improve the care for individuals with long-term conditions. This will help reduce the demand placed on hospital services.

Our main findings

11. Our review considered the following question: 'Is the Health Board securing the transformation that is necessary to create more sustainable models of care that reduce demand on the acute sector and provide better services for patients, specifically through the key interrelated areas of chronic conditions management (CCM) and unscheduled care?'

12. We concluded that the Health Board is reshaping community services but resource and capacity planning and stakeholder engagement are not yet effective enough to support reduced demand on acute services and sustainable improvements in performance.

[3] Abertawe Bro Morgannwg University Health Board: *Director of Public Health Annual Report*, September 2012.

13. The table below summarises our main sub-conclusions.

Part 1 - The Health Board has taken steps to increase community service provision but not enough demand has been diverted from pressurised acute services

1a. Emergency departments remain under significant pressure and there are issues with performance and patient flow

- Emergency departments continue to experience high workloads while attendances at minor injury units are declining
- Patients brought to hospital by ambulance constitute a major part of emergency department demand, with an increase in conveyances to Morriston and a rise in the number of Category A calls
- Increased attendances and emergency department staffing are causing workload pressures
- Despite a period of improvement, emergency department waiting-time performance falls short of the four-hour target
- Many patients arriving at the emergency department by ambulance wait too long for handover to hospital staff
- The Health Board has taken actions to improve patient flows but the impact on performance against targets is yet to be seen and joint working between the emergency department and the rest of the hospital is not fully effective

1b. The rate of emergency admissions for a range of chronic conditions has improved but progress on reducing multiple admission rates, lengths of stay and delayed transfers of care has been mixed

- Emergency admission rates for a number of chronic conditions have reduced.
- There has been mixed performance for reducing multiple admissions and lengths of stay for chronic conditions.
- Delayed transfers of care present a continuing challenge despite actions taken to improve the discharge planning process.
- The Health Board is working on a number of fronts to reduce avoidable referrals and emergency admissions from primary care although there is a lack of confidence in the information available to support GPs in reviewing their referral and admission profile.

1c. There has been positive progress in extending the range of community services and developing out-of-hours primary care but more needs to be done to reduce reliance on acute services

- The range of community services which support people with chronic conditions has increased and although there is more to do, plans to increase the capacity and capability of community resource teams are progressing.
- Access to primary care is generally good and out-of-hours services appear to be working well, but the capacity and expertise that already exists within core primary care hours may not be being used to their optimum.

Part 1 – The Health Board has taken steps to increase community service provision but not enough demand has been diverted from pressurised acute services

1d. Marketing has had no apparent impact on demand for unscheduled services, progress on developing a single point of access has been slow and more people could benefit from patient education programmes

- The Health Board has engaged proactively to inform the public but marketing work has so far had no apparent impact on people's use of unscheduled care services.
- Progress on developing a communications hub has been slow due to a range of national and local barriers.
- Progress in establishing patient education programmes, information and support networks has been positive and needs to be sustained.

Part 2 – Sustainable improvement depends on better resource and capacity planning across all localities and settings and effective stakeholder engagement on the future hospital network

2a. The Health Board is developing its strategic approach but cannot be clear about its vision and workforce planning until the future network of hospital services is decided

- Setting the Direction and Changing for the Better have been key drivers for transforming services for unscheduled care and chronic conditions but need to be supported by more detailed and joined-up implementation locality plans.
- National and regional decisions about the future network of hospital services are vital before the Health Board can intelligently plan the future of its unscheduled care and chronic conditions services.
- Better capacity planning is vital to address a number of key risks around the unscheduled care and chronic conditions workforce.

2b. Good structures for implementing Setting the Direction have been set up but strategic oversight of unscheduled care improvements and focus on measures of quality and whole system performance can be further improved

- Effort in putting together governance infrastructure should set the Health Board in good stead although scope exits to strengthen arrangements for driving unscheduled care improvements and alignment with actions targeted at chronic conditions management.
- To ensure robust performance management, the Health Board needs to do more to focus on measures of quality and whole system performance.

2c. The Health Board is committed to staff engagement and partnership working and must build on this to achieve necessary service transformation

- Clinical leaders are in place and engagement with staff and GPs is very positive, but particular challenges remain in respect of emergency departments and securing transformational change.
- The Health Board is committed to working in partnership and building on these foundations will be essential to securing sustainable improvements and service transformation.

Recommendations

14. Since our fieldwork, the Health Board has continued to take action to build community service capacity and improve unscheduled care systems and performance. The Health Board reports progress having been made in a number of areas in 2013-13 (summarised in Appendix 14), but recognises that this has not led to sustainable improvement and achievement of the unscheduled care standards. A detailed unscheduled care improvement programme is in place for 2013-14, recognising Ministerial and Welsh Government expectations for a whole system response, and cross-referencing actions to the national Unscheduled Care Programe workstreams established in 2013[4]. The Health Board also recognises that linkages exist between the unscheduled care improvement actions and the plans being progressed by the Western Bay Health and Social Care Programme.

15. The Health Board's 2013-14 unscheduled care improvement programme includes an extensive and complex set of actions intended to bring about whole system improvement. The Health Board has identified a number of actions to be completed in 2013-14 but achieving the whole-system changes intended will require sustained focus beyond 2013-14. The Health Board will need to prioritise actions and keep them under close review, so that momementum is maintained. The Health Board has secured external support from September 2013 to review current plans and ensure sustainable improvement results.

16. The improvement areas identified from this review are set out in the table below, under the themes of the current Health Board Improvement Programme. Given the range and complexity of actions for the Health Board, we support integration of actions arising from this review into the existing Health Board improvement programme. The programme actions include the broad improvement issues identified in this report, but the Health Board will need to consolidate some aspects into the improvement actions.

[4] The national Unscheduled Care Work Programme agreed by Chief Executives, identifies 10 project areas that need to be embedded as appropriate in local Unschedled Care Improvement Plans.

Pre-hospital pathway

Minimising avoidable Emergency Department attendances / emergency admissions, including, working with:

- The ambulance service to design/implement appropriate alternative pathways.
- GPs to improve the ways in which data on practices' referral and admission rates are used to manage down avoidable referrals/admissions.

Optimising the role of primary care - in-hours and out-of hours, including:

- Expanding the range of options available to GPs to support them in preventing avoidable admissions eg, hot clinics and rapid access diagnostics.
- Optimising same day access to primary care by considering improvement work based on the principles set out by the Primary Care Foundation.
- Ensuring value for money is secured from enhanced services for extended opening.
- Considering the cost/benefit of further integrating the out-of-hours primary care service with its existing emergency department services.
- Expediting the roll out of the Individual Health Record to ensure patient information is widely available to unscheduled care clinicians across the Health Board.

Influencing the way in which the public uses services, including:

- Improving the way in which patients are 'directed' to the most appropriate service through the development of the communications hub and single point of access.
- Ensuring the messages from Choose Well are more widely understood and have the impact of influencing people's access behaviour.
- Continuing to redirect patients from emergency departments where more appropriate alternative services exist and considering agreeing/reserving a set number of GP appointments for patients being redirected to primary care.

Supporting individuals to self-care, including:

- Increasing the number of patient education programmes to meet Ministerial expectations, whilst maintaining/improving attendance and completion rates.
- Measuring the impact of patient education programmes on supporting people with chronic conditions, as well as the numbers of individuals completing the course.

Emergency Departments

Managing workforce, workload and models of working in emergency departments:

- Reviewing the workforce to ensure staffing levels are sufficient to provide safe high quality care and causes of poor staff morale are addressed.
- Ensuring effective triage and assessment models are in place in all departments and the lead nurse role is filled at the Princess of Wales emergency department.
- Agreeing the emergency nurse practitioner model needed at both emergency departments.
- Putting in place an action plan for meeting the College of Emergency Medicine guidelines on consultant staffing.
- Strengthening escalation processes.

Emergency Departments

Managing ambulance handovers at emergency departments to minimise delays, and ensuring that:

- The patient handover process strikes an appropriate balance between speed of handover and quality of care/patient safety.
- Handover times are recorded accurately.

Optimising patient flows through the emergency department, including:

- Securing greater support for the emergency department from the in-house specialty teams to ensure timley responses and senior decision making for emergency department patients.
- Reviewing purpose, capacity and relationships of clinical decisions and assessment units with emergency departments and whether they operate in a sufficiently integrated way.

In-patient flow and discharge support

Optimising patient flows in the acute hospital:

- Improving discharge planning and patient review proceseses to minimise delays in the transfer of care.

Effective management of services

Strengthening performance monitoring and management, including:

- Extending performance measures to include patient outcomes and experience.
- Monitoring and managing the average waiting time in emergency departments, as well as performance on the four-hour waiting time target.
- Prioritising improvements to the emergency department information system (Myrddin).

Enhancing strategic planning and oversight:

- Establishing a Health Board wide unscheduled care group and ensuring greater central oversight of locality-based plans.

Partnership working:

- Agreeing a set of outcomes that all partners intend to achieve for citizens who require unscheduled care or have a chronic condition.

Capacity plans

Planning capacity and the community workforce

- Develop capacity plans for the required in-patient capacity and bed equivalents, to safely and efficiently manage demand.
- Strengthen the approach to workforce modelling to understand the workforce required to deliver new models of care (and the necessary training).

Detailed report

The Health Board has taken steps to increase community service provision but not enough demand has been diverted from pressurised acute services

17. Across Wales, demand for hospital services is high with increasing numbers of emergency department attendances and emergency admissions. Managing demand is about ensuring patients receive the right care, in the right place, at the right time. Where demand is poorly managed, hospital services tend to experience increased pressure, which may impact on operational efficiency and effectiveness. This section of the report discusses the progress that the Health Board has made in recent years to transform its chronic conditions and unscheduled care services to help reduce demand on the acute sector by developing out-of-hospital services, supporting self-care and helping signpost patients to the services which are most appropriate to their needs.

Emergency departments remain under significant pressure and there are issues with performance and patient flow

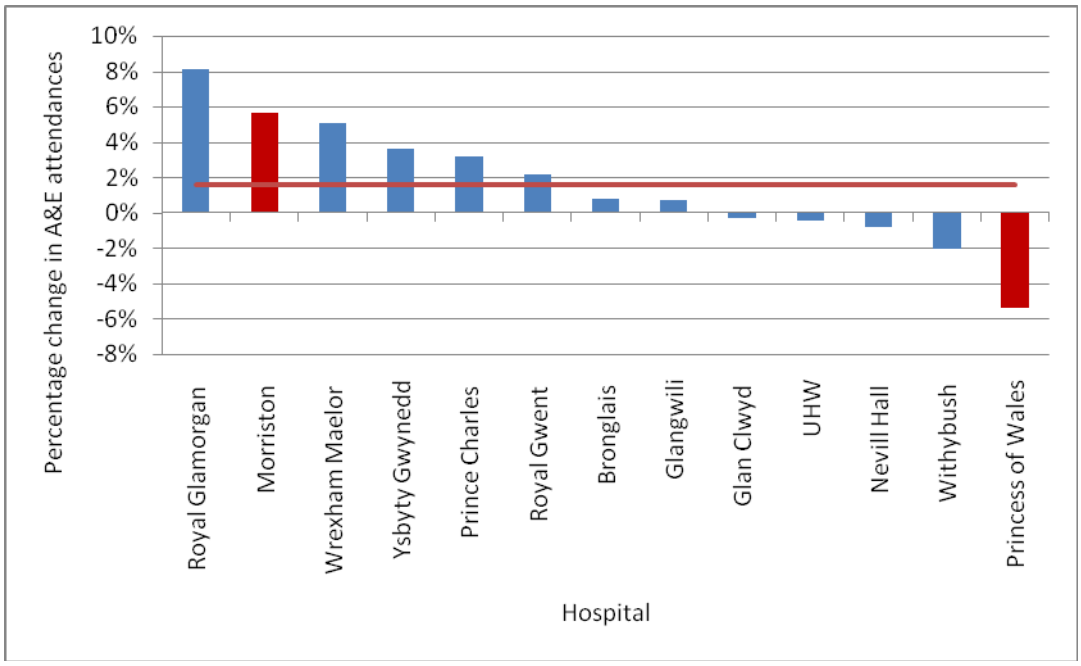
Emergency departments continue to experience high workloads while attendances at minor injury units are declining

18. There are roughly 2,000 attendances at major accident and emergency (A&E) departments[5] each day across Wales. The Welsh Government's *Delivering Emergency Care Service*s strategy highlighted a year-on-year increase in the number of patients attending hospital emergency departments. As well as the general upward trend in demand, emergency departments can also face sharp peaks in activity that, if not managed effectively, can result in congestion within the department and a slowing down in the provision of care to patients.

19. Between 2010 and 2011, there was a small rise (1.6 per cent) in the total number of attendances at major emergency departments across Wales (see Appendix 1). During that period, attendances at the Health Board increased 0.7 per cent. Exhibit 1 shows that at Morriston Hospital attendances increased by 5.7 per cent but decreased by a similar proportion at the Princess of Wales Hospital (5.4 per cent).

[5] Major A&E departments are available continuously 24 hours a day to provide the resuscitation, assessment and treatment of acute illness and injury in patients of all ages.

Exhibit 1. Percentage change in A&E attendances between 2010 and 2011



Source: Wales Audit Office analysis of A&E attendances derived from StatsWales [statswales.wales.gov.uk].

20. Exhibit 2 shows that over the longer term attendances at the Health Board's major emergency departments increased by three per cent between 2009 and 2011. Meanwhile, demand at the Health Board's 'other'[6] emergency departments decreased by 12 per cent. Overall, attendances at all the health boards' emergency care facilities reduced by less than one per cent. This suggests that the Health Board's 'other' or minor emergency departments had not taken demand away from the major departments.[7]

[6] These data include Singleton Minor Injuries Unit and Neath Port Talbot Local Accident Centre.

[7] During 2012-13, and following our fieldwork, the Health Board reports that total attendances have not increased significantly. The introduction of Advanced Paramedic Practitioners and new pathways with the Welsh Ambulance Service Trust (WAST) are reported to have reduced attendances by 1,500 since the autumn of 2012. However, attendances of patients over 65 years of age have increased within the total number of attendances.

Exhibit 2. Long-term trend in demand at hospital emergency departments

The figure shows the number of attendances at the Health Board's hospital emergency departments between 2009 and 2011.

	2009	2010	2011
Major A&E departments	**138,258**	**141,396**	**142,326**
Other A&E/minor injury units	**48,857**	**45,110**	**42,833**
Total for all emergency care facilities*	**187,115**	**186,764**	**185,287**

*** The figures for major and minor attendance do not always sum to the total for all emergency care facilities. The frequency with which hospitals/units submit data on attendances differs. The Welsh Government produces a combined figure for all facilities to take account of these differences.**

Source: Wales Audit Office analysis of attendances at emergency departments derived from StatsWales [statswales.wales.gov.uk].

Patients brought to hospital by ambulance constitute a major part of emergency department demand, with an increase in conveyances to Morriston and a rise in the number of Category A calls

21. Approximately one-quarter of patients attending A&E departments across Wales in 2010-11 arrived by ambulance (Appendix 2) [8]. At Morriston Hospital, 29 per cent of attendees arrived by ambulance, the second highest proportion in Wales, while 22 per cent of attendees at Princess of Wales arrived by ambulance (second lowest proportion in Wales). The high proportion of patients arriving by ambulance is contributing to the pressures in the Morriston emergency department. The difference in the proportion of patients arriving by ambulance at Morriston and Princess of Wales seems to support the perception (described by staff) that the emergency department at Morriston is the default destination for ambulance conveyances.

22. Emergency department staff perceive that demand is being managed in a disjointed way, with ambulances conveying a disproportionate number of patients to the Morriston department when it is already under significant pressure. This may partly explain the rise in attendances at Morriston in recent years. The need to close Neath Port Talbot Hospital to emergency medical admissions will also have impacted on demand at Morriston.

[8] These data do not include the University Hospital of Wales and the Royal Glamorgan Hospital. Data were not available at this time.

23. At the time of reporting, the ambulance service had analysed the data on conveyances to both hospitals. Data for the first five months of 2012 show that the number of Swansea residents conveyed to Morriston reduced by four per cent compared with the first five months of 2011. However, there has been a 43 per cent increase in ambulance conveyances to Morriston Hospital for Neath Port Talbot residents in the first five months of 2012 compared with the same period in 2011. The rise is attributed in part to the decision to minimise the number of ambulances diverted to Neath Port Talbot Hospital given difficulties ensuring adequate cover from medical staff. Conveyances of Bridgend residents to the Princess of Wales also showed marginal reductions for the first five months of 2012 compared with 2011. Although the overall number of ambulance conveyances may be reducing, the number of conveyances to Morriston has risen, and the total conveyances categorised as Category A (life threatening) is increasing at both hospitals[9].

24. In 2010-11, nearly half (45 per cent) of the patients arriving by ambulance at Princess of Wales Hospital did not require primary or secondary care follow-up, whilst at Morriston a smaller proportion (15 per cent) of patients did not need follow-up. These represented the second highest and second lowest figures in Wales[10]. These data suggest that there may be scope to reduce the number of patients conveyed to hospital via ambulance, particularly at Princess of Wales. The Health Board should work with the ambulance service to see if there are opportunities to manage demand for ambulance services more effectively.

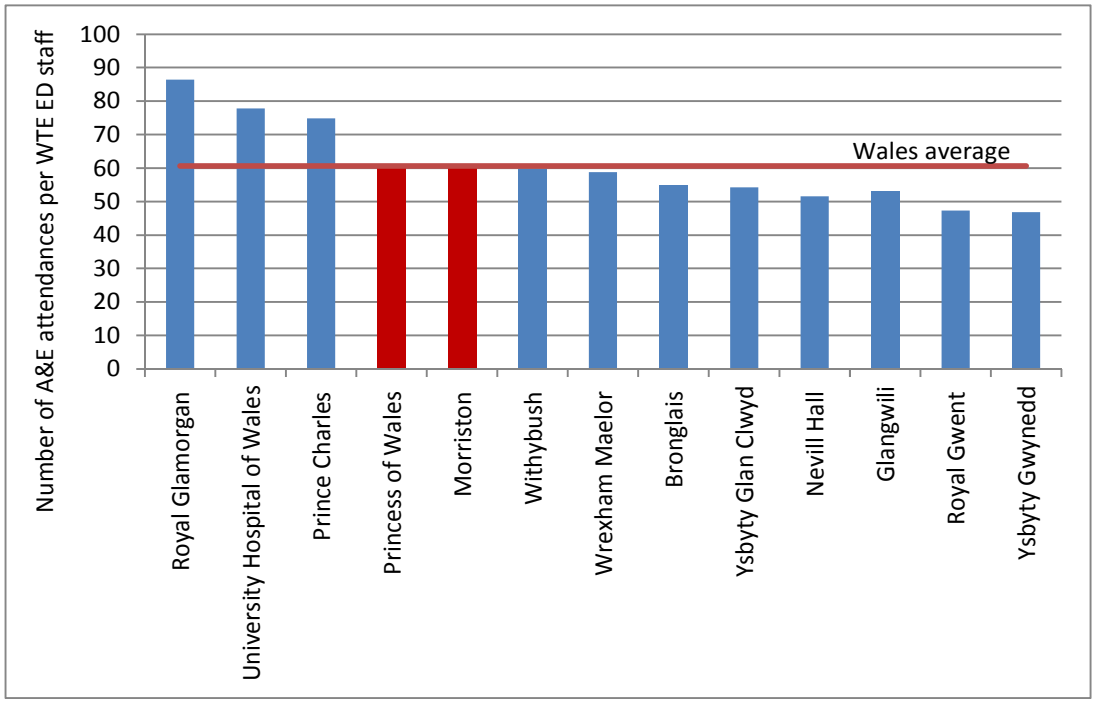
Increased attendances and emergency department staffing are causing workload pressures

25. In November 2011, workload pressure, measured as attendances per (whole-time equivalent (WTE) staff (all medical and nursing staff), was just above the Wales average (58.3) at the major departments. Attendances per WTE staff at the Princess of Wales Hospital and Morriston Hospital were 60.9 and 60.8 respectively (Exhibit 3). Meanwhile, attendances at the minor departments were higher than the Wales average (878.5 per WTE), with attendances per WTE staff member at Singleton Hospital more than double the Wales average (Exhibit 4).

[9] Since our fieldwork, the Health Board reports that data for 2012-13 shows an increase in ambulance demand, both in terms of the number of ambulance arrivals (11.3 per cent) and clinical acuity of calls (15.8 per cent increase in Category A arrivals).

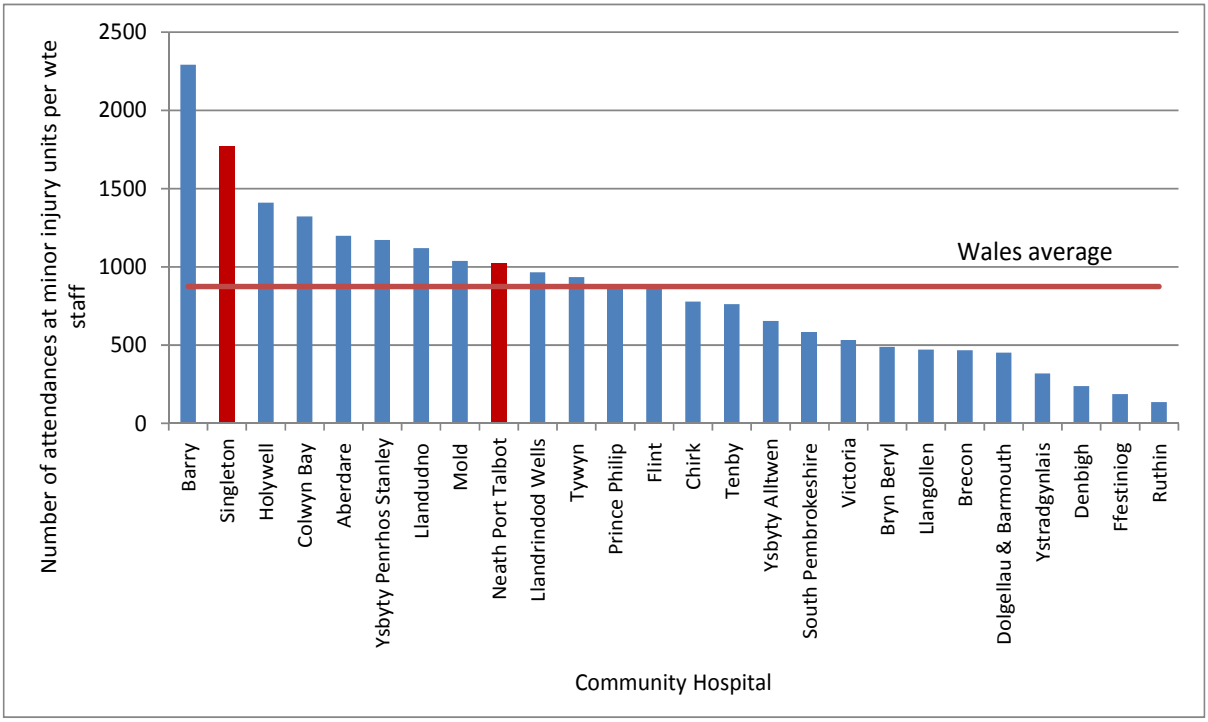
[10] These data do not include the University Hospital of Wales and the Royal Glamorgan Hospital. Data were not available at this time.

Exhibit 3. Number of attendances at major emergency department in Wales per WTE A&E staff (including locum medical staff) in November 2011



Source: Wales Audit Office analysis of workforce data provided by health boards in November 2011; data on A&E attendances in November 2011 derived from StatsWales [statswales.wales.gov.uk].

Exhibit 4. Number of attendances at minor emergency departments and minor injuries units per WTE staff in 2010-11

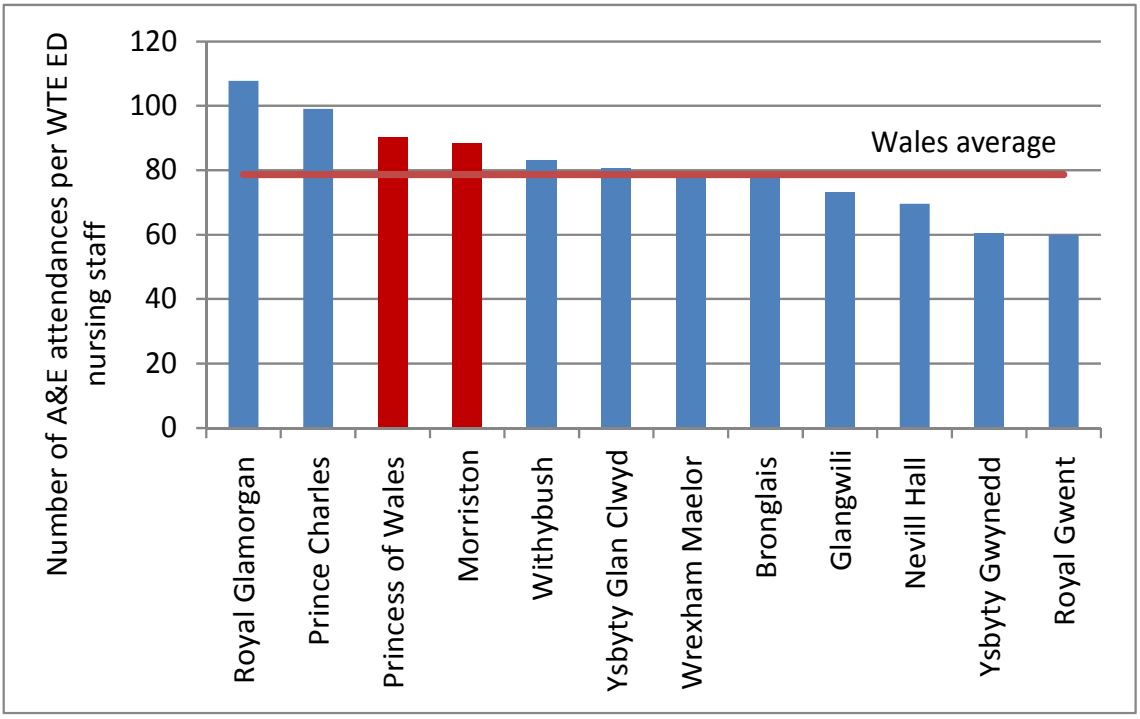


Data on workforce and number of attendances are not available for Ysbyty Cwm Rhondda.

Source: Wales Audit Office analysis of data collected from health boards in November 2011; workforce data relate to staff in post in November 2011 while data on attendances relate to 2010-11.

26. Exhibit 5 shows the total number of attendances at major emergency departments per WTE nursing staff across Wales in November 2011. Attendances per WTE nursing staff at Princess of Wales and Morriston were above the Wales average (78.9). This suggests that nurse staffing levels may be lower than needed given current levels of activity although both emergency departments have increased the numbers of nursing staff over the last three years (Exhibit 6). Staff at Princess of Wales described nurse staffing levels as 'frightening' at times, in particular, the lack of a triage nurse for the minors' stream. This lack of a triage nurse means that there is greater reliance on the receptionist to prioritise patients. When we visited the Princess of Wales emergency department, we found that receptionists had a brief guidebook to help them to identify patients with urgent clinical needs but they had not received any formal training to fulfil this role.

Exhibit 5: Number of attendances at major emergency departments in Wales per WTE nursing staff in November 2011



Workforce data are not available for University Hospital of Wales.

Source: Wales Audit Office analysis of workforce data provided by health boards in November 2011; data on A&E attendances in November 2011 derived from StatsWales [statswales.wales.gov.uk].

Exhibit 6: Change in the numbers of nursing staff deployed at major emergency departments

Hospital	Pay bands	WTE number of nursing staff	
		At March 2008	At November 2011
Morriston Hospital	1 to 4	0	9.05
	5 to 9	51.65	67.05
Princess of Wales Hospital	1 to 4	0	9.20
	5 to 9	40.23	44.40
Total		**91.88**	**129.7**

Source: Wales Audit Office analysis of workforce data provided by health boards in November 2011.

27. The College of Emergency Medicine now recommends that every accident and emergency department should have at least 10 emergency medicine consultants to provide up to 16 hours' 'on-site shop-floor' cover seven days a week[11]. The hours of cover at Morriston Hospital and the Princess of Wales Hospital do not meet the college guidelines (Appendix 3). Princess of Wales had good shop floor coverage from consultants (9 am to 9 pm at weekdays and weekends) compared with other departments in Wales but coverage had reduced by one hour each day since our work in 2007-08 when consultants were available between 8 am and 9 pm.
Morriston Hospital had cover from 9am to 5pm on weekdays and 9 am to 4 pm on weekends. Further, the Health Board finds it difficult to fill the middle-grade rota to ensure 24-hour cover in the department. Addressing senior decision maker presence is a key factor in managing patient flows and the Health Board needs to address this as a priority.

28. The WTE number of consultants at Morriston's and Princess of Wales' emergency departments has increased since our work in 2007-08[12] but the increase is still not enough to meet the college guidelines (Appendix 4). The Health Board is committed to try and meet college guidelines and it has indicated that it is seeking to appoint another two consultants at Morriston.

[11] College of Emergency Medicine, *Emergency Medicine Operational Handbook, The Way Ahead*, December 2011.

[12] Between 2007-08 and 2010-11, the number of WTE consultants at Morriston increased from 3.7 to 6.9 WTE and at Princess of Wales, the number increased from 3 to 4.2 WTE.

29. The National Unscheduled Care Board's June 2011 document *Ten High Impact Steps to Transform Unscheduled Care* states that health boards should assess the percentage of time that senior clinical decision makers are actually on the shop floor compared with planned coverage. The Health Board has assessed shop floor coverage by senior clinical decision makers at Morriston Hospital but not at Princess of Wales Hospital.

30. Medical staff vacancies were low at the Health Board's major emergency departments and there were no nursing vacancies at Princess of Wales Hospital (Appendix 3 and Appendix 4). However there was a seven per cent nurse vacancy rate at Morriston Hospital's emergency department. This compares with a four per cent rate across Wales. Such vacancies add to the pressure experienced by staff in post.

31. Our fieldwork highlighted issues relating to poor morale within the emergency departments, and most notably at Morriston, where the department was undergoing major redevelopment to improve capacity and facilities during 2012. The sickness absence rate at Morriston ranged from 15 per cent to 20 per cent during winter 2011-12 and, acknowledging that workload pressure and stress were likely to be contributing factors, managers were taking some specific improvement actions. At the time of our fieldwork, a stress management hypnotherapist was due to carry out stress management sessions with staff and the Health Board was employing a clinical educator to address lack of training and development as another cause of low morale.

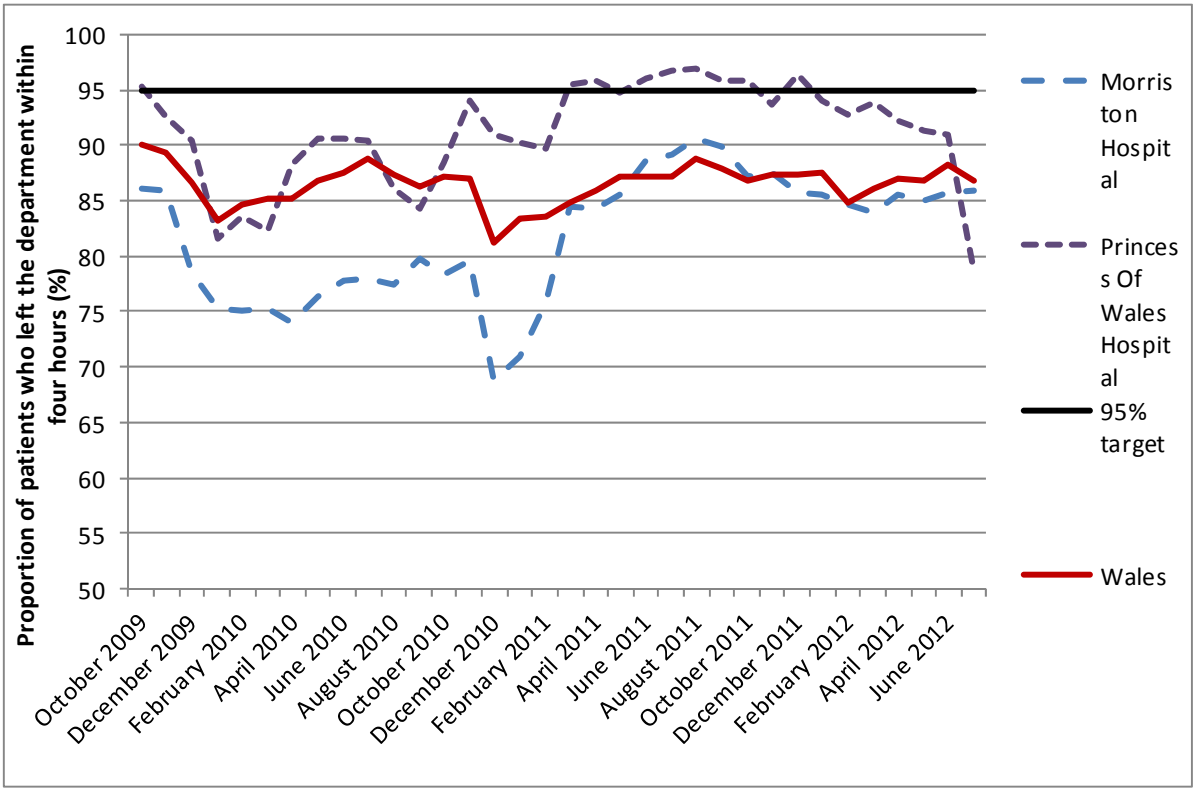
Despite a period of improvement, emergency department waiting time performance falls short of the four-hour target

32. To ensure patients receive rapid assessment and treatment, hospital emergency departments have been set a national target of ensuring at least 95 per cent of their patients spend no longer than four hours in the department from arrival until admission, transfer or discharge and that 99 per cent spend no longer than eight hours.

33. Performance against the four-hour waiting time target at Morriston Hospital has been consistently poor since October 2009 (Exhibit 7). In 2010, the emergency department was placed under special measures because of its continued poor performance. In March 2011, performance matched the Wales average for the first time in 18 months. During early 2011 there was a period of improvement at both of the Health Board's major departments and while the pattern reflects the all-Wales trend there has been deterioration since summer 2011[13].

[13] Since our fieldwork, the Health Board confirms that performance against the four-hour standard deteriorated during 2012-13. The report to the Board, Setpember 2013, shows that at 90.4 per cent the Health Board is not meeting the 95 per cent national 4 hour target, with Princess of Wales performance at 90.65 per cent and Morriston at 85.4 per cent.

Exhibit 7. Trend in proportion of patients who spend less than four hours in the emergency department from arrival until admission, transfer or discharge



Source: Wales Audit Office analysis of data on A&E attendances derived from StatsWales [statswales.wales.gov.uk].

Note: From December 2011, the Welsh Government changed the way in which breaches to the waiting time targets are counted. If it is clinically appropriate for patients to remain within the emergency department for longer than four hours, this is no longer counted as a breach. The Y axis is truncated.

34. With any target there is a risk that in seeking to meet the required performance level, health organisations will focus less on other important aspects of care. With the four-hour target, there is a risk that health boards focus too much on the four-hour threshold at the expense of looking more broadly at the timeliness of their care. For this reason we requested information from health boards on their average waiting times in hospital emergency departments.

35. Across Wales, individuals attending emergency departments are waiting longer before leaving the department (Appendix 8). Patients attending Morriston in 2007-08 spent, on average, 138 minutes in the department (arrival to departure) compared with 198 minutes in 2010-11. The average time spent in the Morriston department was the

second highest in Wales. At the Princess of Wales the increase was more modest with the average time spent in the department rising from 110 minutes in 2007-08 to 117 minutes in 2010-11. This was one of the lowest in Wales.[14]

Many patients arriving at the emergency department by ambulance wait too long for handover to hospital staff

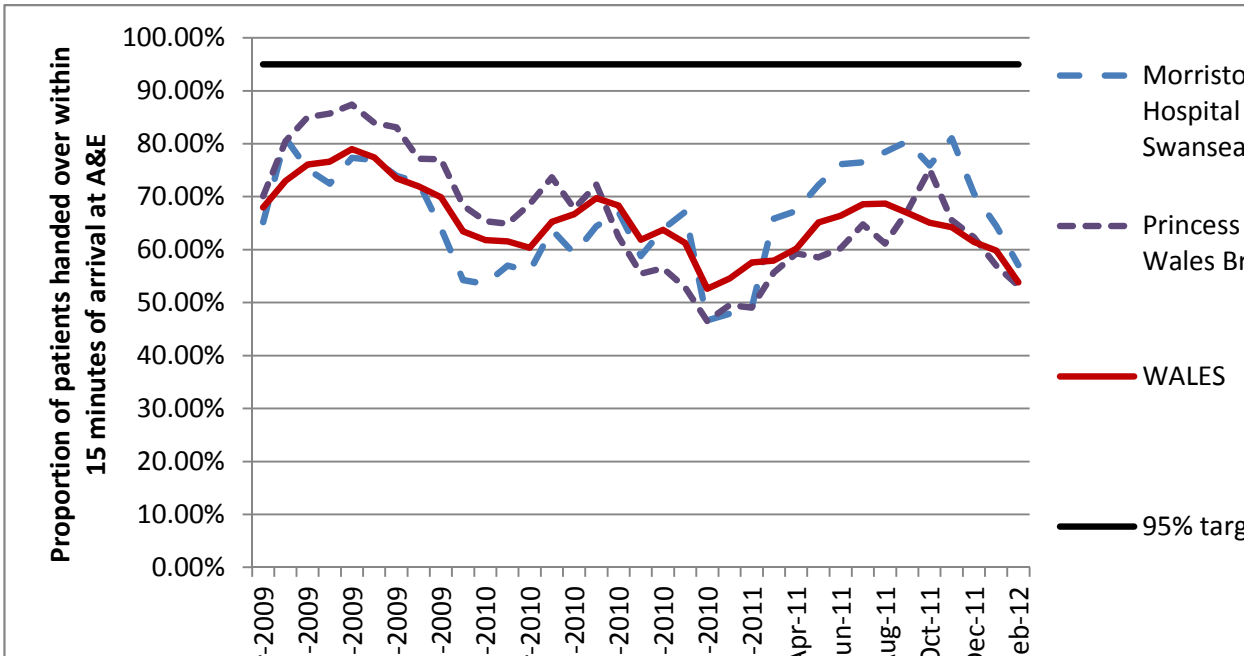
36. When emergency departments experience elevated pressures, this can delay the handover of patients from ambulance crews to hospital staff. Such delays have detrimental impacts on patients who often await medical attention in the back of an ambulance or on trolleys in hospital corridors. These delays also affect the ambulance service's ability to respond quickly to other emergency calls. The Welsh Government introduced a 15-minute handover target in April 2008. More recently, the Welsh Government's *Delivery Framework for NHS Wales for 2011-12* sets out the minimum expectation that 95 per cent of all cardiac arrest, stroke and major trauma patients will be handed over within 15 minutes while continuous improvement in handover performance is expected for all patients.

37. The handover period starts from when ambulance crew notifies the A&E staff they have arrived with a patient. The period ends when the ambulance crew transfer the patient's clinical care to the A&E staff. Exhibit 8 shows that handover performance (while reflecting the all-Wales pattern), consistently falls below the 95 per cent target[15].

[14] No data were available for Royal Glamorgan or University Hospital of Wales.

[15] Data reported to the Board for June 2013, identify that at 66 per cent, the Health Board fell short of the 15 minute ambulance handover target.

Exhibit 8. Trend in proportion of patients handed over within 15 minutes of arrival in the emergency department



Source: Wales Audit Office analysis of data provided by the Welsh Ambulance Services NHS Trust.

Note: Y axis truncated.

38. During our interviews and visits, staff told us that managing patient handovers was a corporate priority. Staff said patient handovers were being given much more attention by senior management and operational staff were more aware of the importance of rapid handovers. Other improvements involved more regular communications with the ambulance service and alert emails to senior Health Board managers whenever ambulance handovers are delayed. However, some ambulance staff raised concerns (Box 1) that emergency department staff, on occasions, use the ambulance arrival screens to register that a patient handover is complete when it is not. Other ambulance staff expressed concerns that the pressure on beds in the emergency department, and the pressure on staff to complete handovers quickly, can be a distraction from ensuring clinical information is exchanged safely and comprehensively during the handover (Box 2). The Health Board should ensure its staff are using the data screens appropriately. If handovers are recorded as completed sooner than in reality, this masks poor performance and prevents the Health Board from identifying occasions when patients may have had a poor experience. The Health Board should also review the effectiveness with which clinical information is exchanged at handover, to ensure that elevated pressures are not to the detriment of patient safety and continuity of care.

Box 1. Examples of the concerns about the handover process expressed by paramedics that we interviewed during fieldwork visits to the Health Board's A&E departments

- 'Nurses record that the patient handover is complete whilst the patient is still on [the ambulance] trolley.'
- 'Handover times are not recorded accurately because A&E staff complete the handover process too early.'
- 'Data terminals are not an accurate representation. Nurses handover on terminals too early, ie, before handover.'
- 'Stop hospital staff from completing handover on the data terminals before the patient is handed over in order to beat the target. The patient can still be on the [ambulance] trolley….. There is a knock on impact on WAST timing, control think crews are ready to go when they are not.'
- 'Nurses update screens with handover time whilst patients are still on the [ambulance] trolley. The response time is more important and more relevant. After that, patient care is more important than handover times.'
- 'Crews are met quicker now. However, patients are checked out on data terminal before handover.'

Source: Wales Audit Office interviews with ambulance crews at Princess of Wales and Morriston emergency departments.

Box 2. Some paramedics said that the high pressures in the emergency department can act as a distraction to effective handover of clinical information

- '…seen quicker by the triage nurse but sometimes the triage nurse may deal with the handover too quickly, they do not get a chance to speak properly with ambulance crew.'
- 'Handovers are quicker but not necessarily better for patients. Triage nurses are seeing too many patients too quickly.'
- 'Sometimes more time is needed in the handover process particularly when a patient has come in without friends or relatives and needs reassurance, and to build up rapport with the ambulance crew.'
- 'Nursing staff try their best but patients are losing out as rushed into hospital, seen quickly by the nurse and then there are still no beds. Management and patient care seems to be more about managing a clock.'
- 'The focus on handover time does not lead to better clinical outcomes. Sometimes triage nurses are too focused on handover times and focus on moving a patient into a bed rather than listening to paramedic explain the patient's condition.'
- 'Patient handover is not important for patient care. But is important for the LHB. Focus needs to be on patient care.'
- 'Timing of handover not important, clinical outcomes more important.'
- 'Should focus on the patient, not the handover time.'

Source: Wales Audit Office interviews with ambulance crews at Princess of Wales and Morriston emergency departments.

39. Appendix 9 shows that at the time of our fieldwork, the ambulance hours lost at Morriston Hospital (above the 20 minutes allowed for ambulance handover) were consistently within the worst performing emergency departments in Wales.

The Health Board has taken actions to improve patient flows but the impact on performance against targets is yet to be seen and joint working between the emergency department and the rest of the hospital is not fully effective

40. Our fieldwork found that both major emergency departments were struggling to ensure good patient flows, with both departments susceptible to congestion. We were told that at Morriston, there was no apparent correlation between attendance numbers and four-hour performance, suggesting that outflow of patients from the department, and not just front door demand, is a main determinant of waiting time performance.

41. The health board has taken several actions to improve the flow of patients from the emergency department including:

- Ensuring there is a greater managerial presence in Morriston emergency department. The onsite manager has been based within the department in the evenings with a view to managing patient flows by facilitating discharges and transfers.
- Staffing changes at Morriston's emergency department. These changes have included a small increase in the number of emergency nurse practitioners (ENPs), an additional middle grade doctor overnight and the introduction of a triage nurse for the majors' stream.
- Capital investment to expand the Morriston emergency department, with scheduled completion for summer 2012. It provides a large expansion of the department with two additional triage rooms, an area for rapid assessment of arrivals by ambulance and a larger children's emergency department with its own waiting area and a larger general reception area. The improvements to the internal layout should help to improve patient flows within the department although with current leves of emergency demand, we are told that capacity within the department is still under pressure.
- The use of 26 available beds on one ward at Morriston Hospital to provide extra capacity to deal with the peak in medical admissions during the winter in 2011-12. However, we were told that when the beds reverted back to their normal use, bottlenecks occurred within the emergency department. Subsequently, the Health Board has continued to provide surge capacity (26 beds in Morriston and 13 beds in Princess of Wales.

42. Despite these actions, there is widespread recognition that patient flows remain problematic. Without solutions to these problems, the expansion at Morriston risks becoming a larger holding bay for patients who need to be admitted.

43. Of particular concern is the relationship between the emergency departments and other key departments within the hospital. For example, at both departments, but particularly at Morriston, we were told that in-house specialty teams could do more to

provide sufficient timely support for the emergency department. Although there has been a recent example of effective collaborative working between an emergency department and speciality clinicians, this was a specific response to manage a significant level of demand which threatened business continuity at the Morriston department. However, slow responses from in-house specialty doctors to requests for assessments within the emergency department are in general seen as problematic by emergency department staff.

44. The Health Board has set up clinical interface meetings in an effort to encourage greater ownership of unscheduled care from the in-house specialties and better dialogue between the emergency department and the in-house specialties. These meetings appear to have been limited in their effectiveness and an Unscheduled Care Board is now being established.

45. Another concern is the apparent strained relationship between the Morriston emergency department staff and the clinical decisions unit. We were told that these relations are strained, partly due to the workload and competing pressure for beds in order to admit patients. This is an area where we feel the Health Board should carry out further work to assess and improve the extent of the problem.

46. There is considerable scope to improve the functioning of clinical decision units (CDUs) at both major sites. Whilst we were told that the introduction of the CDU at Morriston in 2011 had been a largely positive step, it appears that there are particular problems with the functioning of the medical side of the CDU. Staff described that unit acting as an additional ward, rather than a short stay unit, partly due to infrequent ward rounds and subsequent infrequent discharges. We were told that there was a need for much more detailed care pathway documentation, including clear, strict protocols that define the specific actions that should be taken for patients with specific conditions.

47. Similarly, we were told that the CDU and other elements of the front door model at Princess of Wales were not functioning well. We were told that the CDU was used too frequently as a stepping stone to admission, rather than as a unit for assessment with a view to discharging patients. There also appears to be large scope for improvement in the functioning of the ambulatory care unit. This is frequently used as an overspill area for emergency department patients awaiting admission. Furthermore, its opening hours are restricted to 9 am to 5 pm Monday to Friday, which does not match its pattern of demand. There is a need to do work to increase the number and effectiveness of ambulatory care pathways.

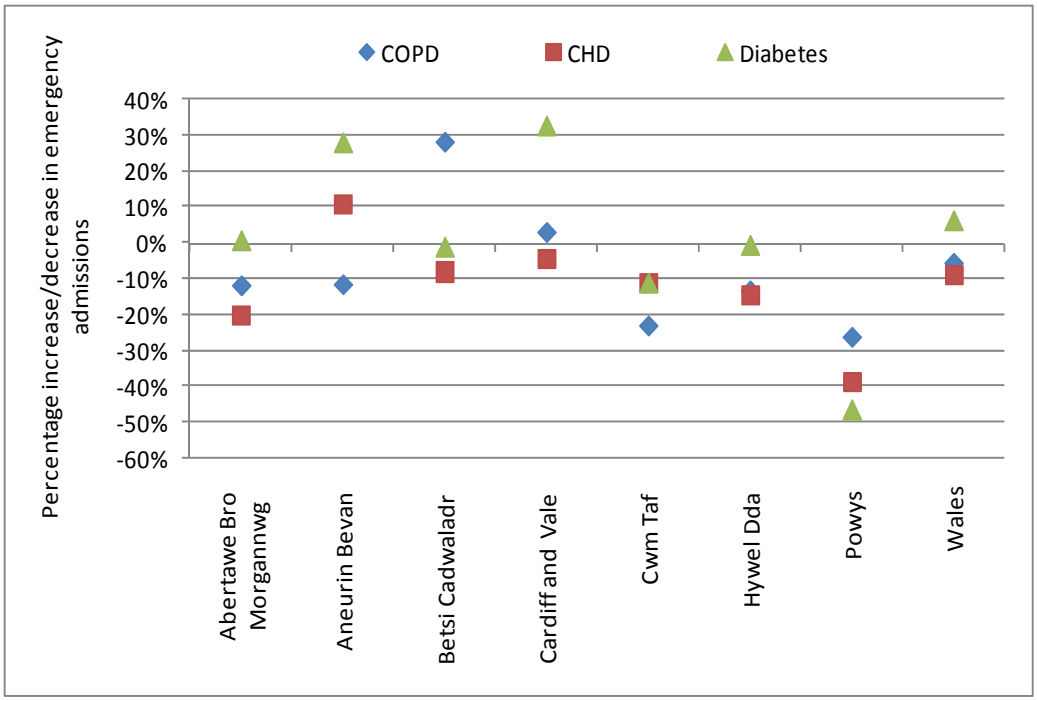
The rate of emergency admissions for a range of chronic conditions has improved but progress on reducing multiple admission rates, lengths of stay and delayed transfers of care has been mixed

Emergency admission rates for a number of chronic conditions have reduced

48. The Welsh Government's CCM model and framework signalled a need to rebalance services on a whole-system basis and providing more care in community settings. One of the key aims of the CCM model and framework was to reduce the number of avoidable emergency admissions and readmissions, and ensure that lengths of stay were not excessive. Achieving this will help ensure that acute sector resources are used more appropriately, and support a more efficient 'flow' of patients through the hospital. Problems at a ward level caused by high emergency demand, long lengths of stay and delayed discharges can also have a knock-on effect on the transit of patients through the emergency department.

49. Since the start of 2007-08, NHS bodies have been expected to achieve reductions in admissions for chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD) and diabetes. Over the last five years, the number of emergency admissions for COPD and CHD fell across the NHS in Wales by six per cent and nine per cent respectively. However, the number of emergency admissions for diabetes increased by six per cent (Exhibit 10). The Health Board's performance is better than the average for Wales and they have seen significant decreases in admissions for COPD and CHD, while there has been no change in the emergency admissions for diabetes. There has also been a downward trend in the number of emergency admissions for a range of other chronic conditions, such as asthma and angina.

Exhibit 10: Percentage change in the number of emergency admissions for Health Board residents due to chronic conditions between 2006-07 and 2010-11



Source: Wales Audit Office analysis of the Patient Episode Database for Wales.

There has been mixed performance for reducing multiple admissions and lengths of stay for chronic conditions

50. NHS bodies are expected to reduce the multiple admission rate ie, the proportion of repeat admissions, to 14.6 per cent or less and the average length of stay to 5.7 days or less for these three chronic conditions. Performance against these targets is measured on a rolling 12-month basis (the performance reported for any single month therefore representing the average over the previous 12 months rather than the in-month performance). Appendices 6 and 7 show that the Health Board's performance over the last five years has been mixed. In summary:

- the multiple admission rate and average lengths of stay for COPD are relatively unchanged over the last five years;
- the multiple admission rate for CHD continues to fall and is below target, however, lengths of stay have risen; and
- the multiple admission rate for diabetes remains above target while lengths of stay have redcued below target.

Delayed transfers of care present a continuing challenge despite actions taken to improve the discharge planning process

51. Timely transfer and discharge arrangements are important in ensuring that hospitals effectively manage emergency pressures. If discharge arrangements are not effective, patients can experience a delayed transfer of care and spend too long in hospital. This can pose risks to their independence, as well as prevent flows of patients from the emergency department to the wards. The Welsh Government's *Delivery Framework for NHS Wales for 2011/2012*, includes a Tier 2 target of continuing to improve performance in relation to delayed transfers of care.

52. The Health Board has taken a number of actions to improve the discharge planning process. In summary:

- There has been some progress towards ensuring in-house specialist teams carry out ward rounds early in the day to improve a patient's chance of being discharged earlier. However, this practice is not widespread or consistent and is made more difficult when patients are outliers in other speciality beds.
- The Health Board has convened multi-agency 'length of stay meetings' to discuss patients that could be discharged, and these meetings have focused on unblocking difficulties with discharge.
- The Health Board is trying to embed the estimated date of discharge (EDD) system but there are difficulties setting realistic EDDs. Improving the accuracy of EDDs would contribute to more realistic expectations and ensure that all staff involved in planning for discharge are working towards the same goals. We also found that some wards are recording the EDD on the white boards, that are used in clinical areas. This visible cue prompts staff to focus on the targeted discharge date.

53. The Health Board has specialist nurses that are tasked with facilitating discharges at both of its major acute sites. Discharge liaison nurses, who specialise in complex discharges, and the specialist interface nurse have been co-located at the Princess of Wales Hospital, which appears a positive step to enhance joint working. The recent departure of the district nurse liaison from Morriston Hospital presents a challenge to the Health Board as the liaison nurse played an important role in facilitating discharges and improving joint working with community services.

54. Exhibit 9 shows that whilst the extent of delayed transfers of care within the Health Board reduced consistently between 2006-07 and 2009-10, there was an increase in 2010-11. This was true of the number of patients experiencing delays and the number of bed days lost as a result of these delays. The major cause of the increase between 2009-10 and 2010-11 was due to a 96 per cent increase in the number of patients who experienced a delay because of 'social care reasons'.

Exhibit 9: Trend in the number of patients experiencing a delayed transfer of care from acute and community facilities (excluding mental health facilities) at the Health Board

	Number of patients experiencing a delayed transfer of care	Number of lost bed days	Average lost bed days per patient
2006-07	835	47,329	56.7
2007-08	820	52,205	63.7
2008-09	699	45,447	65.0
2009-10	613	40,995	66.9
2010-11	693	42,740	61.7

Source: Data provided by NHS Wales Informatics Service

55. The trend in delayed transfers of care varies by unitary authority area. Appendix 10 show that between 2005-06 and 2010-11, the number of lost bed days generally increased in Bridgend, whilst in Neath Port Talbot and Swansea, performance has varied but the total number of lost bed days in 2010-11 remains similar to that in 2005-06.

The Health Board is working on a number of fronts to reduce avoidable referrals and emergency admissions from primary care although there is a lack of confidence in the information available to support GPs in reviewing their referral and admission profile

56. Part of the solution to reducing unnecessary admissions involves sharing information with GP practices about their admission rates. By analysing such information and comparing with peers, practices become more aware of their current ways of working and may be able to learn from the ways in which other practices work.

57. Responses to our survey of general practices[16] suggest there is scope to improve the impact of data provided to each practice on emergency admissions as part of the Quality and Outcomes Framework (QOF). Eleven of the 21 practices in the Health Board area responding to our survey believed that data on emergency admissions were helpful. Ten practices believed the data were actually used by the practice whilst only one practice agreed or strongly agreed that the data will lead to changes in the

[16] In November 2011, we e-mailed a questionnaire survey to general practice managers at 498 GP practices in Wales. Practice managers were asked to complete the survey on behalf of the practice. The overall response rate across Wales was poor with only 26 per cent of practices responding. At the Health Board, only 21 of the 78 practices surveyed (27 per cent) responded, despite encouragement from the Health Board to do so. While unlikely to be representative of all practices across Abertawe Bro Morgannwg, we have used these responses to illustrate particular issues.

way practices provide services. Only three practices believe that the data will lead to improvements in patient care.

58. All three locality management teams have carried out, or are carrying out, work to assess the appropriateness of emergency referrals from GPs to acute hospitals. The work in Swansea found that the vast majority of referrals were appropriate. The audit at the Princess of Wales Hospital looked at all emergency admissions over a seven-day period to assess whether referrals were appropriate and whether they could have been prevented by referring patients to alternative services or whether further alternative services were required.

59. There are ad hoc arrangements in place to try to prevent further inappropriate referrals from primary care. For such referrals to Princess of Wales, the Bridgend locality community service manager contacts the referring practice to discuss what could have been done to prevent the referral. At Morriston, the clinical director of emergency medicine writes to the referring GP but does not have the time to do this for every inappropriate referral.

60. Two of the Health Board's localities have recently developed a procedure for minimising referrals from primary care at times of elevated acute hospital pressure. In Bridgend and Neath Port Talbot, Health Board managers send out emails to primary care practices and community services to inform them of the acute pressures and to reinforce the need to use alternative services whenever clinically appropriate. However, it is not clear if these arrangements are having the intended impact, that is, reducing avoidable attendances.

61. Minimising unnecessary admissions will not be possible if GPs are not aware of, or do not have access to an adequate range of support services, such as rapid diagnostics, access to consultant advice and hot clinics. If such services are not available, or are hard to access, GPs may be dissuaded from using them. Only three of the 21 practices responding to our survey perceived that they had good access to either telephone or e-mail advice from consultants (or other specialists) to help manage a patient's acute condition and avoid an emergency admission/hospital attendance or emergency department attendance when appropriate. Only six practices perceived that they had good access to 'rapid access clinics' or 'hot clinics' and only five said they had good access to diagnostic services. Box 3 provides some of the comments about rapid access clinics and diagnostic services provided in response to our survey of GP practices.

Box 3. GP practice perceptions about rapid access to clinics and diagnostic services

- 'Rapid access clinics need to be set up within the new community networks as waiting times for routine scans are now 21 weeks. Resources should be shared more within the networks ….'
- 'There are continuous piecemeal restrictions placed on certain investigations available to GPs, such as ultrasound scans of shoulders and necks and CT/MRI scans of joints. There are also no rapid access clinics for chest and cardiac referrals.'

62. Nine of the 21 practices responding to our survey perceived that they could refer patients to a good range of community services to avoid emergency admissions/hospital attendances and A&E attendances when appropriate. Knowledge and awareness of support facilities/services may be an issue. Only seven of the 21 practices agreed or strongly agreed that they had enough information about the range of community services available to prevent avoidable admissions.

63. At the time of our fieldwork, the Health Board planned to revise its model for taking referrals from GPs by introducing an acute care GP at Singleton Minor Injuries Unit. This acute care GP will carry out telephone triage for all GP referrals, as well as limited space and facilities for face-to-face assessments. The acute care GP will also have access to diagnostic slots and hot clinic appointments. The Health Board is following a model used in a number of hospitals in the south-west of England, which have managed to reduce demand on admission and assessment units by introducing the role of an acute care GP. The Health Board should ensure there is robust evaluation of this role during the pilot phase.

64. Several staff from primary and secondary care told us during interviews about their concerns regarding the quality and timeliness of discharge summaries. There is a risk of readmission if a patient is discharged from hospital without sufficient, timely information being provided to their GP. The concerns of staff were in relation to all discharge summaries but there were specific concerns about the summaries produced within the new emergency department computer system, Myrddin.

There has been positive progress in extending the range of community services and developing out-of-hours primary care but more needs to be done to reduce reliance on acute services

The range of community services which support people with chronic conditions has increased and although there is more to do, plans to increase the capacity and capability of community resource teams are progressing

65. Our previous audit work highlighted the fact that community services were often fragmented and poorly co-ordinated with many services unavailable 24 hours a day. We also found that patients who were at risk of readmission to hospital were not consistently identified or offered adequate support to reduce that risk.

66. The Welsh Government's CCM model and framework signalled the need to rebalance services on a whole-system basis meaning relocating care and treatment closer to home. It identifies four levels of care, ranging from primary prevention through to complex case management, to ensure support is targeted and effectively co-ordinated, according to individuals' risk and care needs.

Risk stratification is not yet fully embedded although information is being used to help understand triggers for unplanned admissions

67. Delivery of the proposed model relies on health boards identifying the needs of their communities and to 'stratify' practice populations according to levels of risk. Those individuals identified at greatest risk of unplanned admissions should be actively managed to ensure they receive the right care in the most appropriate place.

68. In 2009, The NHS Wales Informatics Service (NWIS) developed a software tool that provided GP practices with a list of patients ranked according to their percentage likelihood of emergency admission to hospital within the next 12 months, referred to as the PRISM (Predictive Risk Stratifaction Model) tool.

69. Initially piloted in a number of GP practices, the PRISM tool was intended to be rolled out to all GP practices across Wales. At the time of our fieldwork, just over half of GP practices across the Health Board were testing PRISM although practices were raising a number of concerns about the way in which the information might be used. Delays in the national rollout have meant that there are no firm dates to rollout PRISM to the remaining practices as yet, preventing the Health Board from implementing full risk stratification for patients with chronic conditions. However, in the meantime, information on unplanned admissions is regularly shared with the community networks to understand the triggers for these admissions.

Models of step-up care and community based rehabilitation are being developed

70. Our previous work on chronic conditions found that the role of community hospitals in helping to manage chronic conditions was unclear. Community hospitals were typically not used to prevent or divert acute hospital admissions or to facilitate early discharge home for patients with chronic conditions.

71. Data published by the Welsh Government show that across Wales the average number of daily-staffed beds reduced 5.5 per cent between 2009-10 and 2010-11. Across Abertawe Bro Morgannwg hospitals, the reduction was two per cent with similar reductions seen at both acute and community hospitals. Since 2006, the Health Board has made changes to its network of community hospitals, closing three. However, the Health Board is continuing to develop the remaining community hospitals so they become a focal point in each locality to provide patients with rapid access to appropriate rehabilitation and support to regain their independence.

72. In addition, the Health Board has begun to introduce step-up care models in conjunction with independent care providers, to support people in the community and minimise unnecessary acute hospital admissions. Evaluating the effectiveness of such models should include assessment of the effectiveness of communication and co-ordination of in-reach services to the patient across providers and teams.

Building on investment in community services and the formation of CRTs, the Health Board is planning the necessary next steps to extend CRT capacity and capability

73. In 2008, the Welsh Government made £15 million of transitional funding available to NHS bodies for the years spanning 2008-09, 2009-10 and 2010-11. The funding was intended to support NHS bodies in achieving more sustainable, effective and efficient health and social care services, through better planning and integration of services and resources, strengthened community-based services and a shift in the balance of care between hospital and community settings.

74. The Health Board and its predecessor bodies received a total of £1.75 million in transitional funding over the three years. This funding was used to help implement the chronic conditions integrated model and framework in a number of ways, such as:

- helping to establish the locality model and care coordinator roles;
- improving medicines management in domicilary care;
- developing a dataset to monitor improvements in services for chronic conditions management; and
- training primary care staff in the delivery of patient education programmes for diabetes.

75. Budgetary information provided by the Health Board (and distinct from the transitional funding) also indicates increased funding for intermediate care and chronic conditions services over the last five years. In 2005-06, the combined budget for intermediate care and chronic conditions services was estimated at £3.72 million. By 2011-12, the budget was £9 million for the 10 services in place at the time of our fieldwork, including the community resource teams. Six of these services were funded from the Health Board's revenue allocation while the remainder were funded in collaboration with the Welsh Government and local authority partners.

76. Historically, the use of primary care contracts in creating capacity to care and support patients in the right place has been limited. In 2006-07, the Health Board's predecessors spent £5.38 million on GMS enhanced services with one-third of the expenditure used to improve primary care access and to provide a very small number of services for patients with chronic conditions or unscheduled needs. By 2010-11, expenditure on GMS enhanced services had increased by 16 per cent to £6.22 million. In addition to the GMS contract, the Health Board commissions a small number of enhanced services from local community pharmacies for a more modest level of expenditure.

77. *Setting the Direction* and the CCM model and framework both advocate the need for an integrated multidisciplinary team that focuses on co-ordinating community services across geographical localities for individuals with complex health and social care needs. These Community Resource Teams (CRTs) will target care and support to help individuals identified at the greatest risk of hospital admission to maintain independence in their own communities. Information provided by health boards as part of this audit shows that CRTs are at different stages of development across Wales, but

for the most part, provide an umbrella for a number of intermediate care services, predominantly reablement.

78. At the Health Board, a number of previously disparate 'intermediate care' services, which existed in predecessor bodies prior to the 2009 NHS reorganisation, have been consolidated. These services have been rationalised under the umbrella of a single Specialist Community Resource Team (CRT), with one CRT per locality to ensure close alignment with Social Services. These teams act as a bridge between the community networks and hospital-based care, and provide therapy, reablement services and specialist nursing resources. There is a particular emphasis on avoiding admission and facilitating discharge through:

- urgent assessment in the home or in a clinic;
- emergency response from the ambulance service, a&e or assessment units;
- specialist clinical advice to support care plans and develop skills;
- intensive nursing and therapy support in the home;
- reablement and community rehabilitation; and
- palliative care.

79. The CRTs are multi-professional and include nurses, therapists, social workers, support staff, and are supported by consultants. The teams have access to day hospital facilities to support the care they provide. Each of the CRTs has developed a presence within the major emergency departments to maximise opportunities to avoid admissions. In collaboration with the ambulance service, the CRTs are developing new pathways for patients presenting with a fall.

80. The CRTs are also trying to develop strong links with GPs to make sure that patients get referred at the right stage, before admission becomes a necessity. To facilitate this each team is developing a single point of access to make sure that professionals and patients get to the right service first time. This will include close links with third sector and independent sector services. In addition, some of the specialist resources from traditional hospital based services will increasingly operate as part of this team, including consultants in some specialties and specialist nurses and practitioners.

81. The Health Board recognises that there is more to be done to extend CRT capacity and capability. The next stages of CRT development will focus on extending the coverage of these teams over a seven-day period, and formalising pooled budgets between health and social care, as recognised in the Health Board's Annual Plan for 2012-13. The Health Board also recognises that more robust performance and outcome information will be key to strengthening the role of these teams as they play a key role in reshaping hospital services and capacity.

82. In addition to the CRTs, a well-established team of nurses for chronic conditions management operates across the community networks within the Swansea locality. These nurses, who are practice based, receive data on hospital admissions for patients registered with Swansea practices. The caseload of each nurse is determined by the cluster of practices with which they work. The Health Board has indicated that

these nurses have become an integral part of practice teams and are instrumental in monitoring those patients who are admitted to hospital three or more times each year.

83. Although previously disparate intermediate care services have been brought together through the development of CRTs, there remain some variations in the operation of individual services and different service models remain for chronic conditions management. The Swansea team of chronic conditions management nurses is not replicated in the other localities, where the CRTs fulfil the role and function. While we recognise that service models should account for differences in local need, the Health Board should evaluate both approaches and determine the best service model for delivering improvement in each locality and across the Health Board as a whole.

84. Our previous audit of CCM at the Health Board's predecessor bodies in 2006 found that where service evaluations had been carried out, these were predominantly about patient satisfaction and cost effectiveness. By 2011, the picture had changed with individual services evaluated or audited in relation to a number of other criteria, including patient outcomes, admissions avoided, reductions in lengths of stay or dependency on domiciliary care, as well as patient satisfaction and cost-effectiveness.

85. Box 4 highlights work underway to support people with COPD or people who experience a fall.

Box 4: Community based services for patients with COPD

A multiagency group has been developing plans to roll out a whole pathway approach to chronic obstructive pulmonary disease (COPD) on a consistent basis across the whole Health Board. COPD was chosen as it is a significant challenge for the Health Board. At least 10 per cent of all unplanned admissions to hospital are as a consequence of COPD and this proportion is even greater during the winter. Most admissions are for people 65 years or older with advanced disease, who experience multiple admissions. Redesign of the pathway spans health promotion and self-care to hospital-based specialist services. A number of components of the plan are currently being implemented, for example, a local enhanced service in primary care which focuses on education and self management. Of critical importance has been the development of 'quality metrics' alongside the pathway which will aim to measure the changes that take place as a result.

Services for patients who fall

A pilot project is underway in which patients who have a fall and call the ambulance service for help are referred to the CRT, where it is safe and appropriate to do so. These patients then receive an assessment and any subsequent support from the CRT to help prevent further falls. Patients categorised as 'low risk' are referred to the Age Concern programme.

Residents of care homes have been identified as being at particular risk of falling and are being specifically targeted for intervention by the CRT. A number of specific schemes are underway across the three localities, including Telecare in Bridgend whereby over 1,000 users are able to indicate that they have fallen and call for assistance from a mobile response team.

Access to primary care is generally good and out-of-hours services appear to be working well, but the capacity and expertise that already exists within core primary care hours may not be being used to their optimum

The Health Board has not yet focused enough on optimising access to primary care during core hours and there is doubt about the value for money of extended access arrangements

86. The urgent care provided by GPs and other primary care professionals is a vital part of the unscheduled care system in Wales with roughly 5.5 million unscheduled encounters each year. When patients are unable to access primary care services urgently, not only do they have a poorer experience but they often default to acute services. Defaulting to acute services, such as ambulance and emergency department services, is costly and results in increased demand elsewhere in the system.

87. Findings from the 2011 Welsh GP Access Survey, which was conducted in February 2011, suggest that a relatively high proportion (86 per cent) of GP practice patients across the Health Board area were able to see or speak to a GP or other healthcare professional on the same or next day but there were large variations across practices (Appendix 11). Practices in the Neath Port Talbot locality generally performed better.

88. Our survey of GPs found that there is definite scope to improve access arrangements in primary care and more broadly to ensure that the existing capacity within primary care to deal with unscheduled care is optimised. Of the 21 practices responding to our survey:

- fourteen had sought patients' views about how to improve access to same day care;
- thirteen had used the Welsh GP Access Survey to review their access arrangements; and
- only three had reviewed the pattern of telephone calls received from patients.

89. The survey also suggests there is scope to utilise appointments more effectively. Practices responding to our survey estimated that eight per cent of GP consultations are used for patients with non-clinical needs (ie, they see a doctor to ask for an insurance form to be signed), while an estimated 15 per cent do not attend their appointment. The Health Board has acknowledged that patients not attending primary care appointments is an issue that needs to be addressed. The Health Board is considering rolling out a scheme that was trialled in Bridgend that succeeded in significantly reducing wasted appointments. The scheme focused on the receptionist's role in booking appointments and involved simple interventions such as asking patients to write down their appointment times and dates, and asking the patient to repeat back the details they have just been given by the receptionist.

90. Despite these findings, our interviews with Health Board staff tended to suggest that access to primary care is not considered a major issue for the Health Board. Whilst the Health Board may not be the worst area in Wales for access to primary care, we consider there is a need for the Health Board to focus more on the issue because of

the considerable benefits possible from optimising the capacity and expertise for unscheduled care that already exist within core hours for primary care[17].

91. In a 2009 report,supported by the Royal College of General Practitioners and the British Medical Association's General Practitioners Committee, the Primary Care Foundation highlighted a wide range of issues for practices to consider that have the potential to free up capacity within their core hours. None of the practices responding to our survey had used the Primary Care Foundation's work in anyway. Across Wales, only 13 per cent of practices had done so.

92. The Health Board may not be securing value for money from its enhanced services for extended primary care opening hours. Twenty-five practices receive a total of just over £300,000 for providing these enhanced services but uptake of the extended services is poor and the Health Board needs to carry out further work to assess whether this expenditure is justified, especially as the findings above suggest there is scope to improve access through optimising arrangements within core hours.

93. The Health Board has established a primary care access forum to make further improvements in access. The forum is chaired by one of the locality directors and has representation from the localities, LMC and Community Health Council. The forum will report monthly to the Primary Care Development Group on a number of priorities, such as:

- reviewing the joint Health Board and LMC guidance on minimum standards of access;
- reviewing the extended access enhanced service to ensure it is achieving impact and providing value for money; and
- reviewing good practice and guidance from the Primary Care Foundation on improving access.

The standardisation of out-of-hours primary care services is a positive step and the service appears to be functioning well

94. The aim of primary care out-of-hours services is to ensure individuals with urgent primary care needs, which cannot wait until the next available in-hours surgery are met and that other patients accessing the service are given appropriate advice and information. The primary care out-of-hours period is defined as from 6.30 pm until 8 am on weekdays and all weekends, bank holidays and public holidays.

95. The Health Board has made very good progress in improving its arrangements for out-of-hours primary care, with an in-house service now provided across all three localities. The benefits of standardisation are suggested in the results of our GP survey that showed all but one of the practices rated out-of-hours services as 'very good'. The proportion of practices that rated the out-of-hours service as either very good or good was the highest in Wales at 95 per cent.

[17] Core hours are defined as being from 8 am through to 6.30 pm.

96. Appendix 12 shows that the Health Board's expenditure on out-of-hours General Medical Services (GMS) per registered patient is the second lowest in Wales and the out-of-hours services expenditure as a percentage of the total GMS expenditure is the lowest in Wales.

97. The Welsh Government's *Ten High Impact Steps to Transform Unscheduled Care* states that primary care out-of-hours units should ideally be 'functionally integrated within emergency departments'. This means the unit and the emergency department should have common reception and common operational processes. Whilst the facilities used by the out-of-hours service in Abertawe Bro Morgannwg are not fully integrated with the emergency department, they are all located close to each of the emergency departments (at Morriston, Princess of Wales and Neath Port Talbot).

98. Despite the lack of formal integration, we identified very positive joint working between the emergency department staff and the out-of-hours service staff, particularly at Morriston. At times of peak demand, the doctor within the out-of-hours service in Morriston and Princess of Wales will proactively in-reach to the emergency department to filter out patients that can be safely seen by a primary care professional. We were also told about positive involvement of the out-of-hours managers within service planning in the Health Board. Good joint working between these services is ensuring that around 100 patients per week are diverted from the Morriston emergency department to the out-of-hours service. This is a positive redirection of patients to a service that more suits their needs, whilst intelligently managing down the demand in the emergency department. The Health Board recognises ,however, that it needs to do more to increase the number of patients that are diverted in this way at Princess of Wales.

99. Unlike other services in Wales, the Health Board's out-of-hours service has not suffered difficulties in ensuring GPs put themselves forward to work out-of-hours shifts to date. We were told that local GPs feel strong 'ownership' of the out-of-hours service and that this may be because of wide acknowledgement of the quality of the service and because of the service's previous successes in Swansea. However, future recruitment to the service is not guarenteed and this position will need to be kept under review with the OOH service managers.

Despite a relatively slow start, roll out of the Integrated Health Record is now progressing and is available within the out-of-hours service

100. Better integrated working between the acute hospital and primary care could be facilitated through faster and wider roll out of the Individual Health Record (IHR). The IHR allows a summary of patients' GP records to be made available electronically to other unscheduled care services. The IHR is seen as important for improving the safety of out-of-hours consultations, as well as speeding up decision-making.
For example, if a patient presents with an exacerbation of their chronic condition, the out-of-hours GP will see what treatment was initiated the last time. Across Wales, just over half of GP practices are using the IHR covering nearly half the registered patients

(Exhibit 11). In October 2011, the Health Board was the only one in Wales where the IHR had not yet been made available.

101. At the time of our fieldwork in January 2012 there had been a minimal roll out of the IHR in the Health Board. The IHR was only accessible within the out-of-hours service and was not accessible in the hospital's short stay units, emergency departments or minor injury units. The IHR was also not widely available across all areas of the Health Board. In Swansea, the roll out was due to be implemented in November 2011 but did not happen for technical reasons.

102. Since our fieldwork, the Health Board has indicated that the IHR is available to the acute GP assessment unit at Singleton Hospital, as well as the primary care out-of-hours service. In addition, the Health Board's IHR implementation group and the communications hub group have both identified the potential for IHR to provide the basis of a single patient record across all health and social care services, and across community, primary and secondary care.

Exhibit 11: Extent of the roll out of the Integrated Health Record (IHR) at October 2011

Health boards	Percentage of practices using IHRs	Percentage of patients covered
Abertawe Bro Morgannwg University LHB	0	0
Aneurin Bevan LHB	82	80
Betsi Cadwaladr University LHB	45	41
Cardiff & Vale University LHB	55	53
Cwm Taf LHB	98	97
Hywel Dda LHB	49	49
Powys Teaching LHB	11	5
Wales	51	48

Source: NWIS Programme Update, October 2011.

Marketing has had no apparent impact on demand for unscheduled services, progress on developing a single point of access has been slow and more people could benefit from patient education programmes

The Health Board has engaged proactively to inform the public but marketing work has so far had no apparent impact on people's use of unscheduled care services

103. Our 2009 report on unscheduled care noted that, as a consequence of the complexity of the system of health and social care, the public can be uncertain about how and where to seek help. This uncertainty stems from the wide range of different access points within the system and the variation in service provision at different times and in different parts of Wales.

104. The 2009 report recommended that a national communications strategy should be developed to improve public understanding about how to most appropriately access care. In response to this recommendation, in March 2011 the Welsh Government launched the national Choose Well campaign which aimed to 'facilitate the use of more informed and effective decision making by the public when accessing NHS services and to allow pressurised healthcare resources to be appropriately used based on clinical need'.

105. The Health Board has used the Choose Well campaign in a number of local initiatives. Information about the campaign is included on the Health Board's website, posters are displayed in GP practices and 13 television monitors positioned in public spaces across the Health Board's premises are being used to reinforce the Choose Well message. None of these initiatives has been evaluated and it is not clear whether they have had any impact on influencing the behaviour of the public.

106. The emergency department attendance data presented earlier in this report would suggest there has been no discernible impact on demand despite the perception that the public has good knowledge about the availability of services in-hours and which are the most appropriate to use. We note that the Health Board's marketing work has been carried out without any specific funding being made available for this purpose but it needs to build on the perceived success of other local information campaigns for flu vaccination and avoiding hospital visits when suffering with diarrhoea and vomiting.

107. Since our fieldwork, the Health Board has proactively worked to inform the public about emergency department demand and waiting times. Working with the local media and using their website and other social media, the Health Board has at times of high demand, encouraged people with minor injuries to attend the Neath Port Talbot and Singleton units, to alleviate pressures in the major emergency departments and minimise patient waiting times. This is a proactive reponse to help manage acute pressures on specific units although the success of these public information initiatives is not yet known. Changing public behaviour is likely to need sustained focus for some

time and the Health Board will need to continue to engage and actively provide information about appropriate access to care.

Redirection of patients from the emergency department to alternative services is not yet sufficiently formalised

108. The Primary Care Foundation's 2011 report[18] on unscheduled care commissioning highlighted the importance of providing information to the public about how to use the care system, at the point at which they access care. The report states: 'For the message about how to use health services to get across, it needs reiterating consistently as a routine part of the consultation in all urgent care services over many years.'

109. Morriston's emergency department has a formal policy for redirecting patients who come to the department but would be more appropriately treated in primary care. However, at Morriston and at the other emergency departments, these patients are very rarely redirected to primary care during normal working hours because staff are reluctant to say no to patients in case they are not able to access primary care services.

110. The Health Board is considering changing triage arrangements at Morriston so that the process includes consideration of redirection to primary care or other services. During our interviews, a number of staff suggested there would be benefits from GP practices reserving a small number of urgent appointments every day, which emergency departments could use for primary care-type patients it wishes to redirect. The Health Board may want to consider these suggestions, given that direct access to such appointments would be likely to reassure emergency department staff that their redirected patients will definitely be seen within primary care. Redirection to out-of-hours primary care services appears to work comparatively well (as discussed in paragraph 88).

111. The health board does not yet know the extent to which primary care patients are attending its emergency departments. An audit is now underway at Morriston to retrospectively assess patients' casualty cards and notes, to ascertain whether they might have been seen more appropriately in primary care. The results of this audit will be important for guiding future work on this issue.

112. In addition to redirecting patients who present at the emergency department, the Health Board is taking a slightly different approach to managing demand from people who frequently attend these departments and might be helped by other services. At Morriston's emergency department, the District Nurse Liaison (DNL) has led work on identifying patients who attend more than 10 times per year. The nurse meets with these patients, as well as with community services, community psychiatric nurses, the ambulance service and social workers with a view to putting together strategies for

[18] Primary Care Foundation: *Breaking the mould without breaking the system: new ideas and resources for clinical commissioners on the journey towards 24/7 integrated urgent care*, November 2011.

dealing with these people's needs and avoiding unnecessary admissions/attendances. When the patient presents at the emergency department, they are identified as a frequent attender by a sticker on their casualty card which highlights that the receptionist holds a file containing a strategy for managing this patient. At the time of our audit there were 26 patients at Morriston with such a strategy in place but the subsequent loss of the DNL role at Morriston places doubts on the future of this scheme.

Progress on developing a communications hub has been slow due to a range of national and local barriers

113. Our 2009 report on unscheduled care recommended that health boards should seek to provide better access points to services. Part of the vision described in *Setting the Direction* includes the development of communications hubs acting as single points of access for the co-ordination, scheduling and tracking of care across the interface between the hospital and community setting. The vision states that integrated access to information would support better decision making and improved co-ordination of care.

114. The communications hub in the Health Board is still in development.
The Communications Hub Task and Finish Group has been established and has agreed the following core principles for the functions that the hub should provide:

- Ability to identify the person contacting the hub – the staff within the hub should be able to identify the user by searching for them within existing information systems across health and social care. This will allow them to view that person's current record.
- Provision of a summary record about the service user – instead of hub staff having access to all information within all health and social care systems, the plan is to provide them with a summary of this information. This will facilitate efficient, rapid assessment and provision of services.
- Use of existing systems – no additional funding is available to deliver the communications hub so the group is working on the principle of delivering the hub using existing systems.
- Integration of networks, computers and telephony – the hub will require integration between health and local government systems. The reduction in duplication in IT infrastructure should release some resources to invest in further developments.

115. Under current proposals, the Health Board intends the hub to provide information to citizens about the availability of services via a website and telephone. A single phone number for non-emergency cases will be available. Call handlers will be trained to perform a scripted triage function and will be able to direct callers to appropriate services. They will also be able to book appointments or home visits from relevant services.

116. Whilst progress thus far may have been slower than anticipated, there is no doubt that the delivery of such a communications hub is a particularly challenging project. We consider that the following issues represent considerable barriers that must be overcome if the hub is to succeed:

- There are different models of services in the Health Board's localities. We understand the group has struggled to develop a top-down solution for the communications hub that fits with the model in each locality and has now had to resort to a bottom-up approach. If a universal solution/model cannot be found, this risks the communications hub adding to what is already a complicated range of services and access points to the system of health and social care.
- Difficulties in joining up the information held on individual citizens. In the Health Board area, there are three social services information systems, two secondary care patient administration systems and four major primary care information systems. Whilst the IHR has potential to join up health-related information, there would still be barriers posed by having separate social care information. However, the 2012-13 annual plan includes agreement of inter-agency information sharing arrangements.
- There is no business case for developing the communications hub and there is no funding available for its development. Whilst there is potential to release resources by removing duplicate information systems, the lack of funding up front is a considerable barrier to progress.
- There remains no definitive directory of services. Directories of service ensure that professionals and citizens get a comprehensive and up-to-date picture of the services available, their times of operation and their referral criteria. In the Health Board area there are several directories but they have not yet been integrated, which means that information is fragmented.

Progress in establishing patient education programmes, information and support networks has been positive and needs to be sustained

117. It is essential that individuals are encouraged and supported in looking after their own health and well-being. Self-care is associated with positive outcomes for individuals, as well as helping to reduce reliance on healthcare services. The Welsh Government's framework for self-care[19] sets out the key elements of support for self-care, such as information and signposting and skills training for patients.

118. Our previous audit of CCM at the Health Board's predecessor bodies in 2006 found that around half of the community services for people with chronic conditions included aspects of patient education or support for self-care. By 2011, community services for patients with chronic conditions included patient education and support for self-care. The Health Board also continues to support the generic education programmes for

[19] Welsh Government, *Improving Health and Well being in Wales, A Framework for Supported Self-care*, October 2009.

patients (Expert Patient Programmes (EPPs)), as well as disease-specific programmes, such as those for diabetes or asthma.

119. The EPP programmes aim to give participants the confidence to look after their own health needs. In a ministerial letter to Chief Executives in 2009, the Minister for Health indicated that Health Boards should aim to get one per cent of the chronic condition population through EPP courses over the following three to four years.

120. Although the Health Board supported 43 EPP courses between April 2010 and December 2011, the number of courses, and consequently the number of people registering for a course, has varied each quarter (Exhibit 12). More than four-fifths (83 per cent) of individuals who registered to attend a course, took up a place and completed it. The completion rate (that is the number of individuals registering for a course and completing it) was the highest amongst the health boards; the Wales average was 63 per cent (Appendix 13). However, in order to achieve the expectations set out in the ministerial letter, the Health Board will need to ensure that five times as many individuals complete a course.

Exhibit 12: Quarterly trends in the provision of Education Programmes for Patients* at the Health Board

Quarter and year	Number of courses	Numbers of people registering for EPP courses	Number of people who did not attend	Number who drop out once course started	Number of registrants completing a course
Q1 – 2010-11	3	38	9	2	27
Q2 – 2010-11	4	44	10	3	31
Q3 – 2010-11	8	91	8	5	78
Q4 – 2010-11	9	86	11	4	71
Q1 – 2011-12	9	96	1	8	87
Q2 – 2011-12	5	52	1	6	45
Q3 – 2011-12	5	59	8	5	46
Overall total	**43**	**466**	**48**	**33**	**385**

*Data relate to programmes for both those with chronic conditions (Chronic Disease Self Management Programme) and those caring for someone with a chronic condition (Looking After Me programmes).

Source: Data derived from national quarterly reports from Education Programme for Patients Cymru.

121. In addition to more structured education programmes, a number of other community-based services that the Health Board supports incorporate a specific element of patient education and support for self-care. For example, the Health Board has developed a handbook for diabetic patients and has purchased the British Lung Foundation booklet to be provided to COPD patients. During our interviews we were told that that information provision for these patients is a good step but in itself is not enough to ensure COPD and diabetes patients receive optimal care and support. These specific examples now need to be supplemented by a range of broader interventions. The Health Board has developed enhanced services for diabetes and COPD to provide patients with enhanced, structured education, which it intends to roll-out more widely. We also understand the Health Board's communications team is considering using Facebook to create networks of people with particular chronic conditions. This is a good idea to develop a positive network for sharing information and support.

Sustainable improvement depends on better resource and capacity planning across all localities and settings and effective stakeholder engagement on the future hospital network

122. This section of the report considers the Health Board's future vision for unscheduled care and chronic conditions, and its likelihood of success in establishing genuinely sustainable models of care.

The Health Board is developing its strategic approach but cannot be clear about its vision and workforce planning until the future network of hospital services is decided

Setting the Direction and *Changing for the Better* have been key drivers for transforming services for unscheduled care and chronic conditions but need to be supported by more detailed and joined-up implementation locality plans

123. In January 2011, the Health Board published its five-year plan entitled *Changing for the Better*. The plan sets out the Health Board's long-term goals in relation to quality, service delivery and resources. The plan, which reflects the principles of *Setting the Direction*, sets out the need to rebalance the model of care provision between community and hospital settings, to address unscheduled care and long-term conditions. In summary, it sets out the need to develop capacity and capability to enable a significant shift in unscheduled care activity from hospital to community and primary care settings, 24 hours, seven days a week and to improve services for people with, or at risk of, chronic conditions.

124. Taking these goals, and the associated priorities for action, and delivering the intended improvements is now key to transforming services. This work is being taken forward through a number of workshops with staff, based on the key priority areas within the five-year plan and include work streams for unscheduled care and long-term conditions. It is too early to assess the strengths and weaknesses of this approach but the priority must be to translate the high-level vision into more detailed and joined-up plans.

125. Without these more detailed plans, particularly for unscheduled care, improvement work has tended to focus on a range of isolated issues rather than whole-systems solutions. For example, up until now, a major focus for improvement has been on improving four-hour waiting time performance in the emergency department. This is understandable because of the historic poor performance within the Health Board and the work has resulted in improvements, but we consider the time is now right to focus on broader, systematic planning that will secure more sustainable improvements. Whilst there appears to be a genuine desire to focus on whole systems solutions, this is still in its infancy.

126. The Health Board also needs to improve its planning specifically to solve problems around the management of demand and spreading of good practice across all localities. Up until now, plans have tended to be developed at a locality level, rather than at a Health Board level. Whilst this approach has benefits for ensuring the needs of local people are kept in focus, there is now a need to ensure greater consistency across localities. For example, unscheduled care improvement plans exist in all three localities but they appear to have been constructed in quite different ways.
Going forward, the Health Board will need greater, corporate oversight of these plans. The introduction of an Unscheduled Care Board now planned, will likely be supportive of this aim.

National and regional decisions about the future network of hospital services are vital before the Health Board can intelligently plan the future of its unscheduled care and chronic conditions services

127. National and regional discussions about the network of hospitals that will exist in future are vital to ensuring patients across Wales have appropriate access to services, such as those at emergency departments. The five-year plan acknowledges the need for clarity over the future roles of each of the major acute hospitals. The plan states the need to centralise some services and sets out a future model of services where Morriston is the centre of specialist emergency and complex care across the Health Board area. Under these proposals, other general acute hospitals would continue to accept emergency medical patients while accident and emergency services would be retained at Princess of Wales and Morriston.

128. In August 2012, the Health Board had to stop acute medicine services at Neath Port Talbot Hospital because of a shortage of suitably experienced medical staff. Instead, all medical emergency admissions and GP admissions are directed to Morriston, Singleton or Princess of Wales hospitals. The nurse-led minor injury service at Neath Port Talbot Hospital continues to be provided 24 hours a day, seven days a week.

129. The pattern of hospital services cannot be decided by the Health Board in isolation. National and regional discussions about the broader network of hospitals are vital to ensuring patients across Wales have appropriate access to services. Changing the pattern of hospital services is a highly emotive subject and is notoriously difficult to implement. Effective involvement and engagement with the public and other stakeholders will be a critical success factor in implementing these plans. Since our fieldwork, the five health boards in south Wales have undertaken an engagement and consultation programme with the public seeking their views about how some specific services, such as emergency department services should be provided in the future. The outcome of the consultation on change options is expected in 2013.

Better capacity planning is vital to address a number of key risks around the unscheduled care and chronic conditions workforce

130. For successful implementation of new, sustainable models of care, it is crucial that there are sustainable changes in the workforce. *Together for Health* recognises that creating a sustainable workforce is a particular challenge in some specialities and workforce issues are becoming a real limitation on certain services.

131. Our fieldwork identified a number of issues with the workforce that must be addressed if sustainable improvement of services is to be secured in future. These issues are summarised in the bullets below:

- **Comparatively low staffing levels.** As already discussed, data collated from emergency departments across Wales suggest that there is a comparatively low level of staffing within the Health Board's emergency departments in relation to the number of attendances.
- **Numbers of consultant staff do not meet the College of Emergency Medicine guidelines.** The number of emergency department consultants do not meet the College of Emergency Medicine guidelines.
- **Inequities in the number of Enhanced Nurse Practitioners (ENPs) deployed at major emergency departments.** More ENPs are deployed at Morriston Hospital than at the Princess of Wales Hospital (6.6 WTE and 1.6 WTE respectively). The lack of dedicated ENPs is seen as an impediment to performance and quality within the Princess of Wales department. The Health Board needs to agree the nursing model needed at each of its emergency departments and ensure that adequate funding is made available.

- **Workload pressure may be impacting on staff morale.** As mentioned earlier, our fieldwork suggests morale issues may be contributing to high sickness levels and therefore magnifying workload pressures.

132. The rebalancing of the care system set out in *Setting the Direction* will require an increased capacity within the community. Workforce plans that consider the number and type of staff in the community will therefore be vital to success. Whilst general practitioners are independent contractors and are generally not directly employed by the Health Board, there is a role for the Health Board in working with primary care to ensure its communities have an appropriate primary care workforce.

133. The Health Board cites staffing issues as one of the key barriers to further improvement in unscheduled care in terms of ward staffing, limited capacity in community services and on-going gaps in medical staffing arrangements at emergency departments. *Changing for the Better* acknowledges the key workforce challenges, including a shortage in junior and middle grade doctors and the national target to shift 10 per cent of the workforce to a community setting between 2010 and 2013. One of the key priorities for action is to develop new workforce models that reduce reliance on trainee doctors and maximise roles of nurses and therapists in unscheduled care. In addition, the training requirements associated with any staff transfers between acute and community settings will need to have been considered.

Good structures for implementing Setting the Direction have been set up but strategic oversight of unscheduled care improvements and focus on measures of quality and whole system performance can be further improved

Effort in putting together governance infrastructure should set the Health Board in good stead although scope exits to strengthen arrangements for driving unscheduled care improvements and alignment with actions targeted at chronic conditions management

134. If the Health Board is to deliver on the ambitions set out in its five-year plan, it must have an organisational and management structure that supports clear responsibilities and lines of accountability. Within that structure there must be individual leaders and groups of staff and stakeholders that are well positioned and empowered to drive service transformation.

135. The Health Board has made good progress in ensuring it has an appropriate infrastructure for driving transformational change. The Primary and Community Services Implementation Board, a multi-disciplinary, multi-agency strategic group responsible for driving the implementation of *Setting the Direction,* has played a pivotal role in this respect. At the time of our fieldwork it was reviewing its remit to increase the focus on evaluating what has already been implemented and increasing the focus on outcomes. The group reports to the Board through its chair, one of the non-executive officers.

136. The Primary and Community Services Implementation Board is supported by an operational group, the Primary Care Development Group and comprises professional staff from the Health Board and GPs. Its role is to develop the detailed service specifications and policy frameworks needed to implement Setting the Direction and the high impact service changes for unscheduled care and chronic conditions promoted by the Welsh Government. In addition, unscheduled care and chronic conditions management are distinct, clinically led programme pathways supporting delivery of the Health Board's strategy 'Taking changing for the better forward'.

137. At a local level, each locality has a primary and community services implementation board and an unscheduled care group. Actions driven locally are brought together through a single localities management board, although at the time of fieldwork there was scope for improvement, in particular:

- Locality-based unscheduled care groups were established in the three areas but the Bridgend locality group folded partly because the group was focused too much on the A&E four-hour waiting time target. The demise of the group may mean that there is a lack of accountability for implementing the local unscheduled care improvement plan in Bridgend.
- There was no Health Board wide unscheduled care group at the time of our audit although the Health Board intended introducing one. The lack of an overarching unscheduled care group increases the risk of poor coordination of planning and delivery across the three localities and may also mean that there is poor alignment with actions targeted at chronic conditions management.

138. Each locality also has a small number of community networks clustered around GP practices. These networks provide the vehicle for primary care teams and community health and social care teams to work together, pooling expertise, to develop new ways of meeting the needs of their local population, shifting the focus onto prevention and promotion, improving the quality and integration of care, and expanding the range of local services.

139. As well as the introduction of specific groups to drive change, we also found evidence of positive changes in relation to the individuals who are now tasked with driving change. A chief operating officer post was due to be established in April 2012, whereas previously there have been operational directors with segregated responsibilities for acute and community services. The new post has the potential to ease tensions regarding the shift of resources from acute to community settings.

To ensure robust performance management, the Health Board needs to do more to focus on measures of quality and whole system performance

140. Information is crucial for informing the planning and delivery of effective services for unscheduled care and chronic conditions, as well as monitoring service provision and patient outcomes. Our previous reports highlighted the paucity of financial information and activity data available, which undermines the ability of NHS bodies to evaluate existing services, plan new services or to support the shift of resources from hospital to community settings.

141. If the Health Board is to successfully transform its models of care, it must be able to intelligently measure its progress towards reaching its goals. Our national report on unscheduled care recommended that health boards should work with partners to agree a set of desired outcomes from their services, and they should consider what measures would indicate the successful delivery of these desired outcomes. We said that these measures should drive change in the system, be agreed with professional leads, and be used to enable the system to learn as new models of unscheduled care are piloted and rolled out.

142. The Health Board acknowledges that it has not yet agreed such a set of desired outcomes with its partner organisations. This is potentially a barrier to joint progress towards whole system transformational change. However, the Health Board has set out evaluation criteria in relation to its priorities within *Changing for the Better*. These criteria are broad and ambitious and cover five themes of effectiveness, prevention, patient experience, access and use of resources. The criteria are in the form of statements of intentions for improvement and have not gone as far as setting target levels. The Health Board has not yet set out how it will quantify progress towards these evaluation criteria. Addressing this need should be taken forward alongside the current development of a community services performance dashboard.

143. Performance information in relation to unscheduled care is regularly considered at a range of local and Health Board level meetings. In our interviews, some staff acknowledged that performance of the CRTs is not enough of a focus in Board meetings and that more regular performance information about the CRTs needs to be provided to both the Board and the Primary and Community Services Implementation Board. While evaluation of individual community services includes a range of evaluation criteria, (as described in paragraph 76), our Structured Assessment work in 2012 found that the information received by the Board largely focuses on acute hospital services, with limited reporting on patient experience and the quality of services. The Health Board needs to develop performace information and reporting on the quality and impact of community services, for both unscheduled and chronic conditions services.

144. In general, unscheduled care performance data within the Health Board focus on the national targets, and in particular, the timeliness of care within the emergency department. We acknowledge that at an operational level, the Health Board does consider some broader measures such as delayed transfers, emergency admissions and outliers. However, there is now a need to expand the range of measures to include the broader consideration of quality, and in particular patient outcome and experience.

145. Our visits to emergency departments highlighted problems with departmental data systems that prevent robust monitoring and evaluation. It is difficult for emergency department staff to extract data from the new Myrddin computer system without seeking the help of IT specialists. Emergency department staff told us that this is a real impediment to using the clinical and performance data that is collected for monitoring and evaluation purposes. We were also told that emergency medicine consultants spend a lot of time checking patient level information because of the problems

associated with the Myrddin system. The previous computer system prevented the input of nonsensical clinical information through a system of prompts and automatic checks. Myrddin does not have these automatic checks which can result in poorer data quality. One consultant estimated that he spends an additional three sessions per week checking patient records to make sure data are robust so that safe, high quality information is passed back to primary care clinicians through discharge letters. This is not an effective use of their time given the need for experienced clinicians to be on the 'shop floor'. The Health Board's clinicians are actively participating in all-Wales work to commission a new, fit-for-purpose Emergency Department system for health boards, in conjunction with the NHS Wales Informatics Service (NWIS).

The Health Board is committed to staff engagement and partnership working and must build on this to achieve necessary service transformation

Clinical leaders are in place and engagement with staff and GPs is very positive, but particular challenges remain in respect of emergency departments and securing transformational change

146. Effective engagement of clinical staff is a critical success factor in driving forward the scale of transformational change required to develop new models of care, including the rebalancing of care towards primary and community services. Without strong clinical leadership and 'buy in' from the wider base of clinical staff, service changes will be difficult to implement.

147. The organisational structure of the Health Board has been designed to promote clinical leadership and engagement, with acute hospital directorates and community localities (covering primary care, community services, and mental health) all being led by a Clinical Director. These senior clinicians are engaged with the senior management team and play an active role within the management structures of the Health Board and in engaging the wider clinical workforce.

148. The Health Board sees clinical leadership and engagement as a critical enabler in delivering service change. In localities, promoting closer working with primary care practitioners and delivering better integration of services across patient pathways and the community/hospital interface are particularly important. To support this, each locality has two clinical directors, one from integrated medicine and one from primary care. Each community network has a GP lead and we heard positive views about the extent to which engagement between the Health Board and primary care has developed and improved.

149. The Health Board has also kept its organisational structures under review to support integrated working and rebalancing of care towards primary and community services. Acute emergency medicine (and responsibility for emergency departments) has been within the management remit of localities since the initial Health Board structures of 2010. However, having two executives with separate responsibilities for acute care

and community services respectively encouraged silo working and created tensions for the rebalancing of care and resources. To address this, the two director posts (Director of Acute Care and Director of Primary, Community and Mental Health Services) were replaced by a Chief Operating Officer post in April 2012. Further, the Heath Board has established strategic planning fora which provide an opportunity for clinical directors and their teams to engage with each other, have collective ownership of corporate issues and consider the impacts of whole system changes across services.

150. The Health Board has taken very positive steps to engage with staff across the organisation. During our fieldwork visits, staff expressed positive views about the Chief Executive's regular emails and blogs, as well as the introduction of a rumour line where staff can ask any executive to confirm or dispel rumours that may be circulating about future changes in the organisation. Open forum sessions with the Chief Executive and his directors provide another opportunity for staff to ask questions or raise concerns.

151. In general staff were motivated and determined to work with colleagues to drive through the transformational changes required. The Health Board's strategy has been to engage clinicians in identifying the strategic objectives to help generate 'buy-in' for the difficult funding and service redesign issues that it is facing. However, the difficult test is yet to come as potentially controversial decisions about changes to services, staffing and the network of hospitals are still being discussed.

152. There are also particular challenges for maintaining staff engagement, in services which are currently experiencing sustained pressure. This is particularly the case for emergency department staff. Since our fieldwork, high levels of emergency demand coupled with staffing and capacity pressures have persisted. The Health Board has put support measures in place for staff (as discussed earlier) and staff have told us that executive officers are supportive and understand concerns and issues raised by staff. However, maintaining engagement, improving staff morale and ensuring that quality and safety are not compromised are priority considerations for the Health Board, given the continued high levels of emergency demand and resultant service pressures.

The Health Board is committed to working in partnership and building on these foundations will be essential to securing sustainable improvements and service transformation

153. Transforming healthcare services relies on changes across organisational boundaries. It requires involvement and agreement from a wide range of partners, including other NHS bodies, local authorities, the ambulance service and many more, some of which were noted earlier.

154. Our interviews with some Health Board senior managers suggest that much of the organisation's focus thus far has been on improving its own emergency departments, rather than broader, partnership work. This approach is understandable due to the poor, historic performance of these departments in relation to waiting times targets.

155. However, the Health Board's commitment to partnership working is evident in the following:

- Multi-agency representation on a number of strategic and operational groups, such as the locality implementation boards, the Primary and Community Services Implementation Board, the *Setting the Direction* implementation board and the locality unscheduled care groups.
- Local authority funding to support the CRT to carry out more rapid community assessments to reduce delayed transfers of care in the Swansea area and to extend the CRT service to Morriston's emergency department at night to prevent social admissions.
- Joint working between the Health Board and Bridgend County Borough Council to increase capacity for reablement by redesignating some care home beds that were poorly utilised.
- The Health Board and Bridgend County Borough Council are testing the impact of linking named social workers to specific wards at the Princess of Wales Hospital in order to improve joint working between the social workers and ward staff.
- Pooled resources to support the management and delivery of a joint equipment service, the Integrated Community Equipment Service.

156. The Welsh Ambulance Services NHS Trust (WAST) is a key partner in transformation and in improving the way in which people experience care. Our fieldwork suggests that joint working with WAST to date has been generally positive although concerns were raised around the planned changes to the WAST management structure and the potential impact that may have on relationships that have developed. There has been some positive working in relation to the development of pathways and joint working with the emergency departments during periods of high demand. However, despite inclusion within the local unscheduled care forums, greater strategic engagement with WAST on issues such as escalation and ambulance diverts is needed[20].

[20] Since our fieldwork, the Health Board has, with WAST, developed three condition based pathways (falls, epilepsy and hypoglycaemia) to avoid hospital attendance, and jointly invested in five Advanced Paramedic Practitioners.

Appendix 1

Number of attendances at major emergency departments

Change in the number of attendances at major emergency departments/accident and emergency (A&E) departments across Wales between 2010 and 2011.

Health Board	Number of A&E attendances		Percentage change
	January 2010 to December 2010	January 2011 to December 2011	
Abertawe Bro Morgannwg University LHB	141,396	142,325	0.7
Aneurin Bevan LHB	130,152	131,521	1.1
Betsi Cadwaladr University LHB	163,931	168,638	2.9
Cardiff & Vale University LHB	125,928	125,402	- 0.4
Cwm Taf LHB	105,253	111,356	5.8
Hywel Dda LHB	97,611	97,344	- 0.3
Wales	764,271	776,586	1.6

Source: Wales Audit Office analysis of data derived from StatsWales.

Appendix 2

Emergency department attendances arriving by ambulance

Proportion of attendances at major emergency departments that arrived by ambulance in 2007-08 and 2010-11.

Hospital	Proportion of A&E attendances that arrive by ambulance (percentage)	
	2007-08	2010-11
Morriston Hospital	27	29
Princess of Wales Hospital	19	22
Nevill Hall Hospital	24	26
Royal Gwent Hospital	28	28
Wrexham Maelor Hospital	20	20
Ysbyty Glan Clwyd	32	33
Ysbyty Gwynedd	24	26
Prince Charles Hospital	22	25
Royal Glamorgan Hospital	NA	NA
University Hospital Wales	NA	29
Bronglais General Hospital	7	9
Glangwili General Hospital	5	27
Withybush General Hospital	22	24
Wales	23	25

Source: Wales Audit Office analysis of data collected from Health Boards in November/December 2011 and from predecessor bodies in 2009.

Appendix 3

Working hours of consultants in major emergency departments

Health Board	Hospitals	Time when a consultant in emergency medicine is available on the 'shop' floor	
		Weekdays	Weekends
Abertawe Bro Morgannwg University LHB	**Morriston Hospital**	**9am to 5pm**	**9am to 4pm**
	Princess of Wales Hospital	**9am to 9pm**	**9am to 9pm**
Aneurin Bevan LHB	Nevill Hall Hospital	9am to 11pm	Up to 6 hours
	Royal Gwent Hospital	8am to 8pm	9am to 4pm
Betsi Cadwaladr University LHB	Wrexham Maelor	8am to 10pm	9am to midnight
	Ysbyty Glan Clwyd	9am to 9pm	9am to 5pm
	Ysbyty Gwynedd	9am to 8pm	12pm to 3pm*
Cardiff & Vale University LHB	University Hospital of Wales	8am to 10pm	8am to 10pm
Cwm Taf LHB	Prince Charles Hospital	9am to 5pm	NA
	Royal Glamorgan Hospital	9am to 5pm	NA
Hywel Dda LHB	Bronglais General Hospital	9am to 5pm	On-call plus Hospital at Night team
	Glangwili General Hospital	9am to 5pm 9am to 7.30pm (Mondays and Wednesdays)	9am to 3pm
	Withybush Hospital	9am to 10pm	1pm to 9pm

*Actual hours reported to be longer in practice.

NA – Not available.

Source: Wales Audit Office analysis of data collected from health boards.

Appendix 4

Number of medical staff at major emergency departments

Numbers of filled and vacant posts for A&E medical staff at the end of November 2011.

Hospital	WTE numbers of medical staff					
	Consultants*		Middle-grade doctors		Junior doctors/ trainees	
	In post	Vacant	In post	Vacant	In post	Vacant
Morriston	**6.9**	**0**	**12.55**	**0**	**15**	**0**
Princess of Wales	**6.4**	**0**	**5.2**	**1**	**11**	**0**
Nevill Hall	3 (+1)	1	3.5	1	10	0
Royal Gwent	9.4	0	8.5 (+0.4)	4	12	0
Wrexham Maelor	7	1	8.1	0	8	0
Ysbyty Glan Clwyd	2 (+1)	2.5	5.5	5	7	0
Ysbyty Gwynedd	3	1	7	2	7	0
Prince Charles	3.4	1.6	3	1	7	1
Royal Glamorgan*	2 (+1)	2	2	7	8	0
Bronglais General	1	0	3	0	7	0
Glangwili General	2	0	4	1	8	0
Withybush General	0 (+2)	2.87	3.8 (+2.2)	3.2	7	0
University Hospital of Wales	8(+2)	4	4	4	22	N/A

(+ x) Indicates the number of locum medical staff deployed at the time of our fieldwork visits to these hospitals.

*At the Royal Glamorgan Hospital, consultant locum cover is for long-term sick leave.

N/A – Data not available.

Source: Wales Audit Office analysis of data collected from health boards.

Appendix 5

Number of nursing staff at major emergency departments

Numbers of filled and vacant posts for A&E nursing staff in Wales at the end of November 2011.

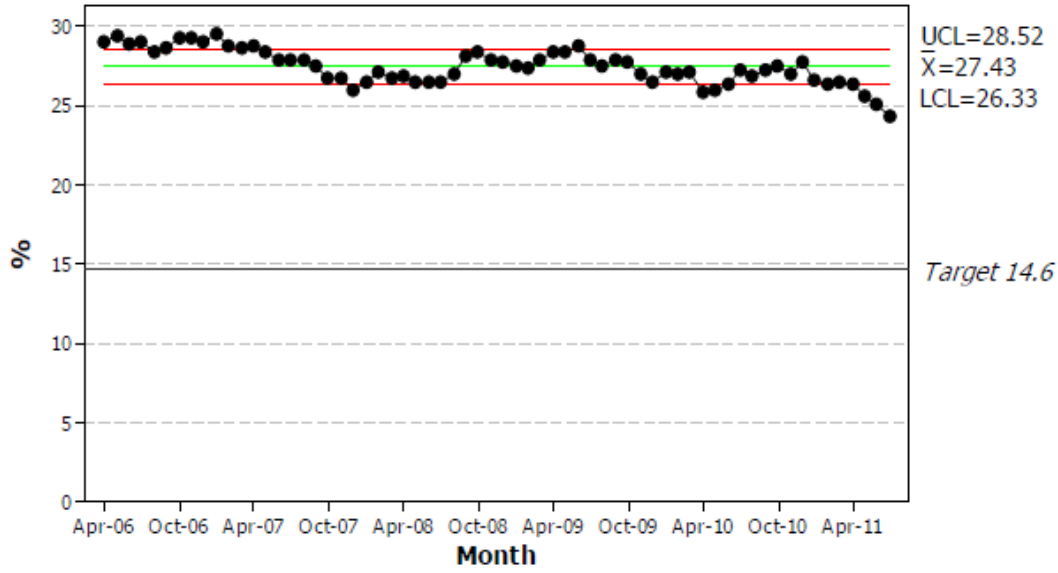
Hospital	Bands 1 to 4		Bands 5 to 9		Vacancy rate (percentage)
	Filled posts	Vacant posts	Filled posts	Vacant posts	
Morriston Hospital	**9.05**	**0**	**67.05**	**6**	**7**
Princess of Wales Hospital	**9.2**	**0**	**44.4**	**0**	**0**
Nevill Hall Hospital	9.87	0.53	42.93	0.56	2
Royal Gwent Hospital	24.26	0.46	89.3	2.51	3
Wrexham Maelor Hospital	1.73	1	66.6	0	1
Ysbyty Glan Clwyd	7.44	0	45.02	0.8	2
Ysbyty Gwynedd	7.57	0.43	50.95	3	6
Prince Charles Hospital	5.6	0.4	35.9	3.2	8
Royal Glamorgan Hospital	7.91	0.24	44.76	5.65	10
Bronglais General Hospital	4.68	0	21.93	0	0
Glangwili General Hospital	3.2	0	35.8	2.8	7
Withybush General Hospital	2.69	0	29.42	2	6
University Hospital of Wales	18.69	0.8	101.87	2.69	3
Wales	113.48	3.86	673.10	29.21	4

Source: Wales Audit Office analysis of data collected from Health Boards.

Appendix 7

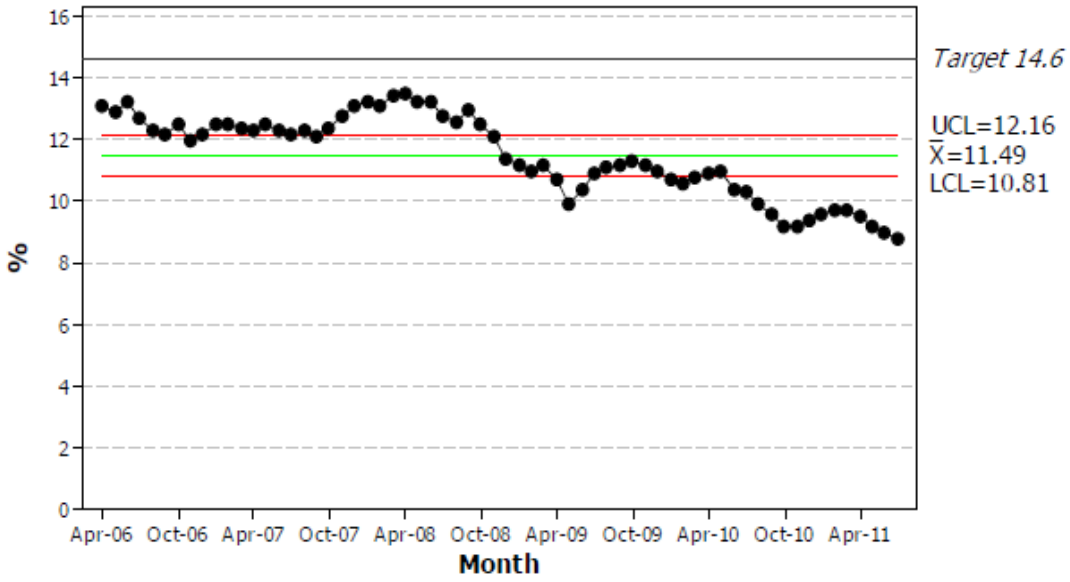
Rolling multiple admission rates for COPD, CHD and diabetes at Abertawe Bro Morgannwg University Health Board

Exhibit 6a: Rolling 12-month multiple admission rate for COPD emergency admissions



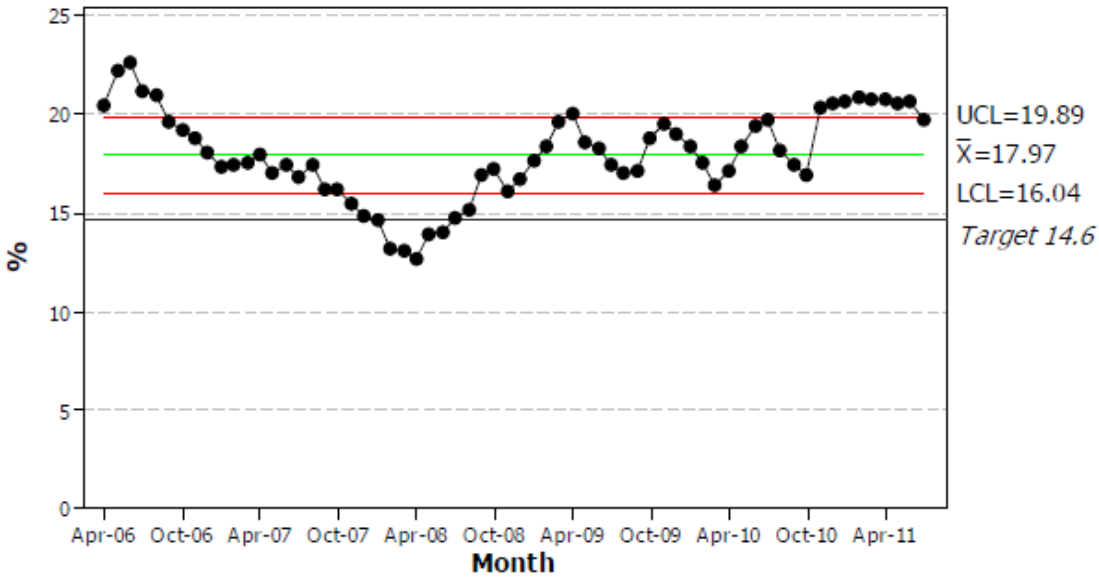
Source: Wales Audit Office analysis of data extracted from NLIAH's report 'Progress Report on the CCM Service Improvement Plan as measured through the CCM Maturity Matrix', October 2011.

Exhibit 6b: Rolling 12-month multiple admission rate for CHD emergency admissions



Source: Wales Audit Office analysis of data extracted from NLIAH's report 'Progress Report on the CCM Service Improvement Plan as measured through the CCM Maturity Matrix', October 2011.

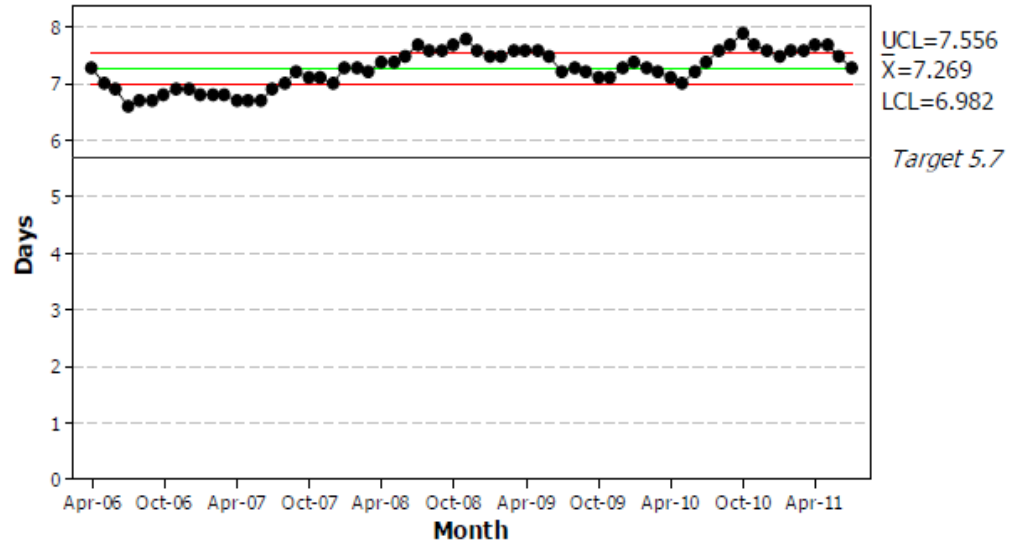
Exhibit 6c: Rolling 12-month multiple admission rate for diabetes emergency admissions



Source: Wales Audit Office analysis of data extracted from NLIAH's report 'Progress Report on the CCM Service Improvement Plan as measured through the CCM Maturity Matrix', October 2011.

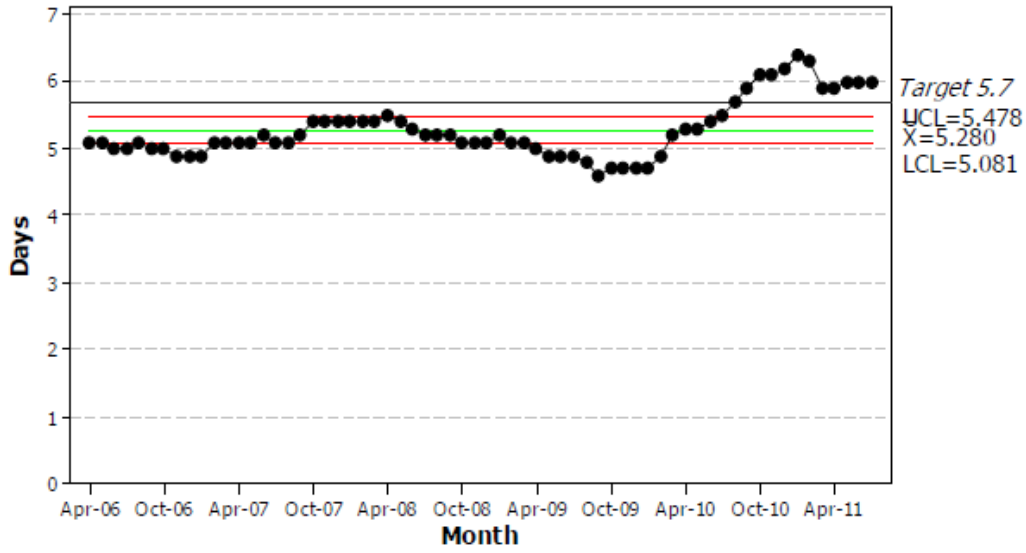
Rolling 12-month average lengths of stay for COPD, CHD and diabetes at Abertawe Bro Morgannwg University Health Board

Exhibit 7a: Rolling 12-month average lengths of stay for COPD emergency admissions



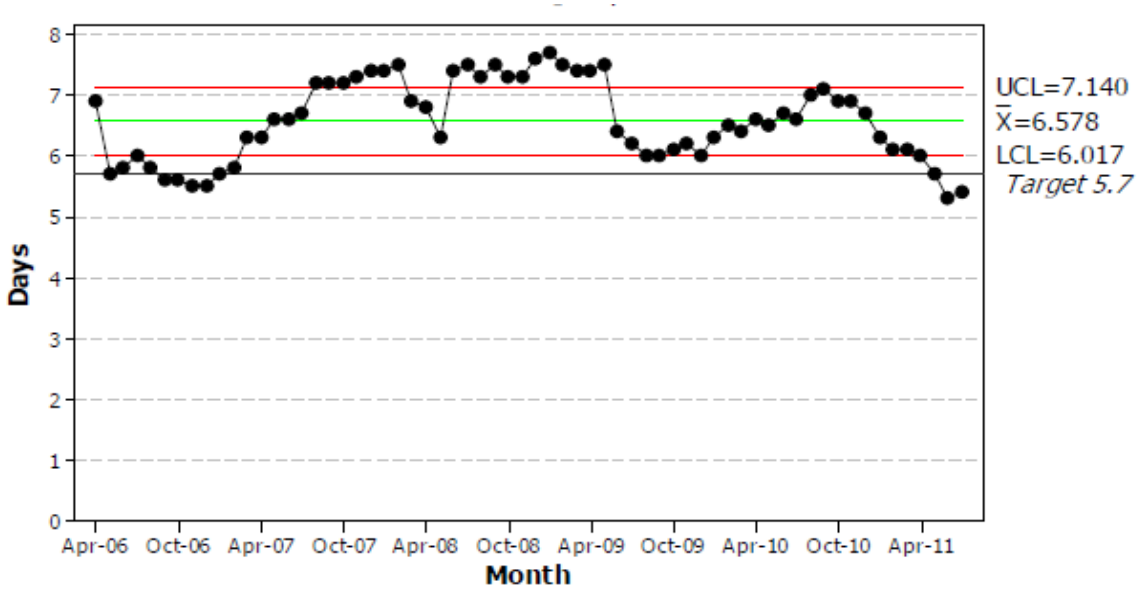
Source: Wales Audit Office analysis of data extracted from NLIAH's report 'Progress Report on the CCM Service Improvement Plan as measured through the CCM Maturity Matrix', October 2011.

Exhibit 7b: Rolling 12-month average lengths of stay for CHD emergency admissions



Source: Wales Audit Office analysis of data extracted from NLIAH's report 'Progress Report on the CCM Service Improvement Plan as measured through the CCM Maturity Matrix', October 2011.

Exhibit 7c: Rolling 12-month average lengths of stay for diabetes emergency admissions



Source: Wales Audit Office analysis of data extracted from NLIAH's report 'Progress Report on the CCM Service Improvement Plan as measured through the CCM Maturity Matrix', October 2011.

Appendix 8

Average time spent in major emergency departments

Average time individuals spent in major A&E departments in 2007-08 and 2010-11.

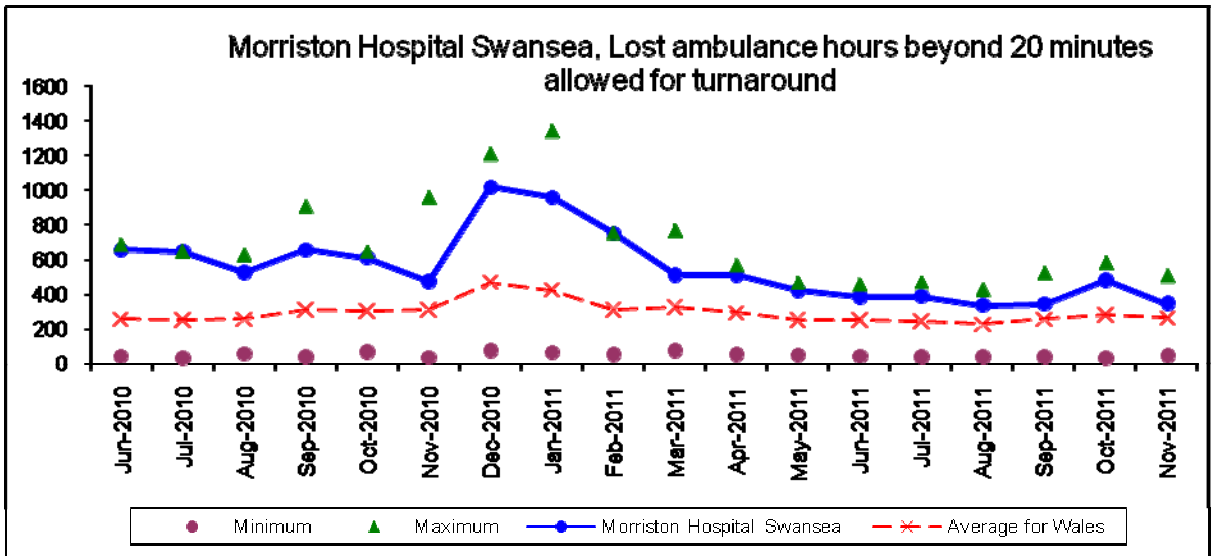
Hospital	Average time patients spend in A&E, from arrival to departure (minutes)	
	2007-08	2010-11
Morriston Hospital	138	198
Princess of Wales	110	117
Nevill Hall Hospital	109	169
Royal Gwent Hospital	147	210
Wrexham Maelor Hospital	127	124
Ysbyty Glan Clwyd	138	156
Ysbyty Gwynedd	106	147
Prince Charles Hospital	136	171
Royal Glamorgan Hospital	94	NA
Bronglais General Hospital	NA	105
Glangwilli General Hospital	NA	165
Withybush General Hospital	116	146
University of Wales Hospital	NA	151
Wales	122	158
NA – data not available		

Source: Wales Audit Office analysis of data collected from health boards in November/December 2011 and from predecessor bodies in 2009.

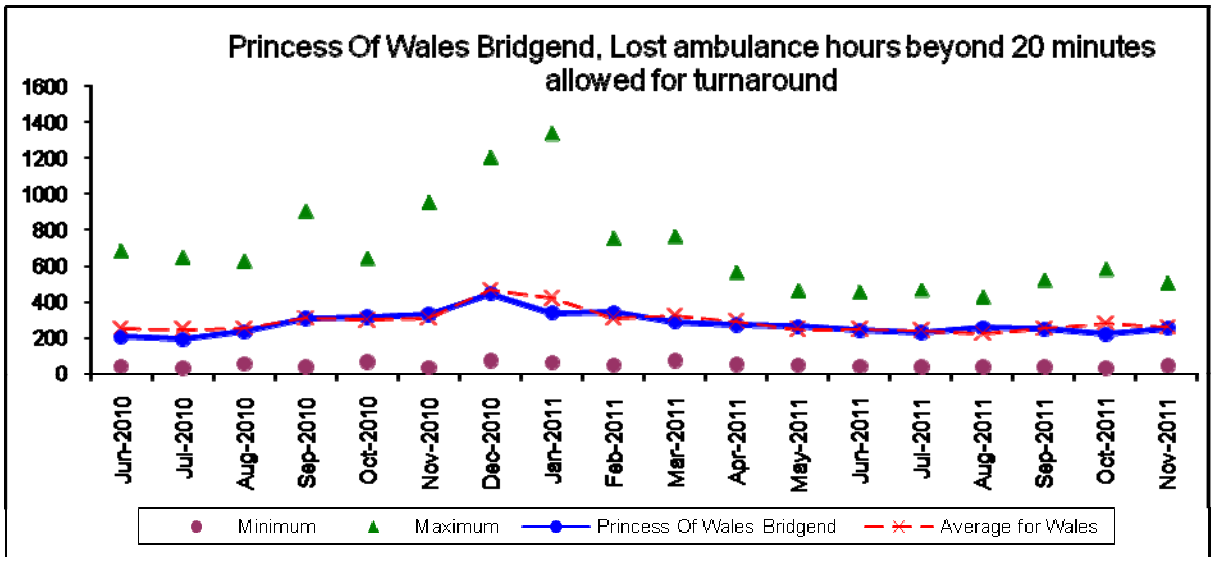
Appendix 9

Lost ambulance hours due to delayed patient handovers

The data below show the number of ambulance hours lost beyond 20 minutes allowed for the patient handover to be completed and the ambulance to be made ready to respond to other emergency calls.



Source: Welsh Ambulance Services Trust.

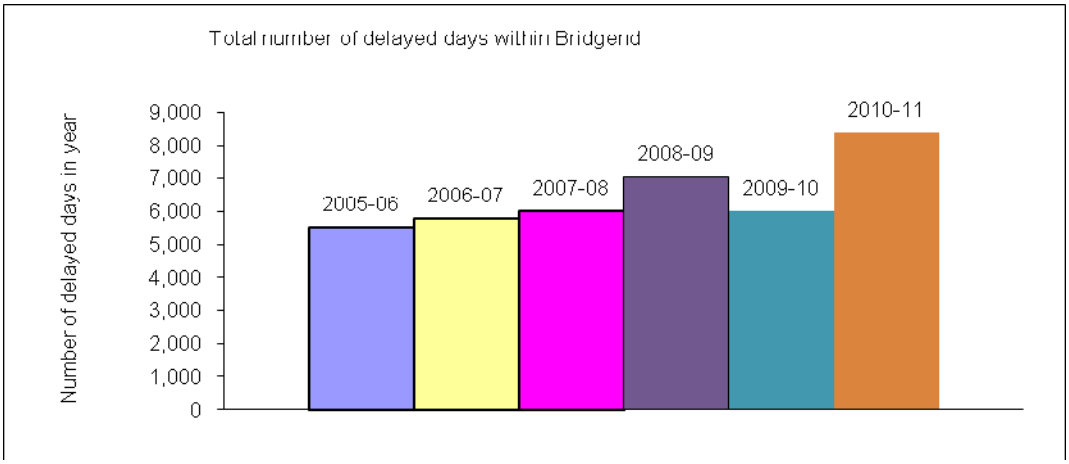


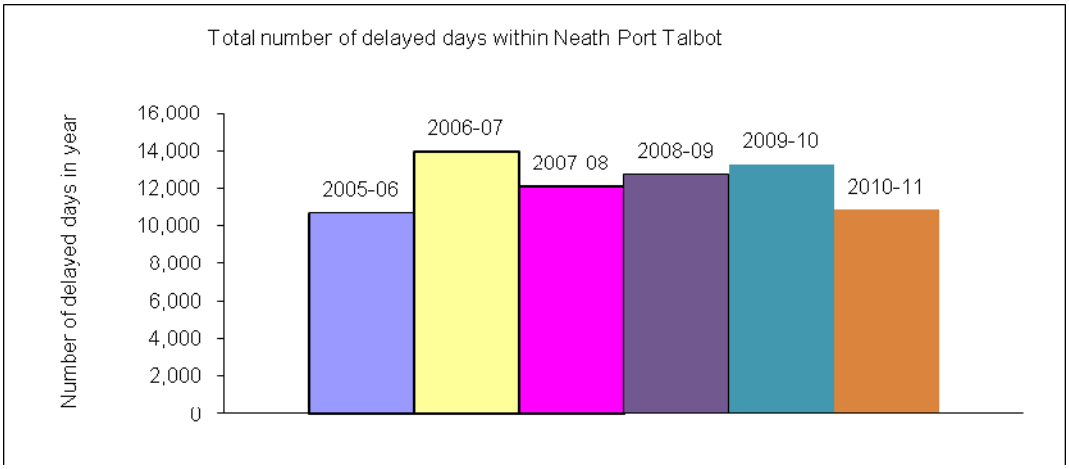
Source: Welsh Ambulance Services NHS Trust.

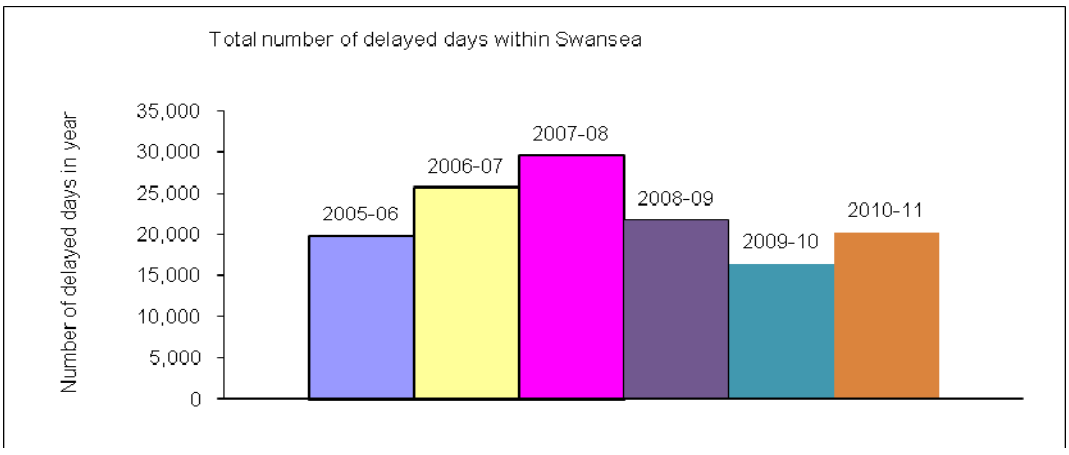
Appendix 10

Delayed transfers of care

The exhibits show the number of bed days lost as a result of people experiencing a delayed transfer of care in the three Health Board localities.





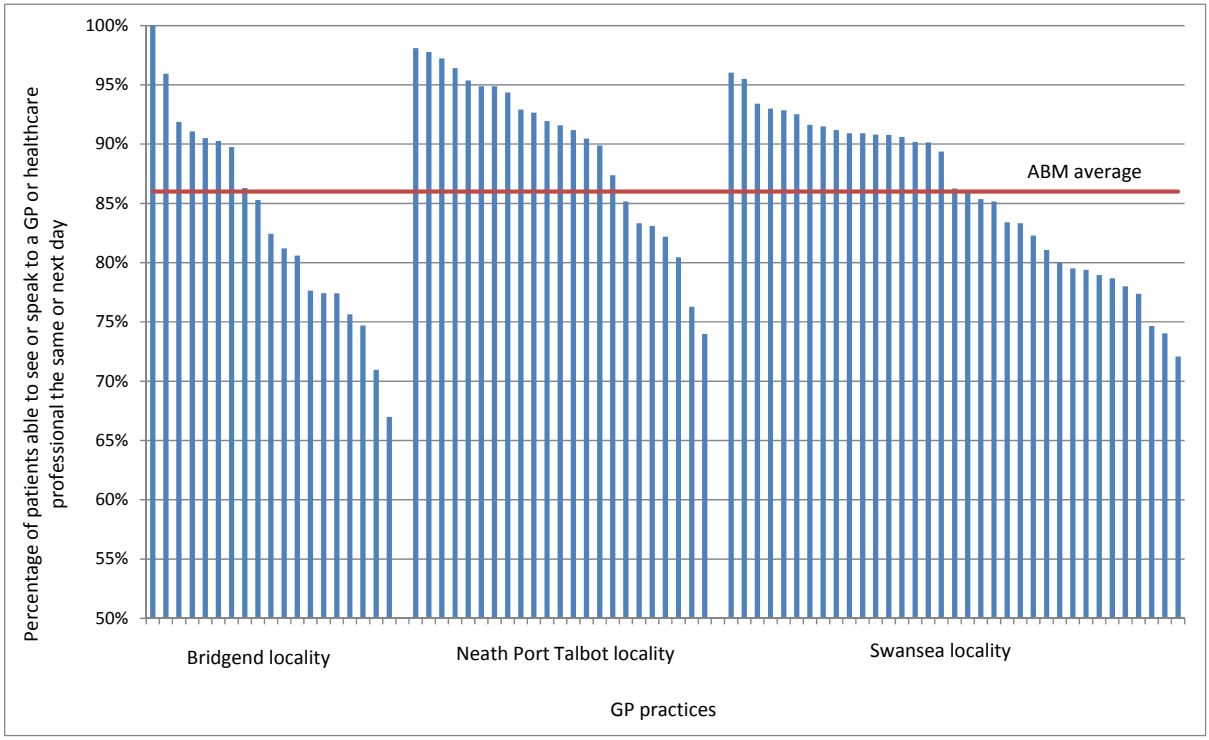


Source: Welsh Government.

Appendix 11

Urgent access to primary care

Percentage of patients registered with GP practices in Abertawe Bro Morgannwg who reported being able to see or speak to a GP or healthcare professional, the same day or next day



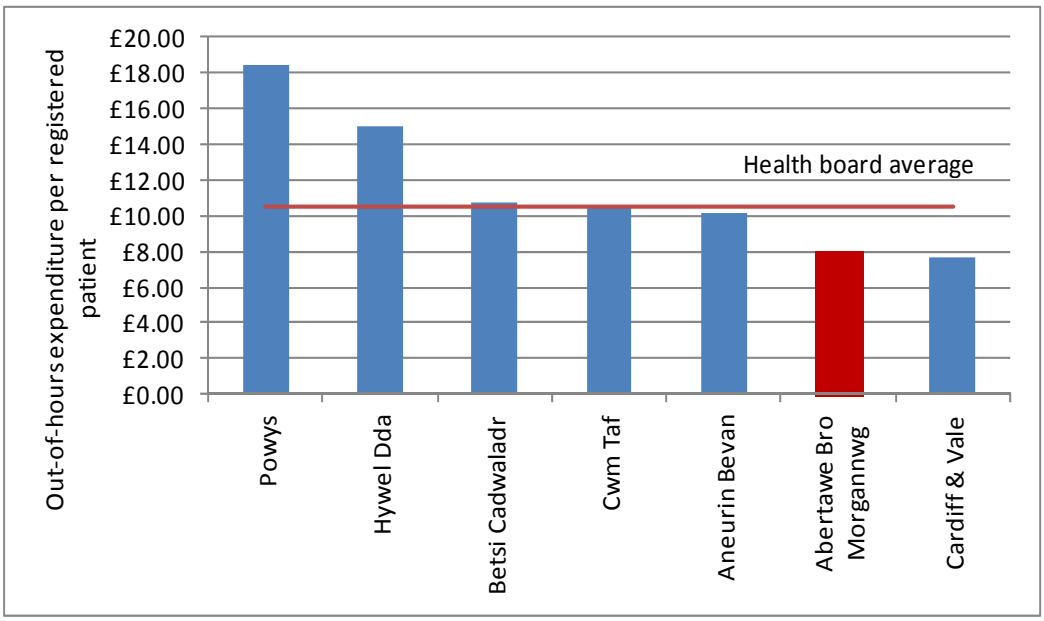
Source: Welsh GP Access Survey, 2010-11, Welsh Government, SDR 103/2011.

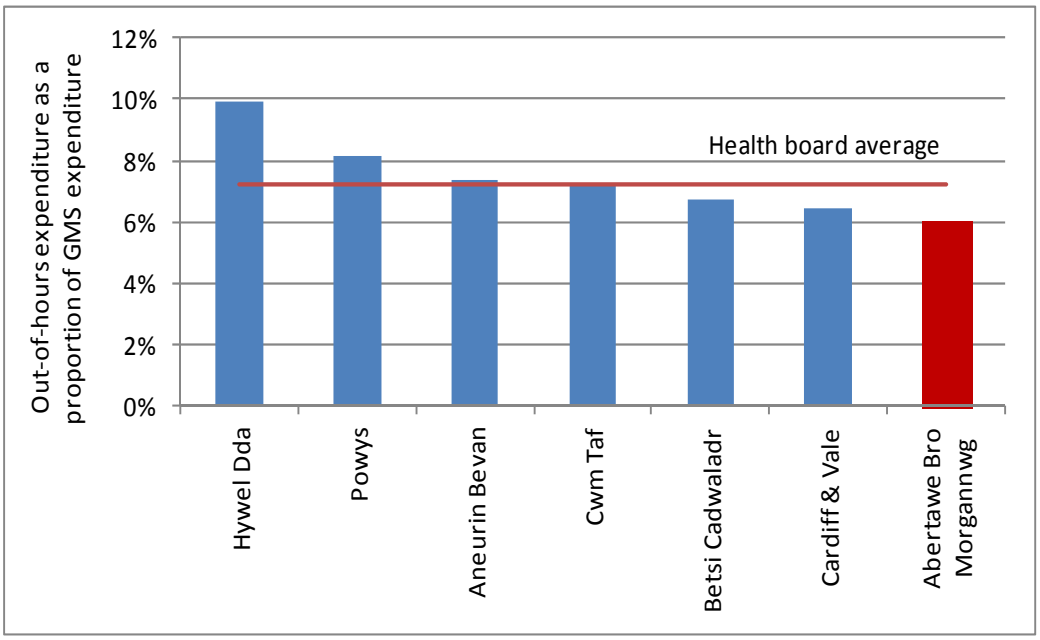
The Y axis is truncated and does not start at zero.

Appendix 12

Expenditure on out-of-hours primary care services

The first chart below shows the expenditure on out-of-hours General Medical Services (GMS) per registered patient. The second chart shows the out-of-hours services expenditure as a percentage of the total GMS expenditure.





Source: Audited LFRs and Welsh Government, General Medical Practitioners in Wales.

Appendix 13

Completion rates for education programmes for patients between April 2010 and December 2011

Health board	Percentage of patients who registered for a course and completed it (percentage)
Abertawe Bro Morgannwg	83
Hywel Dda	78
Powys	71
Aneurin Bevan	62
Cardiff & Vale	57
Betsi Cadwaladr	55
Cwm Taf	54
Wales average	**63**

Source: Data derived from national quarterly reports from EPP Cymru.

Appendix 14

Summary of Health Board progress

Since our fieldwork, the Health Board has continued to take action to build community service capacity and improve unscheduled care systems and performance. The Health Board reports progress having been made in a number of areas across the five workstreams of the Unscheduled Care Improvement Programme in 2013-13, as set out in the table below. These have not been reviewed by the Wales Audit Office, and the Health Board recognises that sustainable improvement and achievement of the unscheduled care standards have yet to be achieved.

Workstream	2012-13 progress reported by the Health Board
Pre-hospital	Establishment of three condition based pathways with the WAST to avoid hospital attendance (falls, epilepsy and hypoglycaemia).
	Joint investment with WAST in five Advanced Paramedic Practitioners to reduce conveyance rates to hospital.
	Primary care Access Forum established to focus on current access, and evaluate the enhanced access scheme.
	Pilot of acute GP Unit at Singleton hospital initiated to provide a single point of access for GPs referring medical patients from Neath Port Talbot and Swansea.
	Over 1400 users of telecare in the Bridgend locality.
Emergency departments	Medical workforce plans to achieve extended Consultant cover put in place in both emergency departmensts.
	Three additional Consultants in Emergency Medicine appointmed to Morriston hospital, bringing the establishment up to 9.6 WTE. *Interest in advertised post at Princess of Wales hospital affected by uncertainty on the outcome of the South Wales Change Programme.*
	Increased emergency department capacity at Morriston hospital following completion of the department redevelopment December 2012.
	Improved staffing of assessment areas and triage following changes to acute medicine provision and transfer of nursing resources from Neath Port Talbot to Morriston and Princess of Wales emergency departments.
Patient flow	Following the transfer of acute medicine from Neath Port Talbot hospital, alternative arrangements put in place for 10,000 emergency referrals per year, and a new repatriation model implemented between hospital sites.
	Developments in Communty Resource Teams and reductions in Delayed Transfers of Care and delayed bed days.
	Patient Flow Improvement Programme established to reinvigorate existing ‘ discharge improvement programme, aligned with 1000 live approach.

Workstream	2012-13 progress reported by the Health Board
Capacity	Beds reconfigured to accommodate NPT service change and transfer of beds to other acute sites.
	Community hospital capacity consolidated on acute sites following changes to community hospital configuration and to improve patient flow.
	Surge capacity (80 beds) established December to March 2013.
	Additional critical care beds commissioned by increasing nursing staff per shift from 19 to 22.
	Critical care nurse bank set up to provide better cover of peaks in demand in terms of cost/quality.
	Capita commissioned to review capacity in 'Swansea' system with recommendations about bed use and models of care informing plans.
Management	Executive on-call arrangements reviewed to increase Executive availability and improve escalation process.

Source: Abertawe Bro Morganwg University Health Board and Partners: Unscheduled Care Improvement Programme 2013/14.

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