WALES AUDIT OFFICE
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Transforming unscheduled care and chronic conditions management

Aneurin Bevan Health Board

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Status of report

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Contents

The Health Board has introduced numerous improvements and is taking a genuinely whole-systems approach to service transformation which is having an impact, although some performance levels remain problematic and services are still experiencing significant pressures. The Health Board's sound structures to address these issues which is supported by good clinical engagement and partnership working provides the foundations for increasing the pace of change in the way services are used by clinicians and the public.

Summary report

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* (the Wanless Review) 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 for the NHS in Wales. It describes the pressures that Welsh hospitals experience for reasons including 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 overreliance on acute hospitals and towards greater use of primary and community services, and an increased focus on preventative 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 could 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 considerable impact of chronic conditions is growing in Wales**. One-third of the adult population in Wales, an estimated 800,000 people, reports having at least one chronic condition, such as diabetes, emphysema or heart disease. This proportion is higher in Wales than the other parts of the United Kingdom. The prevalence of chronic conditions increases with age and given that Wales' 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 therefore has huge potential benefits for unscheduled care services.

5. The Wales Audit Office has previously carried out a large body of work on the areas of 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. Given that it is now more than two years since the publication of this body of work, the Wales Audit Office has undertaken follow-up audit work on chronic conditions and unscheduled care that considers progress against our previous recommendations but also aims to provide new 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.

[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. Aneurin Bevan Health Board (the Health Board) has recognised the need to transform its model of services. The Health Board's Strategic Workforce and Financial Framework identified an over-reliance on hospital capacity with on average 360 patients attending its emergency departments each day. This is combined with high levels of admission for common chronic conditions, inefficient use of primary, community and outpatient facilities often with high Did Not Attend (DNA) rates of seven per cent or more. Hospital Length Of Stay (LOS) for people with chronic conditions is reducing although there is still scope for substantial improvement. The Health Board is also aware that readmission rates for patients with chronic conditions are high, with over 50 per cent coming from medical patients.

9. The Health Board's *Clinical Futures* strategy is the framework for reshaping its clinical services. In restructuring services over the last two years a key focus has been the Gwent Frailty Programme which has led to the development of Community Resource Teams (CRT) and a single point of access communication hub.

Our main findings

10. 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 and unscheduled care?

11. Our main conclusion is:**The Health Board has introduced numerous improvements and is taking a genuinely whole-systems approach to service transformation which is having an impact although some performance levels remain problematic and services are still experiencing significant pressures. The Health Board's sound structures to address these issues which is supported by good clinical engagement and partnership working provides the foundations for increasing the pace of change in the way services are used by clinicians and the public.**

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

Part 1 – The Health Board has introduced an extensive range of service improvements for managing chronic conditions and unscheduled care which are having an impact, although, they have not yet delivered the expected step change in performance or reduced demand

1a. Acute services continue to experience considerable pressure and performance of these services remains below the expected level:

- Emergency departments continue to experience significant pressure but the increase in attendances and emergency admissions is stabilising.
- Despite attempts to improve patient flow and discharges, these areas remain problematic.
- The Health Board is making progress reducing the length of stay for patients who are emergency admissions.
- GP practices were generally positive about the information they were given about emergency admissions but there are mixed views about whether they are given enough support to prevent unnecessary admissions.
- Although there has been a marked improvement with ambulance handovers at the Royal Gwent Hospital, there remains considerable scope to improve performance at both acute sites.

1b. There has been good progress in reshaping out-of-hospital services but there has not yet been the step change required in drawing activity away from acute services:

- Chronic conditions services are being rationalised and whilst much more is being done to manage these conditions in the community there remains scope to use the GMS contract arrangements more constructively to deliver improvements.
- The Health Board has had some success with efforts to minimise demand and improve care for people who repeatedly access services.
- The frailty programme has considerable potential and whilst it is changing the way services are delivered, it is only just starting to make an impact and attract demand away from acute services.
- Improved management of chronic obstructive pulmonary disease (COPD) is reducing emergency admissions, however, the picture is less encouraging for other major chronic conditions such as coronary heart disease and diabetes.
- The new Neighbourhood Care Networks provide a positive model for the engagement and involvement of GPs and primary care teams, although the audit has indicated a more general need to improve aspects of communication with general practice following discharge from hospital.
- The role of community hospitals is much clearer and beds are managed as a single Health Board-wide resource; there is, however, a need to improve awareness of the full range of community services amongst acute hospital staff.
- Some issues with urgent access to primary care remain but the Health Board is implementing important changes.
- Benchmarking suggests there is a need to improve the responsiveness of out-of-hours primary care services and there are risks associated with staff shortages.

Part 1 – The Health Board has introduced an extensive range of service improvements for managing chronic conditions and unscheduled care which are having an impact, although, they have not yet delivered the expected step change in performance or reduced demand

1c. The Health Board has had only limited success in changing the way that the public uses services:

- The Health Board's attempt to divert demand away from hospitals through 'marketing and public awareness' did not have the anticipated impact and the Health Board is now putting greater emphasis on redirecting patients once they access the emergency department.
- The Health Board has developed a single point of access communication hub which is currently limited to the Frailty Programme services, and more can be done to extend its role and function.
- Access to self-care education is comparatively low and much more could be done to improve its impact.

Part 2 – The Health Board has a clear vision and sound structures for delivering transformational change, which is supported by good clinical engagement and partnership working that should now help it more quickly change the way clinicians work and the public use services

2a. The Health Board's clear and ambitious vision for service change is now supported by new and improved workforce planning arrangements:

- The Health Board's clear, overarching strategy for chronic conditions and unscheduled care is rightly ambitious although significant challenges remain in delivering these planned changes.
- The Health Board has prioritised and resourced the delivery of its integrated Clinical Futures workforce planning programme with a clear intention to deliver changes in a whole system context across primary and secondary care.

2b. The Health Board's investment in establishing sound governance structures and management arrangements for its chronic conditions and unscheduled care programmes suggests it is well placed to deliver transformational change:

- The Health Board has a good structure of individual leaders and groups that are driving change.
- The Health Board's approach to performance managing unscheduled care and chronic conditions management has moved much more towards measuring outcomes, although more needs to be done to strengthen its approach to evaluating change.

2c. The Health Board has positive arrangements in place for working with external stakeholders and has made real and sustained progress engaging with clinicians and placing them at the centre of decision-making processes, however, it still faces some important challenges in changing the way clinicians work and the public use services:

- The Health Board's commitment to developing and promoting clinical engagement is having a positive impact.
- Engagement with partners is happening within a positive atmosphere of working towards shared goals and there is scope to further strengthen these relationships.
- The Health Board's recent engagement with the housing sector provides opportunities to address the impact of poor housing on health.

Recommendations

Reducing pressure on services

R1 We restate a recommendation from our August 2010 report *Review of Accident and Emergency Department Medical Staffing*, that the Health Board should seek feedback from emergency department staff about job satisfaction and wellbeing.

R2 The Health Board in partnership with the Welsh Ambulance Services NHS Trust should undertake more detailed work to understand the reasons behind the:

- relatively high number of patients arriving in the emergency department by ambulance; and
- high numbers not requiring any further treatment in primary or secondary care.

Then develop joint strategies to reduce the number the number of patients unnecessarily brought to the emergency department.

Reducing pressure on services

R3 The Health Board should examine whether Emergency Department access to specialty advice for assessment, admission or discharge can be further streamlined to reduce delay and flow bottlenecks. A particular focus should be medical specialty referrals in the Royal Gwent Hospital.

R4 The Health Board should strengthen the current discharge letter arrangements to address the longstanding concern of GPs that letters are often not addressed to the referring GP, but to the practice or lead partner, which can cause delay.

R5 The Health Board with its partner Local Authorities needs to ensure the reasons behind the non-health care related delayed transfer of care identified in the complex list states are addressed as a quickly as possible to minimise their impact.

R6 The Health Board should strengthen the Ambulance Liaison Nurse arrangements in Nevill Hall, replicating the successful initiative in the Royal Gwent Hospital.

R7 The Health Board should revisit the checklist we provided as part of our national report *Patient handovers at hospital emergency departments* to ensure the handover process is as efficient as possible.

Reshaping services	
R8	The Health Board needs to use the Local Enhanced Service provisions of the GMS contract more constructively to develop services that focus on prevention and early intervention for chronic disease management.
R9	The Health Board addressing the lower than expected number of referrals to the Frailty Service should ensure GPs and the GP out of hours service make more use of this service rather than automatically referring patients to hospital.
R10	Building on its successful approach to managing respiratory conditions and avoiding admission and long lengths of stay, the Health Board should examine whether more can be done to improve the management of patients with coronary heart disease and diabetes to reduce their reliance on secondary care services.
R11	As part of its overall strategy to improve the management of diabetes, the Health Board should monitor compliance with its insulin initiation guidelines in primary care.
R12	The Health Board should improve and simplify the information available to clinicians and ward staff on locality services provided through the Gwent Frailty programme to support efficient discharge and care handover arrangements.
R13	The Health Board should develop its own approach to gathering the information that was found in the Welsh GP access survey which will no longer be available in the future to strengthen its overall approach to monitoring and improving access to general practice.
R14	The Health Board using the Primary Care Foundation benchmarking data should look at ways of improving GP out of hours performance in areas such as reducing the time it takes to make a telephone assessment and the resulting number of home visits.
R15	The Health Board needs to work with GPs and their representatives to secure greater commitment to the out of hours services and to reduce staff shortages within that service. The Health Board should look at out of hours service models in other parts of Wales, for example, Abertawe Bro Morgannwg University Health Board and elsewhere in order to help learn how other NHS organisations have overcome this problem.
R16	The Health Board needs to ensure that it is using the findings of the DSU's work on discharge arrangements to make the current arrangements more efficient and effective.
R17	The Health Board should take forward the recommendations of the multiagency Healthy Homes – Healthy Lives conference for strengthening the partnership between health and housing organisations in addressing the impact of housing on health and health inequalities.

Changing the way the public uses services	
R18	The Health Board should revisit its approach to raising public awareness of when it is appropriate to use emergency departments. This should involve consideration of the use of a range of different media to promote public awareness, including the use the television screens in its acute hospitals.
R19	The Health Board needs to strengthen its approach to redirecting patients who attend the emergency department when more appropriate services are available, this should include training and support for staff to undertake this role.
R20	Once the Health Board's review of patient education programmes for chronic condition management has been completed, strengthen the current arrangements to ensure equity and ease of access are improved, and that courses are targeted at the widest range of conditions as possible.
R21	As part of its Setting *the Direction* performance monitoring dashboard, the Health Board should develop a suite of indicators that measure the impact of patient education programmes on supporting people with chronic conditions instead of just focusing on the professional activity undertaken.
R22	The Health Board in partnership with the local authorities should develop an overarching strategy for telehealth to address the poor use of resources and access equity identified in the 2011 Gwent Frailty review.
R23	The Health Board needs to ensure evaluation is built into all chronic condition and unscheduled care service developments to ensure good practice is shared and lessons are learnt.

Developing the workforce

R24 The Health Board should put in place plans to achieve 16 hours of consultant cover at its emergency departments and should begin monitoring the actual number of hours of cover that each unit receives from consultants.

R25 The Health Board should ensure that staff shortages in the out of hours services are not adversely affecting patient experience and quality of care.

R26 The Health Board should strengthen its approach to primary care workforce development as part of an integrated approach to the workforce planning that needs to underpin its service transformation plans.

R27 The Health Board's forthcoming review of Emergency Nurse Practitioner (ENP) services should consider the following issues:

- sickness within the nursing team in emergency departments too often leading to the ENP service not being run;
- some ENPs do not act as ENPs often enough, which can impact on their confidence and result in them not using their full range of extended skills; and
- ENPs are being drawn into the service at Ysbyty Ystrad Fawr and the resultant gaps in ENP cover at Royal Gwent and Nevill Hall are not always backfilled.

R28 The Health Board should strengthen succession planning arrangements for clinical leaders including equipping clinicians with the skills for the role prior to their appointment.

Detailed report

The Health Board has introduced an extensive range of service improvements for managing chronic conditions and unscheduled care which are having an impact, although, they have not yet delivered the expected step change in performance or reduced demand

13. Demand for hospital services is high and rising with increasing numbers of emergency department attendances and emergency admissions. Managing demand is about ensuring patients receive the most appropriate care in the right setting. Reducing inappropriate demand and preventing unplanned admissions should enable hospitals to operate more efficiently and ensure patients who truly need their services are seen as quickly as possible. 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 inappropriate demand on the acute sector by developing out-of-hospital services, supporting self-care and helping signpost patients to the services which are most the appropriate for their needs.

Acute services continue to experience considerable pressure and performance of these services remains below the expected level

Emergency departments continue to experience significant pressure but the increase in attendances and emergency admissions is stabilising

14. 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 upwards 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.

15. Between 2009 and 2011 attendances at the Health Board's main emergency departments in the Royal Gwent (RGH) and Nevill Hall (NHH) hospitals have continued to increase although the rate is slowing down (Exhibit 1). Attendance rates show patients are using minor injury units less but A&E. Although the reasons for this are not known it does suggest more can be done to change the patient choice of service.

Exhibit 1: Long-term trend in demand at hospital emergency departments

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

	2009	2010	2011
Major A&E departments	127,173	130,152	131,521
Minor injury units	32,939	30,858	28,608
Total	**160,112**	**161,219**	**160,313**

Source: Stats Wales

16. Whilst demand may have stabilised, attendances still remain at a high level. In our interviews, emergency department staff told us that the continuing workload pressure is having a negative impact on the morale of staff within these departments. This position was similar to our findings in the August 2010 report *Review of Accident and Emergency Department Medical Staffing*. This report recommended that the Health Board should regularly seek feedback from emergency department staff about job satisfaction and wellbeing. Since the last survey in 2009, we are not aware of any work being undertaken to seek feedback, other than the use of exit interviews from staff leaving the department. We are reiterating the need for regular feedback as part of an overall approach to managing workload pressures.

17. Unplanned follow-up attendances at A&E may be another factor that contributes to pressure in emergency departments, although the proportion of unplanned follow-up attendances at emergency departments is relatively small across Wales (six per cent). Exhibit 2 shows that the rate of unplanned follow-ups is below this level at both NHH and the RGH.

Exhibit 2: Percentage of A&E attendances that were unplanned follow-ups in 2010-11

Hospital	Percentage of unplanned follow-up attendances* (%)
Prince Charles Hospital	18
Wrexham Maelor Hospital	6
Ysbyty Glan Clwyd	5
Nevill Hall Hospital	5
Royal Gwent Hospital	4
Ysbyty Gwynedd	2

Hospital	Percentage of unplanned follow-up attendances* (%)
Bronglais General Hospital	2
Glangwili General Hospital	2
Withybush General Hospital	2
Welsh average	**6**

* At the time of the audit, data were not available for emergency departments at Morriston Hospital, Royal Glamorgan Hospital, Princess of Wales Hospital and the University Hospital of Wales.

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

18. The *Delivering Emergency Care Service*s strategy also noted an increase in the rate of emergency admissions across Wales. Between 2005 and 2011 the number of emergency admissions in the Health Board has increased by 9.9 per cent (Exhibit 3). This rate of increase was more than double than that seen across Wales as a whole (4.1 per cent) during the same period. Recently the picture has changed and in the last year the number of emergency admissions decreased by 0.6 per cent. This is different to the rest of Wales which experienced a 1.2 per cent increase.

Exhibit 3: Trend in the number of emergency admissions

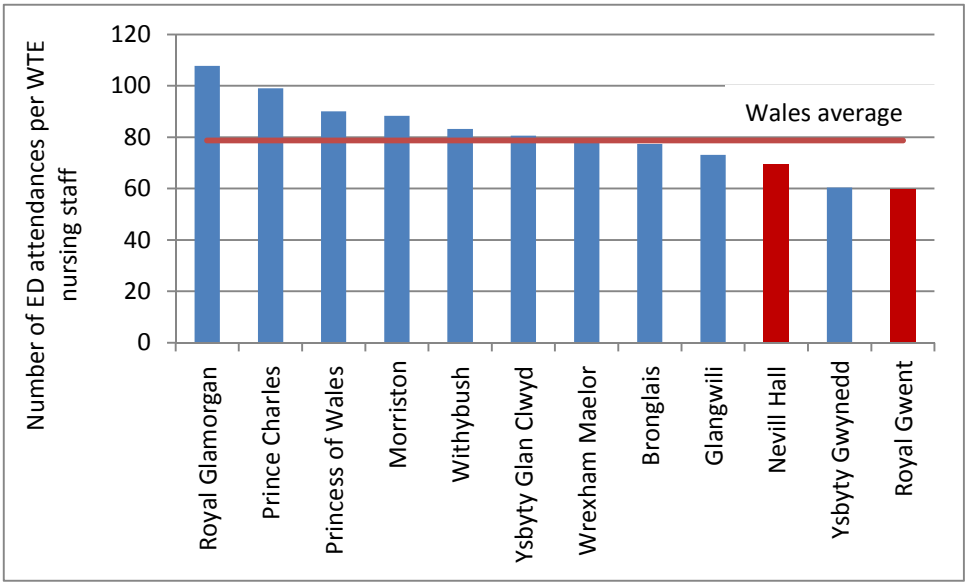
The figure shows the long-term trend in the number of emergency admissions at the Health Board and the percentage change in this number in comparison to previous years.

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
Emergency admissions	71,684	72,723	70,583	72,342	79,259	78,767
Percentage change on previous year (the Health Board)	-	1.4	-2.9	2.5	9.6	-0.6
Percentage change on previous year (all Wales)	-	1.8	-1.9	2.0	1.0	1.2

Source: PEDW

19. Whilst the working environment is demanding, the number of attendances per whole time equivalent nursing staff (bands 1 to 9) in November 2011 is much lower than Wales average (Exhibit 4a). The number of attendances per WTE medical staff are around the Wales average at RGH and slightly lower in NHH (Exhibit 4b). This suggests the pressure experienced by staff in the department is not just down to the volume of patients, further reinforcing the need for the Health Board to undertake staff surveys.

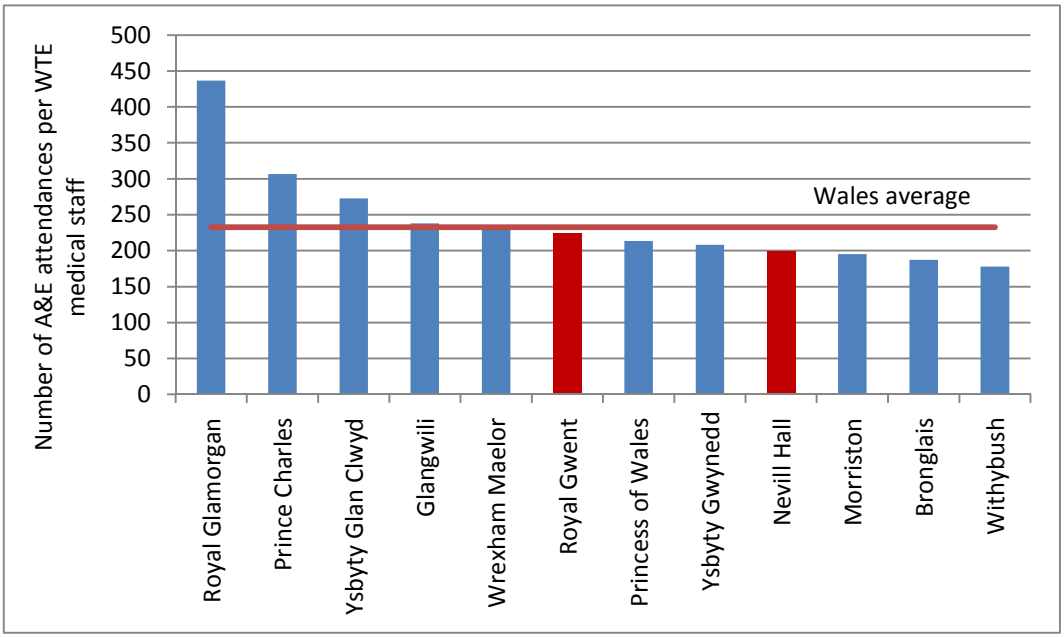
Exhibit 4a: A&E attendances per whole time equivalent nurse (bands 1 to 9) in November 2011



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 4b: A&E attendances per whole time medical staff (including locums) 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].

20. A large proportion of the demand experienced in the emergency department is through patients brought to hospital via ambulance. In 2010-11, at RGH, 28.3 per cent of all attendees arrived by ambulance, which was the third highest in Wales. The level at NHH was 25.9 per cent. Exhibit 5 shows that these proportions are higher than the average across Wales.

Exhibit 5: Proportion of attendances at major A&E departments that arrived by ambulance in 2007-08 and 2010-11

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

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

21. Of the patients that arrived by ambulance, at RGH, 32.2 per cent did not require primary or secondary care follow whilst at NHH the figure was 27.1 per cent. This suggests that once the reasons behind this performance are more fully understood the Health Board and the Welsh Ambulance Services NHS Trust (WAST) may have scope to reduce the number of ambulance patients brought to hospital.

Despite attempts to improve patient flow and discharges, these areas remain problematic

22. People accessing hospital emergency departments are, in the majority of cases, in need of rapid assessment and treatment. For this reason, 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.[3]

23. Since 2010, the Health Board has not met the four-hour target in its major emergency departments and performance against the eight-hour target is consistently worse than the Welsh average.

24. 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. For this reason we requested information from health boards on their average waiting times in hospital emergency departments.

25. In the Health Board, we found that since 2009, the average waiting times at both emergency departments increased by around an hour. Waiting times are around 40 minutes longer at RGH than NHH. With the average time increasing from 147 minutes to 210 minutes at RGH and from 109 minutes to 169 minutes at NHH. Exhibit 6 shows that these waiting times are higher than most A&E departments across Wales.

Exhibit 6: 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
Royal Gwent Hospital	147	210
Morriston Hospital	138	198
Prince Charles Hospital	136	171
Nevill Hall Hospital	109	169
Ysbyty Glan Clwyd	138	156
Ysbyty Gwynedd	106	147
Withybush General Hospital	116	146

[3] We note that new exclusion criteria for measuring emergency department waiting times were set out in a letter from the Welsh Government's Director of Operations (RB/cam/q918787) on 9 December 2011.

Hospital	Average time patients spend in A&E, from arrival to departure (minutes)	
	2007-08	2010-11
Wrexham Maelor Hospital	127	124
Princess of Wales	110	117
Bronglais General Hospital	N/A	105
Royal Glamorgan Hospital	94	N/A

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

26. Our 2009 report noted that emergency department waiting times performance is heavily dependent on the performance of the rest of the hospital. If there is poor flow through the wards due to ineffective bed management, inappropriately long lengths of stay or delays in discharge processes, this has knock-on impacts on flow within the emergency department.

27. The Health Board has rightly recognised that if an emergency department patient is referred to a ward, this referral must be accepted quickly so that the patient receives expert treatment rapidly and so that their space within the emergency department is quickly made available to other patients. For this reason, the Health Board measures the proportion of patients referred to Medicine, Surgery, and Trauma and Orthopaedics leaving the emergency department within two hours. The Health Board also measures the average time between referral and the patient leaving the department. Currently, patients leave the emergency department more quickly in NHH than at RGH (Exhibit 7). In particular, access to the Medicine teams is longer in RGH, suggesting more needs to be done to improve this performance.

Exhibit 7: Measures of patient flow from the emergency department to specialty wards

The figure shows the proportion of patients that leave the emergency department within two hours once referred to a specialty, and the average time between referral and the patient leaving the department.

	Percentage of patients leaving within two hours (percentage)	Average time to departure (HH:MM)
Medicine		
Nevill Hall	69.1	1:40
Royal Gwent	33.2	5:04
Surgery		
Nevill Hall	58.3	1:41
Royal Gwent	55.7	2:38
Trauma and Orthopaedics		
Nevill Hall	48.9	1:49
Royal Gwent	60.0	2:38

Source: Aneurin Bevan Health Board, A&E patient flow meeting papers, 11 November 2011. Data relate to the first week of November 2011.

28. If a high proportion of patients who attend the emergency department are admitted to a hospital bed, this may suggest that emergency department processes are not working effectively to avoid admissions, and affecting patient flow through the hospital. Guidance from the College of Emergency Medicine states that in departments with a normal case mix, the percentage of emergency department patients that are admitted to an inpatient bed (conversion rate) should be between 15 and 20 per cent[4]. The current conversion rates in NHH (23.9 per cent) and RGH (23.8 per cent) are higher than this guideline, suggesting more work needs to be done to reduce admission rates.

The Health Board is making progress reducing the length of stay for patients who are emergency admissions

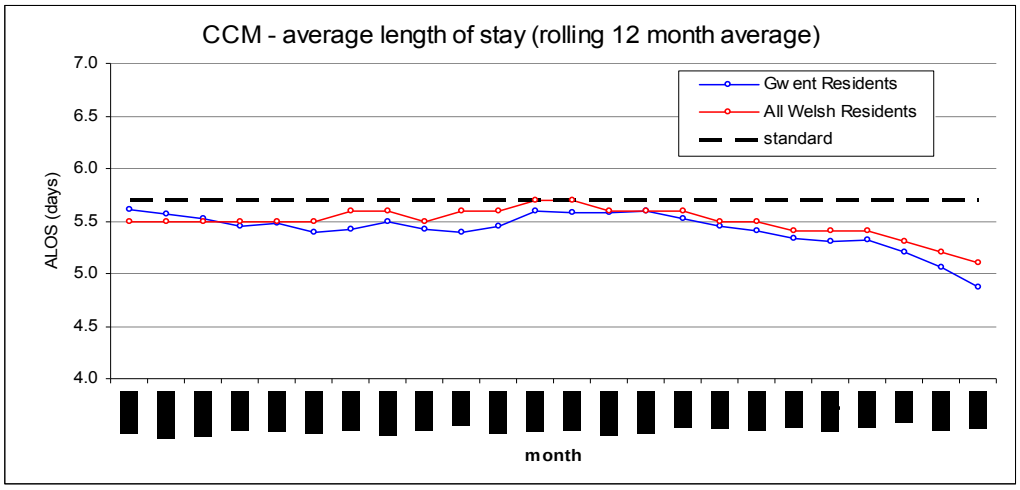
29. One of the key aims of the CCM model and framework was to reduce the number of avoidable emergency admissions and readmissions, and ensure that lengths of stay were not excessive. Achieving this will help ensure that acute sector resources are used more appropriately, and support a more efficient '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.

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

30. In 2010-11, the Health Board's hospitals admitted 6,000 chronic condition patients as emergency admissions and although this was the highest number in Wales as a percentage (eight per cent) was typical for Wales. Once admitted, these patients have an LOS just under five days which is better than the Welsh average and below the Government's 5.7 LOS target (Exhibit 8).

31. Currently, around 70 per cent of emergency multiple admissions are for respiratory and cardiovascular conditions.

Exhibit 8: Chronic Conditions Management Indicator LOS September 2011



Source: Aneurin Bevan Health Board

32. The Health Board has attempted to improve flow by extending the presence of on-site senior managers to specifically facilitate better transit times through the emergency department by identifying blockages and expediting actions. Despite the extended presence of managerial staff, during our interviews we were told that more needs to be done to ensure the in-house specialist ward teams provide greater support to the emergency department, through quicker assessments and admissions, when the emergency department suffers elevated levels of pressure.

33. The Health Board in the absence of any national targets has set its own target of reducing the average LOS for all medical emergency admissions to seven days. Currently, the Health Board's performance is around 8.5 days which is better than most in Wales although still not good enough. Performance against the Health Board's challenging target is reviewed weekly and at NHH, the target has been met only once since May 2011 and, at RGH, it has not been met at all.

34. Efficient processes to discharge patients from the wards will clearly have a positive effect on the transit time of emergency department patients who require admission. Work is underway in the Health Board to improve discharge processes, although more still needs to be done given that:

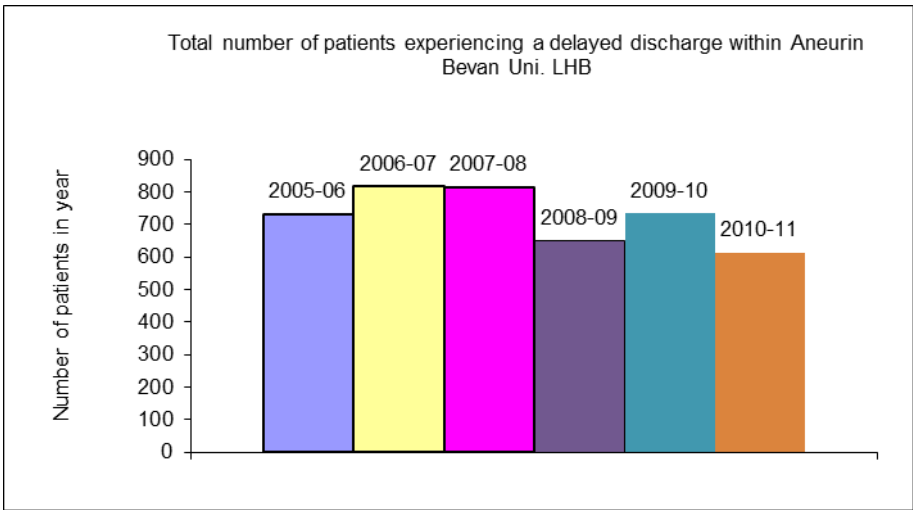
- previous attempts at rolling out an Estimated Date of Discharge (EDD) initiative have been of limited impact and the Delivery and Support Unit found in October 2011 that predictions at ward level continue to fall short of actual discharges; and
- despite having reviewed physician job plans and requiring morning ward rounds to support discharge earlier in the day , this was not happening consistently and the percentage of pre-midday discharges remains consistently low, at around 20 per cent.

35. The Health Board has carried out research to identify 'best in class' lengths of stay for certain conditions in benchmark organisations and is now rolling these out as targets for individual clinicians. As the majority of patients enter the hospital via the medical assessment unit, this is where the Health Board plans to embed the process of working towards the EDD targets.

36. 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. Exhibit 9 shows that there has been a general downwards trend in the number of people who experienced a delayed transfer of care in the Health Board area, since 2007-08. The total number of bed days lost through delayed transfers of care in 2010-11 was 20,733, less than half the number in 2007-08 (47,350). Although the overall trend is improving (Exhibit 10), since July 2011 there has been an increase in the number of people experiencing delays. The reason for these delays is rarely healthcare related, which emphasises the need for the Health Board to continue to work effectively with its local authority partners to minimise delays.

Exhibit 9: Long-term trend in the number of people experiencing a delayed transfer of care

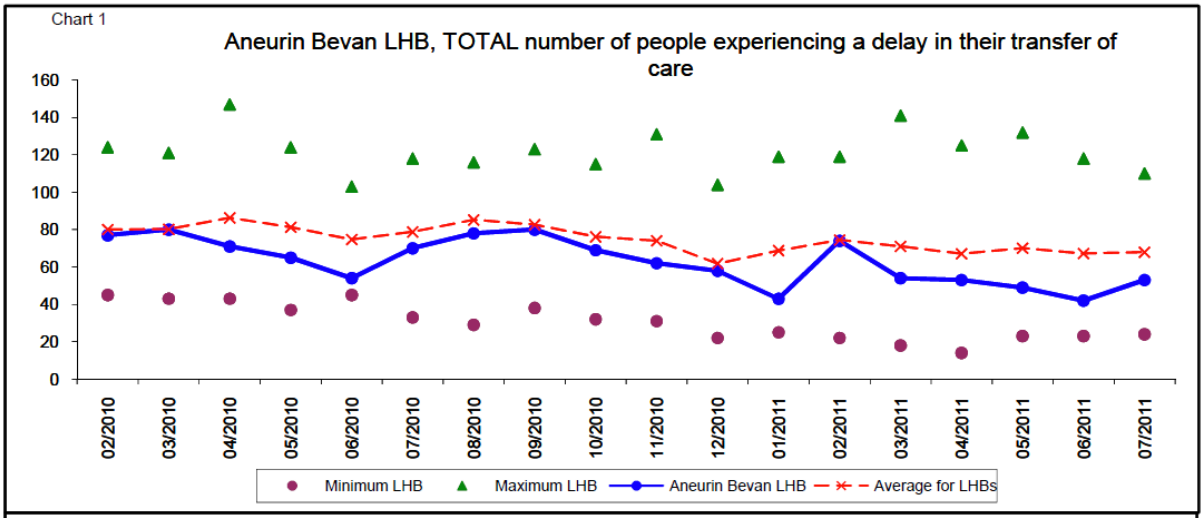
The figure shows the long term trend in the number of people that experienced a delayed transfer of care in the Health Board area.



Source: Welsh Government

Exhibit 10: Monthly data relating to the number of people experiencing a delayed transfer of care

The figure shows the number of people that experienced a delayed transfer of care in the Health Board area.



Source: Welsh Government

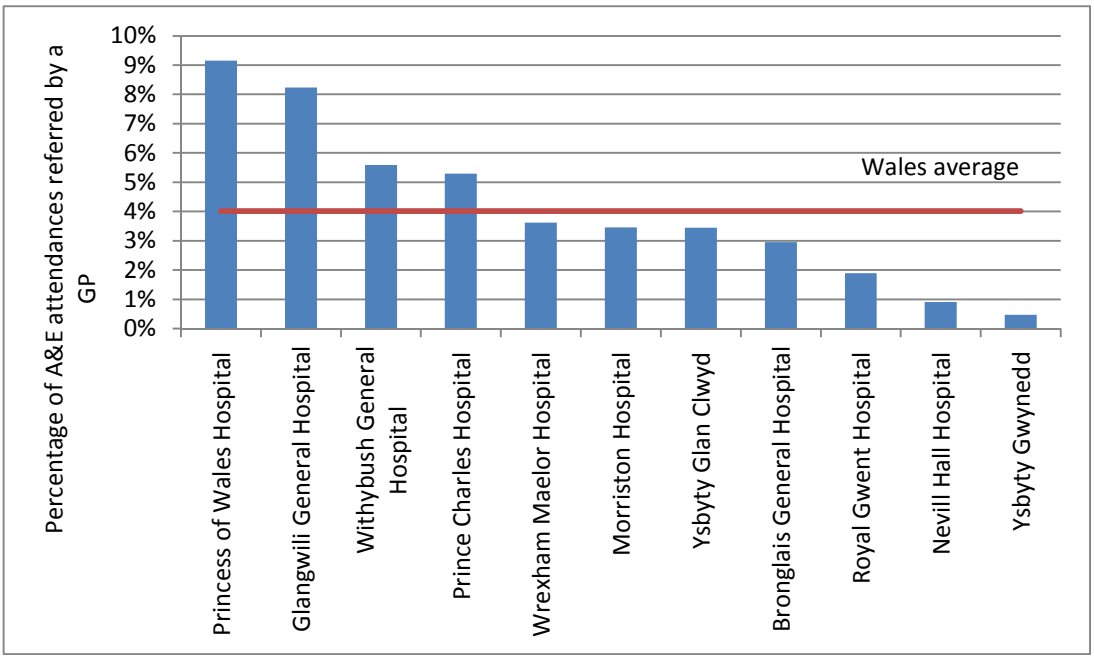
37. The Health Board is putting together plans to change the co-ordination arrangements of its community resource teams, where the Newport team will act on behalf of the other teams facilitating discharges from the Royal Gwent Hospital. The work of these teams is discussed later on in this report.

GP practices were generally positive about the information they were given about emergency admissions but there are mixed views about whether they are given enough support to prevent unnecessary admissions

38. The *Ten High Impact Steps to Transform Unscheduled Care* argues that there is a need to reduce the rate at which primary care refers urgent cases to the acute hospital. The report says that in some practices, the rate of unnecessary admissions can be reduced by 30 per cent.

39. Exhibit 11 shows that at the two emergency departments in Aneurin Bevan Health Board the percentage of attenders who were referred by a GP is lower than the Welsh average. However these data do not consider GP referrals direct to admission/ assessment units, other short stay units or direct to the wards.

Exhibit 11: The percentage of emergency department attenders who were referred by a general practitioner in 2010-11



Source: Wales Audit Office analysis of data provided by Health Boards

40. 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. The Quality and Outcomes Framework (QOF), a programme that aims to reward GP surgeries for providing certain services at recommended standards, includes a mechanism whereby health boards should be sharing emergency admissions data with every practice. Our survey of GP practices (Appendix 2) found that GP practices in the Health Board area had generally more positive views about the ways in which they were given information about emergency admissions data, for example:

- seventy-five per cent of practices have used the data (the Welsh average was 43 per cent);
- some 64 per cent of practices consider the data to be helpful (the Welsh average was 39 per cent); and
- some 57 per cent of practices believe the data will lead to changes in the way practices provide services (the Welsh average was 25 per cent).

41. 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 or to contact, GPs may be dissuaded from using them. Our GP survey showed that whilst practices in the Health Board area were generally more positive about the support available to avoid unnecessary admissions, there remains scope for improvement:

- Fifty-four per cent said they had good access to telephone or email advice from consultants. The Welsh average was 31 per cent.
- Fifty per cent said they had good access to rapid access clinics or hot clinics. The Welsh average was 34 per cent.
- Forty-four per cent said they had good access to diagnostic services. The Welsh average was 32 per cent.
- Fifty-six per cent said there was a good range of community services that assist in avoiding emergency admissions. The Welsh average was 36 per cent.
- Forty-one per cent said they had enough information about the range of community services available to prevent admissions. The Welsh average was 42 per cent.

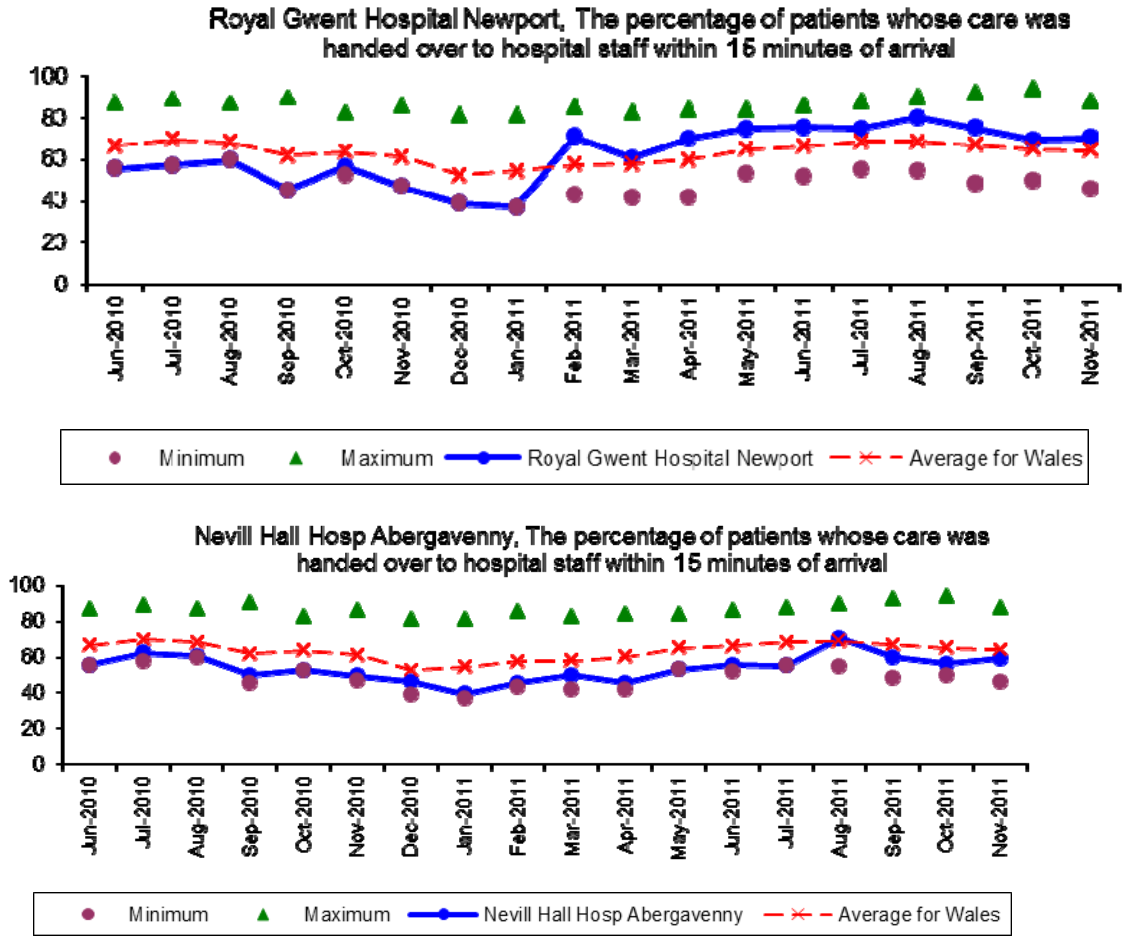
Although there has been a marked improvement with ambulance handovers at the Royal Gwent Hospital, there remains considerable scope to improve performance at both acute sites

42. When emergency departments and the rest of the acute hospital experience elevated pressures, this can have the impact of delaying 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 in trolleys in hospital corridors. These delays also have a detrimental impact on the ambulance service's ability to react quickly to emergencies because when crews are delayed at hospitals they are prevented from responding to other emergency calls.

43. Handover performance has improved significantly at RGH since early 2011, which coincides with the introduction of an ambulance liaison nurse (ALN) at that site (Exhibit 12). The NHH does not have an ALN and performance remains typically worse than the Welsh average. The ALN initiative has clearly had a positive impact with the benefit of releasing ambulance crews to respond to further emergencies. However, whilst performance has improved there are now a higher number of patients being treated in the hospital corridor due to the physical limitations of the emergency department in RGH.

Exhibit 12: Delays to patient handovers

The national target states that NHS organisations will achieve a handover of patients from an emergency ambulance to A&E (in a major A&E department) within 15 minutes. The handover period starts from when the A&E staff are notified by the ambulance crew that a patient has arrived and needs to be seen within the A&E department. The period ends when the patient has been transferred into the clinical care of the A&E staff and the ambulance crew are free to return to the ambulance.

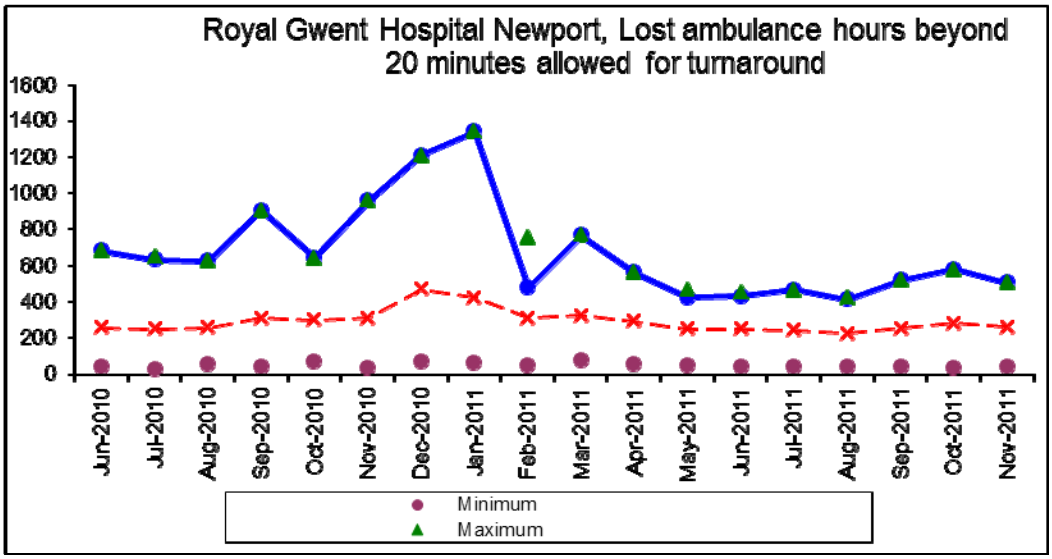


Source: Welsh Ambulance Services NHS Trust

44. Although handover time improvements are welcomed more needs to be done as RGH still has the highest total hours of ambulance crew time lost due to handover in Wales (Exhibit 13).

Exhibit 13: Lost ambulance hours due to delayed handovers

The figure shows the number of hours of ambulance time that were lost due to ambulances taking longer than 20 minutes to hand over and make ready for the next emergency.



Source: Welsh Ambulance Services NHS Trust

45. Another factor to consider in monitoring ambulance handover times is the completeness of data collection. We note that at RGH there has been a significant improvement in the proportion of patient handovers for which handover timing data is now collected. This use of the handover data terminals has increased from around 60 per cent to around 80 per cent and has again coincided with the introduction of the ALN role. Compliance with the use of the data terminals remains very poor at NHH; the figure is typically around 50 per cent, showing more needs to be done at this site to ensure an accurate picture on ambulance handover performance is obtained.

There has been good progress in reshaping out-of-hospital services, but there has not yet been the step change required in drawing activity away from acute services

Chronic conditions services are being rationalised and whilst much more is being done to manage these conditions in the community there remains scope to use the GMS contract arrangements more constructively to deliver improvements

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

47. Shortly afterwards, the Welsh Government's chronic conditions framework and management model signalled the need to rebalance services on a whole-system basis. This relied on health boards identifying the individuals at greatest risk of unplanned admissions and then actively managing them to ensure they receive care in the most appropriate place.

48. Responding to the Welsh Government's framework, the Health Board's predecessors developed a delivery plan (LDP). To manage the delivery of the LDP programme, a chronic conditions management steering group was established. The Health Board's plans enabled it to secure funding from the Welsh Government's Transitional Funding scheme which was then used primarily to fund a temporary improvement team and implement a medicines management scheme.

49. This approach was successful and the LDP programme was completed on time in March 2011 with the Health Board reporting successful delivery of the action plan and meeting the 95 per cent target for commissioning directives.

50. The Health Board's approach to improving services is focused on the high volume conditions through the Diabetes Planning and Delivery Group (DPDG), the Epilepsy Group and the COPD Respiratory Group. These changes continue to be delivered through a programme management approach of defined projects (bundles) developed in the LDP programme to manage the linkages between community and acute services.

51. These are not standalone strategies and they are all integrated with the Health Board's overarching *Clinical Futures Programme* and the joint local authorities and Health Board Gwent Frailty Programme.

52. The *Clinical Futures Programme* is realigning hospital services and moving resources to the community. Already the Health Board's bed configuration has recently reduced from 1,825 (1,295 acute and 530 community) to 1,522 (1,139 acute and 383 community).

53. The Gwent Frailty Programme in April 2011 successfully integrated all the locality intermediate care and reablement teams into six locality Community Resource Teams (CRTs). These teams are now responsible for delivering all the urgent medical assessment, rapid response nursing, emergency social care, reablement and falls management that was done under the previous structures.

54. Generally, the Health Board's focus for improving chronic condition management has been on the later stages of care stratification with the prevention focus coming from a more generalised approach as part its public health strategic framework[5]. This framework focuses on the deprivation issues linked to smoking cessation, obesity and healthier lifestyles.

55. There are opportunities within the GMS contract arrangements to promote better health and prevention through developing Local Enhanced Services (LES). The Health Board's most recent primary care report (2009-10) identified that it has the lowest expenditure on enhanced services across Wales due to the low uptake of LES.

56. This did not change last year and the £859,000 of expenditure was mainly directed at other services, rather than managing chronic conditions, suggesting more could be done through the LES arrangement.

The Health Board has had some success with efforts to minimise the demand and improve care for people who repeatedly access services

57. *Ten High Impact Steps to Transform Unscheduled Care* recognises that some patients repeatedly access services in an urgent manner. These patients typically might have complex medical conditions or may experience regular breakdowns of their chronic conditions packages. The report urges health boards to develop care registers of these patients and for multi-disciplinary teams to develop individualised care plans to meet their needs. This would aim to progressively reduce the frequency of their encounters with the unscheduled care system.

58. The Health Board has not been able to undertake the full chronic condition patient risk stratification because of rollout delays with the national PRISM risk stratification tool. Instead the Health Board has focused on a specific group of patients with complex needs who are regular attendees in the emergency medical admission stream. Specifically, chronic condition patients who experience more than three admissions per year. Once identified, the CRTs case-manage these individuals. Audits carried out by the Health Board suggest that this approach has had 'positive outcomes' in 70 per cent of cases and an internal evaluation found it avoided more than 2,500 episodes of hospital care over the last year.

59. Our survey of GPs shows that 10 out of 26 responding practices have undertaken work themselves or have been involved in work by the Health Board to identify patients who repeatedly attend hospital emergency departments.

[5] *A Healthier Gwent for All*, Aneurin Bevan Health Board Public Health Strategic Framework 2011-2015.

The frailty programme has considerable potential and whilst it is changing the way services are delivered, it is only just starting to make an impact and attract demand away from acute services

60. The Gwent Frailty Programme has been under development since 2007, with the strategic direction and implementation plan agreed by the partners in 2009. The Programme received £6.9 million funding from the Welsh Government's Invest to Save Fund. Starting in 2010-11 the funding which is a repayable loan is phased over three years in roughly equal proportions to pump prime changes in existing services and for the formation and development of the CRTs. The investment needed by the partners varies and is based on the amount of change needed and the services already in place. The vast majority of savings will be realised from releasing Health Board beds and subsequent budget realignments. In addition, there will also be savings realised from a reduction in residential care placements and changes to social care packages.

61. The CRTs have been developed on a franchise model building on existing services and providing local ownership. This means there are planned difference in what teams offer and how this is delivered (Exhibit 14). The CRTs became operational on a phased development basis in April 2011. There were some delays recruiting staff which meant some CRTs have had to take more time than originally planned to develop some services. The current model is based on an 8 am to 8 pm working day which covers the majority of service demand. Currently, an extended day (7 am to 11 pm) service is being piloted in Caerphilly to see what the demand is for increasing access.

Exhibit 14: CRT team availability December 2011

CRT Function	Blaenau Gwent	Caerphilly	Newport	Monmouthshire	Torfaen
Urgent assessment and intervention (Hospital@ Home)	Not available	9am to 5pm (Monday to Friday)	Medical assessment only 9am to 5pm (Monday to Friday)	Urgent assessment from MDT 9am to 5pm (Monday to Friday)	9am to 5pm (Monday to Friday)
Rapid Response (Nursing)	8am to 8pm (7 days)	8am to 8pm (7 days)	8am to 8pm (7 days)	9am to 5pm (7 days)	Not available
Emergency Social care	Not available	24 hours a day, 7 days a week	8am to 8pm (7 days)	Referrals 9am to 5pm Service 24 hours a day, 7 days a week	7.30am to 10pm (7 days)
Reablement	8am to 10pm (Monday to Saturday)	9am to 5pm (Monday to Friday)	8am to 8pm (Monday to Saturday)	9am to 5pm (7 days)	8.30am to 4.30pm (Monday to Friday)
Falls management	8am to 8pm (Monday to Saturday)	Included in above –no dedicated service	8am to 8pm (7 days)	9am to 5pm (Monday to Friday) Urgent only at weekends	9am to 5pm (7 days)

Source: Aneurin Bevan Health Board

62. The new arrangement has seen the introduction of a single point of access 'communication hub' for accessing services provided by the four CRTs (one in each of the following areas; Blaenau Gwent, Caerphilly, Newport and Torfaen) and two Integrated Services Teams (ISTs) in Monmouthshire. The IST model was adopted for Monmouthshire because as well as delivering the CRT functions it allowed some existing services to be included rather than duplicating or disassembling services that were already seen as effective. These additional services included the therapy-led beds at Mardy Park, the Community Hospital Occupational Therapy Services, Monnow Vale Integrated Health and Social Care Unit, Enablement Service for long-term care clients and the allocation of all community referrals and assessments.

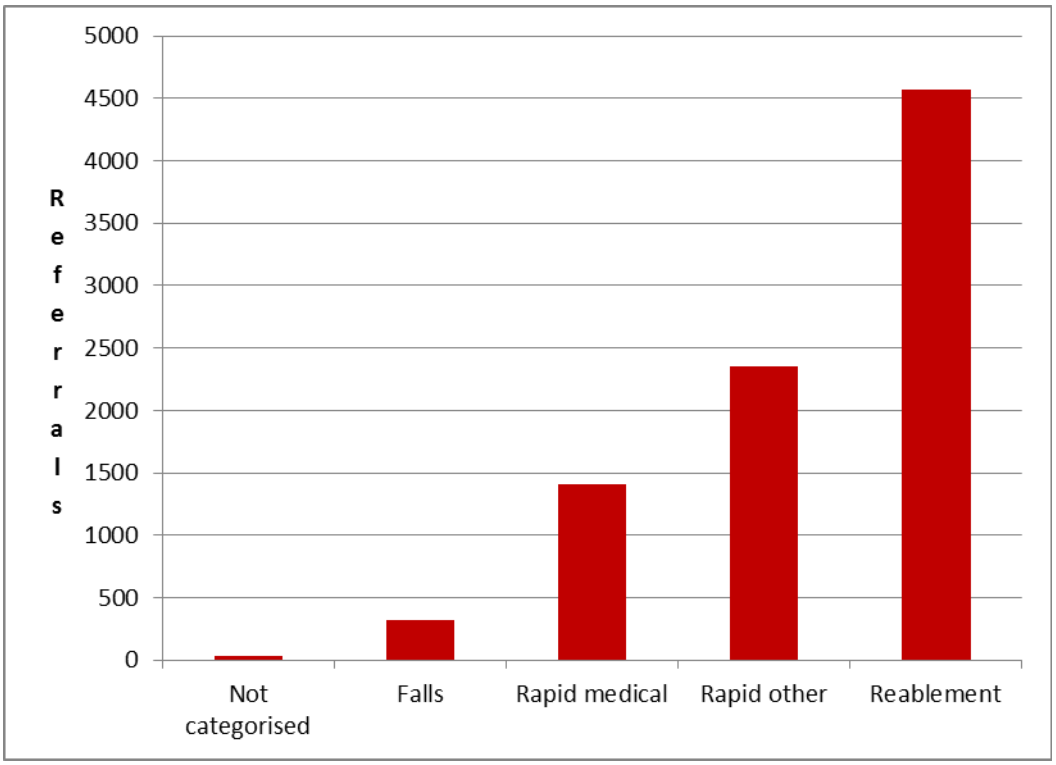
63. Early indications are that the Frailty programme is starting to deliver the step changes required. The Wales Audit Office is conducting an in-depth review of the Gwent Frailty programme during 2012, which will look more closely at the impact of the programme.

64. Between April and December 2011 the CRTs received 8,900 referrals with just under half for reablement services (Exhibit 15). The Frailty Operational Co-ordinating Group has identified that this referral rate is much lower than originally anticipated at this stage of development. The reasons for this appear to be:

- low numbers of referrals from the Newport and Caerphilly localities;
- GPs and the out-of-hours service still referring some patients for hospital admission which could be appropriately managed by the CRTs; and
- a low number of weekend referrals partly due to recruitment issues preventing all services from operating and creating greater awareness with the out-of-hours service and ward staff.

65. This suggests there is still a lot more that could be done promoting the service and ensuring GPs and the out-of-hours service are doing all they can to avoid patients unnecessarily to hospital when alternatives are available.

Exhibit 15: CRT referral distribution April to December 2011

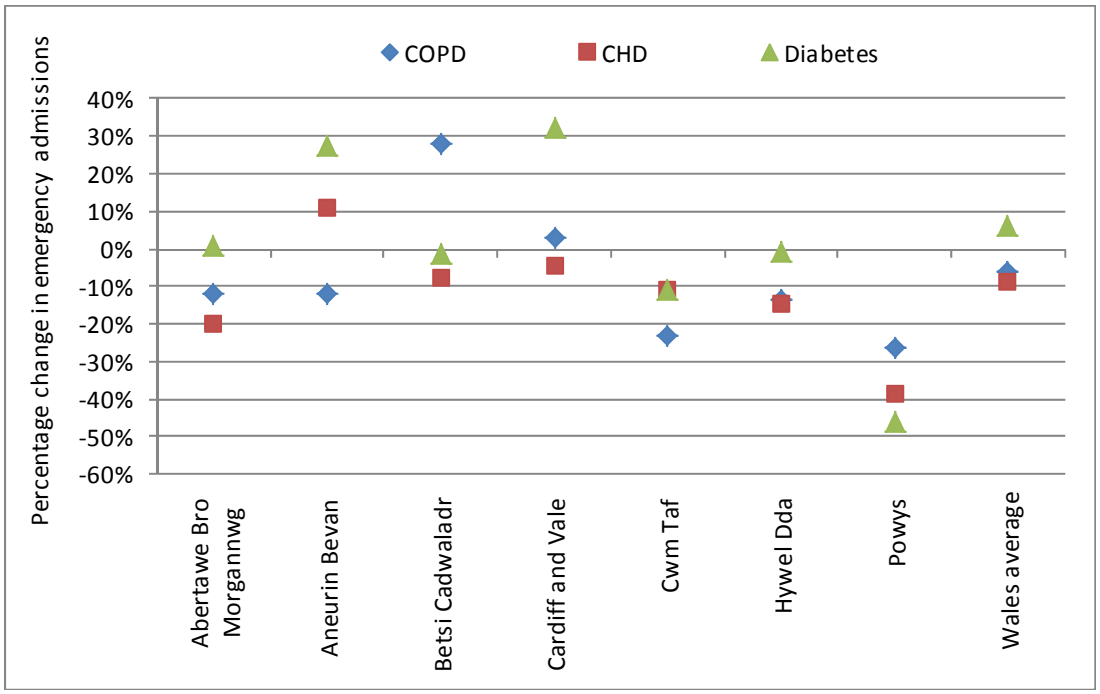


Source: Aneurin Bevan Health Board

Improved management of chronic obstructive pulmonary disease (COPD) is reducing emergency admissions, however, the picture is less encouraging for other major chronic conditions such as coronary heart disease and diabetes

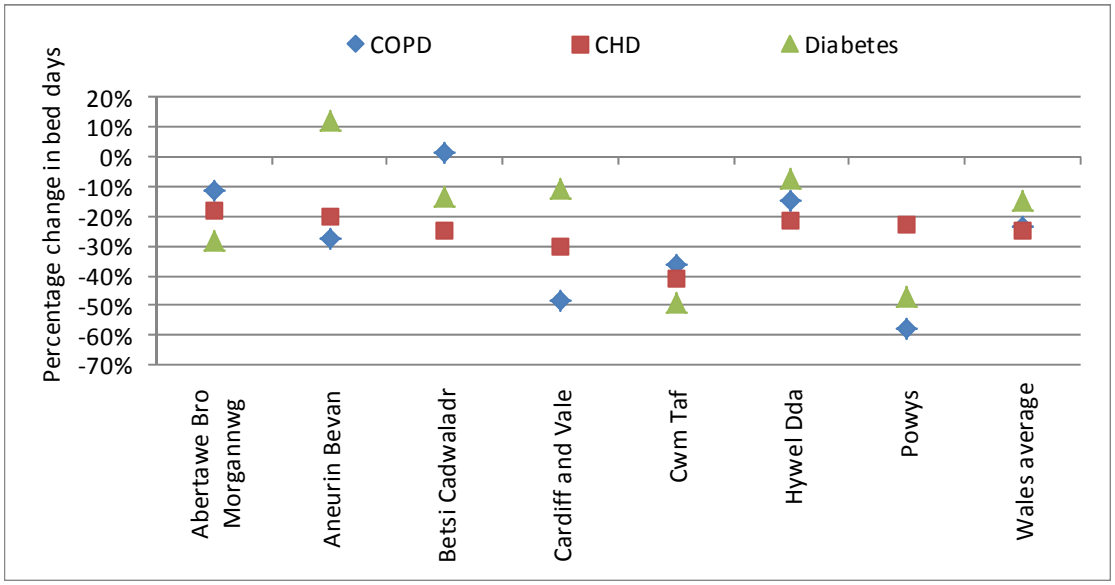
66. Since 2006, the number of hospital admissions due to COPD has decreased by 12 per cent (Exhibit 16). Once admitted these patients now tend to stay in hospital for shorter periods (Exhibit 17).

Exhibit 16: Change in emergency admissions with COPD, CHD and Diabetes 2006-07 to 2010-11



Source: Wales Audit Office

Exhibit 17: Change in occupied beds for COPD, CHD and Diabetes 2006-07 to 2010-11



Source: Wales Audit Office

67. In managing COPD, improving access to consultant and nurse-led hot clinics reduced the waiting list backlog, which now means GPs can immediately refer patients to the service for assessment. Reducing admissions, released resources to establish a home visit service for more vulnerable patients, exacerbation rescue packs have been made available allowing treatment to take place in their normal place of residence rather than hospital. The Health Board has invested in better oxygen assessment which is supported by a nurse specialist reducing the dependency on hospital services. At the same time, access to pulmonary rehabilitation has improved supporting better self-management.

68. All health care professions have placed a great emphasis on Continual Professional Development (CPD) to modernise services. The Health Board has used CPD constructively to strengthen chronic conditions management; a recent example is the joint project with GlaxoSmithKline (GSK) on strengthening primary care respiratory education involving secondary and primary care working together in 43 GP practices.

69. Although services for managing CHD and Diabetes are changing the same step changes have not been realised. The number of patients for these conditions has risen and is amongst the highest in Wales. Although once admitted CHD patients no longer stay as long as they did. Stays have not improved for diabetic patients which have seen some of the greatest increases in Wales.

70. Recently GP access to cardiologists has improved through a dedicated Blackberry line and e-mail response system. GPs we spoke to said this service gave them rapid access to advice which allowed them to better manage patients in the community instead of sending to them to hospital as they had done in the past. GPs favoured the e-mail system because it not only provided an audit trail but was also quicker than using the Blackberry.

71. A similar scheme had been tried out in respiratory medicine last year, but this had not been successful. There was some evidence that this service had not been well communicated to GPs and consequently demand had been very low. In light of the cardiology experience there is scope to re-launch this service and extend it to other high demand specialties.

72. The care of people with diabetes is complex and the setting for the various elements of care will vary over time according to the needs of the patient. The most appropriate setting can form part of agreed protocols between primary care and the secondary care specialist diabetes team. The approach may not be the same in all area as it needs to take into account the different levels of skill and interest in the management of diabetes which particular GP practices have.

73. Historically, diabetic management in Aneurin Bevan has centred on secondary care management. This is changing and through the bundle approach the lead consultant and GP champion have developed a more integrated approach to managing care. The approach to diabetes management varies considerably between the localities, for example, in the Caerphilly locality because one of the GPs was the diabetes champion, support available to GPs was seen as being much better. Many GPs felt there was still more that could be done for example in some locations patients had to be referred back to secondary care for insulin management. Although guidance had been issued on insulin initiation in primary care including new referral and discharge guidance, its adoption has been patchy. GPs also identified that access to diagnostic services needed to be easier as this was preventing better management in the community.

74. Our interviews and surveys indicated that whilst GPs have welcomed local developments in falls management, many would like to see a greater emphasis on falls prevention. For example whilst some patients prone to hypoglycaemic attacks could better access services following a fall, there was little education available to prevent falls in the first place. This would suggest there is scope to look at integrating some care pathways where there are common issues.

The new Neighbourhood Care Networks provide a positive model for the engagement and involvement of GPs and primary care teams, although the audit has indicated a more general need to improve aspects of communication with general practice following discharge from hospital

75. In managing chronic conditions, communication between GPs and secondary care must be efficient and effective allowing care handovers to work well. Across the Health Board, GPs identified a persistent problem with how discharge letters are managed. On referral the GP is clearly identified, in practice, discharge letters are often just sent to the practice or the lead partner named on the PAS practice identifier. In large practices this can increase the time a referring GP sees a discharge letter. Whilst GPs need to ensure practice management arrangements and systems are efficient, the Health Board also needs to ensure its systems do not contribute to delays. It is difficult to quantify the impact of this problem; not resolving it, fuels a perception of system inefficiency between primary and secondary care and does not fully promote patient confidence.

76. The GMS contract arrangement allows the Health Board and GPs through the Quality Outcomes Framework (QOF) to improve care pathways. As previously discussed in the past for chronic condition management the use of LES has not been used to its full extent. Some GPs thought LES could be used to recognise GPs providing specific chronic condition management training to other GPs. This was seen as creatively using more specialised GPs to strengthen the capacity of primary care.

77. One notable success in the Health Board's approach to improving chronic condition management was involving GPs and creating a GP champion for the different work streams. Taking this experience and building on the capacity and expertise this created, the recently created 12 Neighbourhood Care Networks (NCNs) are GP-lead and the current work being undertaken by NCN includes:

- establishing GP practice cross referral to prevent unnecessary acute referrals and admissions;
- piloting specialist software 'PathFinderRF' that supports the management of referrals from primary care; and
- recognising the potential to improve services through the QOF, working jointly with the Local Medical Committee (LMC) to introduce a number of pathways for COPD, heart failure and falls management.

78. The NCN leads, as part of their clinical theme responsibilities are expected to work more closely with secondary care to develop an integrated approach to the design and delivery of clinical pathways. The NCN leads will also intervene earlier when QOF performance information shows under performance. Processes are being developed and there is a clear intention to strengthen information systems to support better management.

79. One potential area for attention is access to GP prescribing information, which can be slow and many GPs have said it impacts on effective management of conditions. The Wales Audit Office during 2012 is examining GP prescribing across Wales and more detailed findings on this issue will be reported during the course of that study.

The role of community hospitals is much clearer and beds are managed as a single Health Board-wide resource; there is, however, a need to improve awareness of the full range of community services amongst acute hospital staff

80. 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.

81. The Health Board now manages hospital beds as a single resource following changes to its previous locality model. This approach is allowing beds to be rationalised and used more effectively and now means patients are placed in the most appropriate bed for their condition even if this means increasingly placing patients in facilities outside of their immediate locality.

82. With clearer integrated care pathways and better managed transfers into community hospitals a Frailty Programme has set a target of a 40 per cent reduction in lengths of stay greater than 28 days for over-75-year olds and a similar reduction in the 21 day LOS for under-75s. The overall trend since April in LOS is down for both groups of patients with the target for over-75s being met for the first time in October 2011. Although it is too early to confirm whether this will be a sustained improvement, the early indications are very promising.

83. However, the changing arrangements are not without problems, and clinicians reported that ward and medical staff were often less familiar with the services available to a patient outside of hospitals immediate locality. The single point of access is intended to overcome this and the Frailty Programme has created a service directory for users which in its current form was seen by many staff as too large and difficult to use.

84. In addition, consultants reported that junior staff would at times act more cautiously and admit patients that could be referred to CRTs or would hold back discharge because they were not familiar with the services available in different localities.

Some issues with urgent access to primary care remain but the Health Board is implementing important changes

85. 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 poor 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.

86. Primary care access continues to be a problem in the Health Board area and is contributing to patients going to secondary care services, when alternatives are available. A mystery shopping exercise carried out by the Gwent Community Health Council (CHC) in 2008 suggested that some people struggle to access GP appointments because of extended closures at practices during lunchtimes and some afternoons.

87. To address this issue in 2008, the Health Board established the Primary Care Access Group, consisting of Health Board managers, primary care practitioners, LMC and CHC. The group has developed the '5As for Access' scheme which was launched in December 2011. The Health Board publishes the full ratings for each practice on its internet sites.

88. There are two pre-qualifying conditions for the access accreditation scheme, no half-day closures and if they have branch surgeries they must comply as well. The scheme considers five criteria if:

- a patient can get an appointment before 8.30 am;
- they can book an appointment in just one phone call and can speak to a person between 8 am and 6.30 pm;
- the practice is open at lunch time; and
- the last routine GP appointment of the day is at 5.50 pm or later.

89. Practices are given an A rating for each of the five standards they meet, however, if they do not meet the pre-qualifying conditions they are given a B rating for every criterion they meet. Currently, there are 11 practices across the Health Board who do not qualify for A ratings, and 26 achieved a five-A rating. These ratings are also displayed in the GP practice.

90. During the development of this scheme, the Welsh GP Access Survey 2011 showed in Aneurin Bevan that when patients tried to access urgent primary care within 24 hours, 76 per cent were able to do so. This was the lowest percentage of all Health Board areas. Also in August 2011, the CHC carried out a survey of emergency department patients at RGH and Newport City Council's Involve Newport Citizens' Panel (Appendix 1) was also surveyed about access to primary care. Both surveys highlighted views from patients that problems accessing GPs meant it was easier to go to the emergency department for care.

91. We consider the introduction of the '5As for Access' scheme to be a positive, innovative development with considerable potential for optimising access to urgent primary care. Ninety-one of the Health Board's 93 practices are taking part in the programme.

92. In addition, the Welsh GP Access Survey will not be carried out in future, and there is a real risk that important trend information will be lost. The Health Board will need to look at introducing its own monitoring arrangements to see if access improves.

93. The Health Board recently commissioned the Primary Care Foundation to carry out improvement work with 24 practices, two from each NCN. These practices representing a typical mix will be benchmarked with each other and against other practices in the UK. As well as looking at how GPs manage urgent access the work will look at managing requests for unscheduled care, how phone advice is provided and using receptionists more effectively in dealing with urgent access issues. The findings will be cascaded to all practices and has the potential for significant improvements in urgent access arrangements. The importance of this work is apparent given the fact that our GP survey indicated a mixed picture in relation to urgent access to primary care:

- Thirty-five per cent had used the 2009 Primary Care Foundation's report[6] to review their arrangements for providing unscheduled care, which was significantly higher than the Welsh average (13 per cent).
- Only 52 per cent of GPs have sought patient views on how to improve access arrangements. This was lower than the Welsh average of 59 per cent.
- Sixty-four per cent have used the results of the Welsh GP Access Survey to review their access arrangements. The Welsh average was 70 per cent.
- Just over half of practices had analysed the number and pattern of telephone calls they receive.
- Whilst 93 per cent of practices provided receptionists with induction training about how to identify cases that have different degrees of urgency, only 58 per cent within the last two years had reviewed the effectiveness with which their receptionists were able to identify such cases.

94. To optimise their access arrangements, practices will need to ensure that capacity and resources are not wasted by patients failing to turn up for appointments. In the Aneurin Bevan area GP practices reported DNA rates averaging eight per cent, which is better than the Welsh average (11 per cent). However, whilst most practices had posters and information about not wasting appointments, little work has been done at looking at the underlying reasons. This suggests there could be scope to further reduce DNAs.

[6] *Urgent care: a practical guide to transforming same-day care in general practice*.

95. Patients also attend GPs for non-medical needs such as getting important insurance documents signed. GPs reported currently that 14 per cent of appointments are used for non-medical reasons, which was the highest in Wales (average 10 per cent). GP practices in the Health Board's area had the highest percentage of patients booking ahead (55 per cent); the Welsh average was 47 per cent. This does suggest that understanding the reasons behind these figures may help practices use appointments more effectively.

Benchmarking suggests there is a need to improve the responsiveness of out-of-hours primary care services and there are risks associated with staff shortages

96. The aim of primary care out-of-hours services is to ensure individuals with urgent primary care needs who cannot wait until the GP surgery reopens are met and that other patients accessing the service are given appropriate advice and information. The primary care out-of-hours covers the hours of 6.30 pm until 8 am on weekdays, and all weekends, bank holidays and public holidays.

97. The out-of-hours service is provided by the Health Board and GPs are paid on a sessional basis to provide this service. The out-of-hours service is co-ordinated at Vantage Point House and patients are seen at three primary care centres, located at St Woolos Hospital, NHH and Ysbyty Ystrad Fawr (YYF). The service also has five medic cars and another two cars which are able to transport patients.

98. *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 a common reception and common operational processes. At Aneurin Bevan, there are three different models for the way these services interface with the emergency department but none of these units is fully integrated with the emergency department. There is potential to integrate services at YYF because they are co-located. It is more difficult at NHH, although they are on the same site the primary care centre is in a different part of the campus. It is substantially more difficult at the St Woolos site in Newport because the primary care centre is on a different site to the main hospital. In our interviews we were told that staff at RGH are reluctant to redirect patients to the out-of-hours service because of the site issue.

99. Currently, in its performance management arrangements the Health Board compares its out-of-hours service against a Primary Care Foundation benchmark group. Whilst there are some inevitable 'like for like' issues with the benchmark group it does show the service:

- performs comparatively well by referring a smaller proportion of patients to hospital assessment units and emergency departments;
- is slower at assessing patients, with a lower percentage of urgent cases assessed within 20 minutes of contacting the service (our interviews suggest there is potential to improve performance by using certain triggers during the assessment, allowing patients to be more quickly streamed/referred to appropriate care pathways); and

- has a comparatively high proportion of home visits, currently 16 per cent of calls to the service result in a home visit compared to a 12 per cent Welsh average.

100. Our survey of GP practices indicated that there is scope to improve out-of-hours services. Although 67 per cent of respondents said that the out-of-hours service was good or better at meeting patient needs, this was lower than the Welsh average of 76 per cent. Moreover, only forty per cent of practices said they receive information about their patients who frequently access the out-of-hours services. The Welsh average was 62 per cent.

101. More worryingly the effectiveness of the out-of-hours service is affected by staffing shortages and the service is frequently unable to fill its overnight doctor shifts. This can have the impact of forcing the closure of one of the three primary care centres as well as causing pressure on the staff working within the service. We were told that this pressure can result in staff carrying out briefer patient assessments and adopting a more risk-averse approach, prompting unnecessary hospital admissions.

102. Staffing shortages are not unique to the Health Board, because some doctors are reluctant to contribute to the service for a range of reasons including the financial implications, medical insurance and personal tax implications and the additional workload pressures. Despite these issues applying across Wales, some health boards, for example Abertawe Bro Morgannwg University Health Board, have successfully persuaded local GPs to fully support the out-of-hours service. We are not aware of any specific work that the Health Board is doing to generate greater ownership of, and commitment to its out-of-hours service from local GPs.

103. The Health Board has made some progress with improving patient care by making GP records available to other unscheduled care services. The Individual Health Record (IHR) now allows the primary care out-of-hours service and some medical assessment units to access the GP records for around 85 per cent of the Gwent population. However, whist access has improved the IHR is only used for five per cent of patients that come to the out-of-hours service. The main reason given for this is that doctors experienced difficulties in the early stage of its introduction and have not used the system since, although improvements have now been made. More now needs to be done to ensure the IHR is used appropriately and to its full extent.

104. The IHR currently is not available in the Health Board's emergency departments or in minor injury units, not least because of IT interface issues outside of the service's direct control.

The Health Board has had limited success in changing the way that the public uses services

The Health Board's attempt to divert demand away from hospitals through 'marketing and public awareness' did not have the anticipated impact and the Health Board is now putting greater emphasis on redirecting patients once they access the emergency department

105. 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. Part of this uncertainty stems from the wide range of different access points within the system. For example, a person suffering a minor injury may decide to attend an emergency department or minor injury unit, see their GP, phone NHS Direct Wales or care for themselves. Influencing this decision can be the actual or perceived operating times for these services during the week or at weekends.

106. To address this issue, our 2009 report recommended that a national communications strategy should be developed to improve public understanding about how to 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'.

107. The Health Board has carried out additional marketing to *Choose Well* because it felt the national campaign did not focus sufficiently on the need to avoid unnecessary demand reaching the emergency department. To address this, the Health Board ran its own *Save A&E for When You Need It* campaign alongside *Choose Well* from mid-January to April 2011. The combined campaign involved the distribution of flyers and posters to GP practices and public buildings, as well as articles in the local media. In addition, when a patient attended the emergency department, hospital staff gave them a campaign flyer if they felt they could have used a different service.

108. The impact of this campaign was evaluated in August 2011 and despite the fact that staff felt it had gone well, the total number of emergency department attendances increased compared to the same period in the previous year. One reason given for this performance was the late start, which was well into winter bed pressures. The campaign is being run again this year with a much earlier start.

109. The Primary Care Foundation's 2011 report[7] 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. This report found changing behaviour and getting the message across about using health services appropriately needed to be done routinely as part of patient contact in all urgent care services.

110. Responding to this, the Health Board has now developed a redirection policy to be used at all emergency departments and minor injury units, aimed at redirecting patients who have presented themselves with primary care conditions back to primary care or dental care. In the past, redirection had been carried out focusing on out-of-hours only and the new ways of working encouraged redirection at all times of the day. The new policy has been operational since September 2011 and there have only been two complaints from members of the public.

111. Typically, up to 12 patients each day at RGH are redirected. Whilst this shows the policy is having an impact, however, there is scope for improvement given that we were told that some junior staff are still reluctant to redirect patients.

112. The effectiveness of the redirection initiative is also reliant, to some extent, on the availability of urgent primary care appointments because the policy states that if such appointments are unavailable, the patient should be treated in the emergency department. The Health Board as part of its evaluation process will need to collate the reasons for redirection to ensure the underlying reasons are adequately addressed, particularly if it is access to GPs.

The Health Board has developed a single point of access communication hub which is currently limited to the Frailty Programme services, and more can be done to extend its role and function

113. Our 2009 report on unscheduled care recommended that health boards should seek to provide better access points to services and that further rationalisation of access points could result in hubs for all referrals to unscheduled care, contactable by phone at all times of the day and night. Similarly, 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.

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

114. As previously discussed, the Health Board and local authorities have established a single point of access communication hub (known as the SPA) for services provided by the Gwent Frailty programme. Referrals to this programme are through professionals only. Currently, patients and carers cannot refer themselves directly to the service. Whilst this may have been a pragmatic solution to introducing the service it runs the risk of patients and carers not seeing the service as the appropriate vehicle for care. In addition access to some reablement services was previously operating on self-referral which had worked well and stopped when the service joined the Frailty Programme.

115. The Delivery and Support Unit (DSU) recognised the potential to use the SPA as the single access point for all hospital discharges. A letter from the Unit in October 2011 highlighted that there are three routes ward staff in the acute hospitals have to take in order to discharge or transfer patients who still have healthcare needs back into the community. These routes are via the district nurses for discharge back to a patient's home, via the SPA for patients requiring intermediate care and via the patient flow team/discharge liaison nurses for transfer to community hospitals.

116. This would suggest there are too many routes a patient can take and simplifying and rationalising the options would make patient management more efficient.

117. If and when the Health Board revises its model for its communications hub to include referrals from the public, it will need to consider working jointly with other public bodies. We understand a working group has been set up to consider integrating various organisations' call centres, including local government contact centres as well as those run by the fire and police services.

Access to self-care education is comparatively low and much more could be done to improve its impact

118. It is essential that individuals are encouraged and supported in looking after their own health and well-being. Our 2008 report on chronic conditions found that the provision of patient education to support self-care was insufficient given the high prevalence of chronic conditions and a growing population of older people. Self-care is associated with positive outcomes for individuals, such as improved knowledge of their condition and better coping behaviours. Other benefits include reduced reliance on healthcare services, which help to sustain services long term. The Welsh Government's framework for self-care[8] describes a continuum of self-care starting with healthy living, self-care of minor ailments with or without the support of professionals, like GPs or pharmacists, to more formal help in managing complex health problems. There are four key elements of self-care support covering this continuum. These are information and signposting, skills training for patients and professionals, peer support networks and assistive technologies, like telehealth.

[8] *Improving Health and Wellbeing in Wales, A Framework for Supported Self Care*, Welsh Government, October 2009.

119. Education Programmes for Patients (EPP) courses are provided on a locality basis. The Health Board recognises this may not be the best model as access varies and courses are not available consistently throughout the year. Between April and December 2011, just under 290 patients registered for EPP courses with only 60 per cent of these completing the course, with a further 22 per cent DNAs. This performance has led the Blaenau Gwent locality team to undertake a review of EPP provision model and its effectiveness. Once this review is complete the Health Board will need to quickly address the underlying issues behind patients completing the programme.

Exhibit 18: Patients attending EPP Courses Aneurin Bevan area April to December 2011

EPP Programme	
Patient registering	288
DNA	63
Percentage DNA	22%
Patients completing course	172
Success rate	60%

Source: EPP Cymru

120. Currently, the Health Board's patient education programmes mainly focus on diabetes where patients can access a range of courses including the X-pert programme (diabetes self-management), DAFYDD (insulin dose adjustment), DESMOND (Diabetes Education and Self-Management programme) and the paediatric diabetes education programme. Currently, a limited number of other condition specific education programmes are provided including, pulmonary rehabilitation classes, cardio-pulmonary rehabilitation classes, weight management education programmes for children and smoking support and education programmes. There is now scope to place a greater emphasis on promoting and developing some of the other condition specific education programmes particularly targeting the high volume conditions used by the Health Board for its service planning models.

121. The Health Board's recently created *Setting the Direction* performance monitoring dashboard now contains a domain measuring education, training and up-skilling for management of chronic conditions. Whilst there is an indicator monitoring the percentage of patients with chronic conditions who attend EPP and patients with a self-management plan, the dashboard is focused on professional uptake with little emphasis on patient access or outcomes. More work is needed to develop indicators which identify the impact of EPP and patient education on self-management of chronic conditions and are the intended outcomes being delivered.

122. Only the Caerphilly and Torfaen locality HSCWB strategies contain commitments to support people in taking greater responsibility for improving their own health and improving their capacity to manage their own health and to get better access to services. However, there is little evidence of any significant change with information provided by the Health Board for this audit showing only 25 per cent of patients had access to education programmes. On average across Wales this was 70 per cent, showing much more needs to be done to improve access.

123. All five localities provide access to care and repair services to help maintain older people in their homes through providing advice and home adaptations. The services are augmented by Health Board services in the Newport (Care and Repair Response and Adaptions Programme) and Caerphilly(Care and Repair Worker) localities. Care and repair services are an essential component for maintaining independence, which suggests more could be done.

124. In addition, the Gwent Frailty project in 2011 undertook a baseline review of telecare[9] and telehealth[10], which found that there is no overarching strategy for telehealth in the Gwent region or at locality levels. Some equipment had been purchased but was often not deployed and what was available varied considerably between localities.

125. Although the position with telecare was found to be better, access and availability was still at relatively low levels. In addition locally there are also differences as to where telecare is hosted, charges made and range of service. Responding to this, a pilot is being undertaken in Newport looking at ways to improve telecare. Addressing these issues is important as one of the Frailty Programme-stated objectives is keeping people 'happily independent' and sustainable: telehealth and telecare services are a key component for this objective.

[9] Telecare uses a combination of alarms, sensors and other equipment, usually in the home, to help people live more independently by monitoring for changes and warning the individual or a control centre. Examples include personal alarms, fall detectors, temperature extremes sensors, carbon monoxide detectors, flood detectors and gas detectors.

[10] Telehealth is the remote monitoring of physiological data, for example, temperature and blood pressure and is used for diagnosis or disease management. It also covers the use of information and communication technology for a remote consultation between health professionals or between a health professional and a patient.

The Health Board has a clear vision and sound structures for delivering transformational change, which is supported by good clinical engagement and partnership working that should now help it more quickly change the way clinicians work and the public use services

126. 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's clear and ambitious vision for service change is now supported by new and improved workforce planning ararngements

The Health Board's clear, overarching strategy for chronic conditions and unscheduled care is rightly ambitious although significant challenges remain in delivering these planned changes

127. The Health Board's, *Clinical Futures* strategy, provides a clear, overreaching framework for delivering and restructuring services. The strategy includes key aims to:

- Increase the range of services provided in community settings. This intention is well aligned to those in *Setting the Direction.*
- Develop a new network of local general hospitals providing routine and emergency care.
- Develop a specialist and critical care centre (SCCC) to provide specialist and critical care that cannot be provided on multiple sites based on sustainability, clinical effectiveness, patient safety and affordability.

128. The strategy has evolved from consultation with the public in 2005 about potential new models of care. A formal public consultation document on *Clinical Futures* was developed in 2006 and the key content of the vision has remained largely constant since that time. The most visible signs of progress in implementing that vision have included the launch of the Gwent Frailty Programme and the opening of two new local hospitals, YYF and Ysbyty Aneurin Bevan (YAB).

129. During our fieldwork we found a generally sound understanding of the vision and the vast majority of people we spoke to strongly support the direction of travel set out in the strategy. The Health Board has been able to progress seemingly difficult aspects of the vision including a reduction in hospital beds and the closure of some hospitals, acting as a catalyst for further change because it shows key stakeholders that transformation is possible.

130. The ambitions set out in *Clinical Futures* have been beneficial when recruiting senior staff. Whilst the Health Board continues to have some recruitment issues, it has been more successful than other health boards in recruiting emergency medicine consultants. Staff told us that this is because some new staff have been attracted by the vision set out in *Clinical Futures* and this is the experience of other specialties for example, specialist cardiologists and orthopaedic surgeons have accepted posts based on future service configuration and the development of the SCCC. This approach is not without risk because failure to deliver the planned changes will inevitably impact on staff retention and the delivery of sustainable service.

131. The SCCC development is a significant component in delivering *Clinical Futures* and a new phasing project was established in April 2010, leading to work starting on a new business case in September 2011. The current modelling assumption for improving unscheduled care and chronic conditions management is based on the SCCC being commissioned and in place by 2017.

132. The successful delivery of *Clinical Futures* would undoubtedly have benefits for both unscheduled care and chronic conditions management but the Health Board has also set out other, lower-level strategies in relation to these areas. The Health Board has set out in its five-year SWFF [11] to deliver by 2015, *Setting the Direction* in its entirety by systematically and consistently developing the capacity in primary and community services.

133. Setting out this intention demonstrates that improving chronic conditions management is a strategic priority for the Health Board and its structures and service development plans reflect this commitment.

134. In relation to unscheduled care, the Health Board has developed an Unscheduled Care Transformation Plan. This plan forms the workload of the Health Board's Unscheduled Care Transformation Board which is discussed later in this report. The broad coverage of the plan is indicative of the genuinely whole-systems approach to improvement being taken by the Health Board.

135. Whilst the vision is clear in most areas, it is less so about the future for minor injury units in Gwent. In November 2011, the Health Board closed the units at Chepstow Hospital, County Hospital and Monnow Vale because of insufficient demand. Demand at other units is expected to change because of *Clinical Futures* developments and the creation of the SCCC, combined with the potential impact of Gwent Frailty.

[11] Our Five Year Framework 2010-2015 an update, version 8, 16 March 2011.

The Health Board has prioritised and resourced the delivery of its integrated *Clinical Futures* workforce planning programme which will deliver changes in a whole system context across primary and secondary care

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

137. Our August 2010 report on emergency department staffing concluded that the organisation has had limited success in resolving long-standing problems such as a high vacancy rates in junior doctor and middle grades leading to an overreliance on locums to maintain services. Currently, four of the 12.5 middle grade posts are vacant at RGH, as is one of the 4.5 middle grade posts at NHH, because one of the post-holders is acting up as a consultant. A more detailed analysis of emergency department medical staffing information is provided in Appendix 1.

138. Responding to this, the Health Board revised its clinical staffing model relying less on middle and junior grade doctors and investing £2.19 million in creating more consultant and Emergency Nurse Practitioners (ENPs) posts. Whilst the number of posts has increased, both units have still to reach the recommended minimum level of 10 consultants as set out by the College of Emergency Medicine[12].

139. The most recent round of recruitment failed to attract any consultant post applications for the remaining vacancy at NHH.

140. The College of Emergency Medicine recommends that consultants should be present in the emergency department for at least 16 hours, seven days a week. Currently, at RGH consultant cover is 12 hours on weekdays and seven hours on weekends, which is less than the typical level found in the benchmark group. This contrasts with NHH where the 14 hour cover is typical but the six hours on weekends, is still less than most other organisations.

141. The *Ten High Impact Steps to Transform Unscheduled Care* document identifies that health boards should be measuring the percentage of time that intended senior clinical decision maker presence is achieved. Currently this information is not collected by the Health Board, and this should be rectified to provide assurance that there is appropriate senior staff cover in emergency departments.

[12] College of Emergency Medicine, Emergency Medicine Consultants, Workforce Recommendations, April 2010. The view of the College is that such rotas require a minimum of 10 wte Consultants in every ED, with greater numbers in those particularly busy departments seeing 80,000 to 100,000 patients a year and in the 24/7 Regional Centres providing major trauma care.

142. The Health Board's unscheduled care model relies on increasing the number of ENPs and it is positive to note that the service at the recently commissioned YYF hospital is ENP-led. However, our interviews with emergency department staff highlighted a range of issues that are still causing concern with the ENP role including:

- ENPs being taken off their role to cover other nurse absences;
- the amount of time some ENPs are spending on the role is insufficient to develop expertise and confidence; and
- the ENP-led service at YYF has resulted in gaps at RGH and NNH which are not always backfilled.

143. This indicates that further work is needed to ensure that the Health Board has sufficient numbers of appropriately experienced ENPs to deliver the model of unscheduled care it has identified. We understand that a review of the ENP roles within the Health Board is currently underway.

144. The rebalancing of the care system set out in *Setting the Direction* requires an increased capacity within the community and therefore robust workforce planning is vital to success. Workforce planning is a Health Board priority which is reflected in the Clinical Futures workforce and organisational development work stream. This work stream is a whole system approach to developing plans which includes the unscheduled care, community and primary care workforce. Whilst GPs are independent contractors and are generally not directly employed by the Health Board, their role is an important workforce consideration and they need to be involved in developing the appropriate primary care workforce. This is of particular note because of the problems being experienced in staffing the out-of-hours primary care service and the problems in filling GP shifts in the ambulance control centre.

145. In developing its approach the Health Board has committed resources to this work stream including a dedicated senior manager and this team is being strengthened during 2012 with an additional two posts. The current work programme which has clear deadlines is well underway to meet a December 2012 change strategy implementation. Although work has yet to start on primary care nursing and support staff, managers are confident of meeting the current November 2012 programme milestone. This will be followed by implementing the change strategy at the end of December.

The Health Board's investment in establishing sound governance structures and management arrangements for its chronic conditions and unscheduled care programmes suggests it is well-placed to deliver transformational change

The Health Board has a good structure of individual leaders and groups that are driving change

146. If the Health Board is to deliver on the ambitions set out in its vision, 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 transformation. We consider that the Health Board has established a comprehensive governance and programme structure which promotes an integrated approach towards delivering and modernising its chronic conditions management and unscheduled care services.

147. In relation to *Clinical Futures*, the Health Board has established a formal Clinical Futures Programme Board, chaired by the Chief Executive and supported by a dedicated programme team. The programme is divided into sub-projects with a senior responsible officer to lead change.

148. Similarly strong arrangements are in place for driving change in unscheduled care and chronic conditions. The Unscheduled Care Transformation Board appears to be a well-constructed forum that includes all major stakeholders. The Board has also ensured it is up to speed with national developments by having an associate medical director who is closely involved in the National Unscheduled Care Board.

149. Our interviews found there was clear organisational, clinical and partner support for the structures that were in place for developing and delivering chronic conditions management services. Our review of working papers confirmed the effectiveness of these arrangements.

150. The Primary Care and Community Services Board (PCCSB) remains as the overarching governance board for chronic conditions. The CCM steering group has just been replaced by a Primary and Community Care Service Development Group, which will oversee and co-ordinate the activities of the COPD, Diabetes, Epilepsy, Stroke, Falls, Case Management (frequent flyers) pathway sub groups and NCNs. There are clear interfaces with other groups and these are set out in Appendix 4.

151. There are good linkages between the unscheduled care transformation board and PCCSB with the chairs and Executive leads being on both boards. Although the arrangements are complex, our stakeholder interviews confirmed this arrangement is seen as working well.

The Health Board's approach to performance managing unscheduled care and chromic conditions management has moved much more towards measuring outcomes although more needs to be done to strengthen its approach to evaluating change

152. 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 to 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.

153. We note that the multi-agency Unscheduled Care Transformation Board has agreed a set of outcomes that the new model of care will deliver. These outcomes are appropriately focused on benefits to service users and should form a good basis for ensuring improvement is focused on improving outcomes for patients, rather than just on improving efficiency within the health and social care system.

154. It is encouraging that the Health Board is progressing work on its scorecards for unscheduled care that consider a broad range of measures that are directly linked to the outcomes agreed by the transformation board. These measures go well beyond the nationally stipulated measures and include a good focus on clinical aspects of care. We do note however that many of these measures are in the early stages of development and further work is required to ensure they result in robust measures of performance and progress that are supported by clinicians. In particular, we note that there appears to be limited progress in developing measures of patient experience and this should be given a greater priority.

155. The Health Board has a stated objective of being 'best in class' and was confidently benchmarking activity against a CHKS peer group. Managers and clinicians reported that the quality of data was improving. In particular, the *Clinical Futures* modelling information was now much more sophisticated and was confidently able to track performance and activity to individual consultants and GPs. This growing confidence meant challenging targets were being set and agreed with clinicians for changing practice, reducing length of stay and identifying where beds were no longer required. The modelling data shows this strategy is starting to deliver the necessary changes.

156. The Health Board's survey returns for this audit identified that that around 50 per cent of chronic condition developments had undertaken some form of outcome evaluation. This did not compare well against others in the survey with most reaching 70 per cent.

157. In the course of our interviews, staff identified that in the past, schemes were rarely reviewed unless it was required under an external funding arrangement. In recent times this has changed, with more projects now identifying real or potential outcomes and including an evaluation phase.

158. Evaluation is an important tool supporting the better use of resources. The Health Board needs to ensure project and programme evaluation becomes an integral part of service modernisation, supporting not only better use of resources but promoting shared learning within and between health boards.

The Health Board has positive arrangements in place for working with external stakeholders and has made real and sustained progress engaging with clinicians and placing them at the centre of decision-making processes, however, it still faces some important challenges in changing the way clinicians work and the public use services

The Health Board's commitment to developing and promoting clinical engagement is having a positive impact

159. 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. In its overall management arrangements the Health Board's divisional and clinical directorate structure is consultant led in partnership with a lead nurse and general manager. This reflects the Health Board's approach of placing clinicians in key leadership roles in delivering and developing services. This approach is particularly evident in the Health Board's arrangements for improving unscheduled care and chronic disease management services.

160. Over the last two years in its approach to improving chronic conditions management a notable success has been appointing a clinical lead for each bundle supported by a GP clinical champion and a multidisciplinary team comprising practice nurses, community nurses, therapists, pharmacists and practice managers. This approach has also been taken with the unscheduled care clinical bundles and has continued with the development of the NCNs. These NCNs are GP-led and comprise multidisciplinary teams. Our interviews with clinicians and GP leads and the Local Management Committee (LMC) found substantial support and optimism for this approach.

161. In its broader approach the recently re-established RGH senior medical staff meeting has had a positive impact with consultants. The Health Board's chief executive and medical director with other executives regularly attend the meeting, which has provided an opportunity for consultants to meet senior managers in a more informal setting. A similar longstanding forum already exists in NHH.

162. In addition to these arrangements, the Health Board recently established a clinical forum for Locality Clinical Directors, NCN leads and the secondary care Clinical and Divisional Directors. This group will now take the lead on developing a more integrated approach to all healthcare planning and delivery within the Health Board. This group had only just met for the first time and our interviews found high expectations amongst clinicians and GPs about what this group could achieve.

163. Over the last two years the Health Board has made considerable efforts to improve communication including a chief executive daily blog. If change is to be successfully delivered, clinicians need to be actively engaged with the process. One consultant reported that until recently he had not been aware of a lot of important work going on in the background until recently joining a procurement working group. He had been encouraged by what was happening and felt more should be done to let his colleagues know of the opportunities that existed to shape change, suggesting there is still more to be done communicating with and engaging the wider body of clinicians in the Health Board.

164. More generally consultants felt over the last two years their involvement in service change and planning had improved significantly. Recent examples included developing e-rostering and e-discharge systems and planning the move to the new YYF hospital. The move to the new hospital had gone particularly well and one consultant commented: 'It does show as a team we can do things well, which is now providing greater confidence to tackle other more demanding issues.'

165. Despite these largely positive findings about clinical engagement we found that this remains a key area for the Health Board to continue to focus upon. Transformational change cannot be delivered without good clinical support. We note three specific areas for improvement:

- despite efforts to promote the Gwent Frailty Programme, referrals from clinicians to this scheme remain too low and faster change is required;
- efforts to change clinicians' discharge practices in the acute hospital have not had enough impact; and
- communicating emergency department diverts from RGH could be improved to ensure staff in NHH understand the reasons for a particular divert and are consulted on any potential impact on their department.

166. Clinical Directors were very positive about the access to training for their role, which the Health Board was positively encouraging through NLIAH's leadership programme and its own skills development programme. The Health Board programme focuses on important areas such as financial management and job planning.

167. Some clinical directors thought there were opportunities and benefits to improve succession planning using the training programme to prepare consultants for a clinical director role in the future.

168. Many consultants said they were much more aware of the financial impact of clinical decisions with one suggesting this should feature more strongly in job planning reviews and performance monitoring. In particular many would like to see stronger discussions about everyone in the clinical team complying with pathways and referral guidelines and certainly when they were breached.

169. With much of the planned transformation relying on rebalancing care towards primary and community services, it is vital that primary care practitioners are fully engaged. We found that there has been good progress in engaging with GPs on redesigning unscheduled care services. For chronic conditions engagement was broadly similar to the rest of Wales more could be done in providing information, practical help and support. Our survey of GP practices found:

- Thirty-nine per cent agreed or strongly agreed that the practice was actively involved with the Health Board in planning work related to unscheduled care during core hours. The Welsh average was 31 per cent.
- Thirty per cent agreed or strongly agreed that the practice was actively involved with the Health Board in work related to the broader redesign of the unscheduled care system. The Welsh average was 22 per cent.
- Forty-four per cent agreed that the practice was actively involved with the Health Board in work related to the planning and redesign of services for patients with chronic conditions. The Welsh average was 45 per cent.
- Thirty per cent agreed or strongly agreed that the Health Board adequately informs the practice about its plans to improve unscheduled care services in the area. The Welsh average was 47 per cent.
- Fifteen per cent agreed or strongly agreed that the Health Board provided the practice with sufficient practical support to help the practice maintain good practice and further improve its unscheduled care services. The Welsh average was 17 per cent.
- None of the practices agreed or strongly agreed that the Health Board provides sufficient support (eg, funding for locum cover) for the practice to be involved in the planning and redesign of unscheduled care services. The Welsh average was 14 per cent.

Engagement with partners is happening within a positive atmosphere of working towards shared goals and there is scope to further strengthen these relationships

170. Transforming the system of health and social care relies on changes across organisational barriers and requires involvement and agreement from a wide range of partners including the public, other health boards, local government, the ambulance service and many more.

171. The Gwent Frailty work had created an environment that had delivered much better working relationships between the Health Board and its Local Authority partners, particularly taking forward issues at a strategic level. The sound foundation delivered from Gwent Frailty is seen as an effective template for future work.

172. Our fieldwork highlighted the positive working relationship between the Gwent Community Health Council (CHC) and the Health Board. The CHC has been proactive in reviewing certain aspects of service delivery, such as urgent access to primary care and assessing the reasons why patients go to the emergency department. Despite some negative messages, the Health Board has clearly responded to the messages from these reviews and sought to improve matters.

173. The Health Board needs to protect this relationship and also consider working more closely with the CHC in carrying out future reviews of services. This is particularly important in the areas of patient experience where, as noted earlier in this report there are no performance indicators for patient experience in the unscheduled care scorecard, and the absence of plans to conduct another Welsh GP Access Survey.

174. The CHC could also play a major role in helping the Health Board's engagement with the public over future changes to the pattern of services. Whilst the Health Board has consulted the public over *Clinical Futures*, this may need to be repeated in relation to the regional plan/clinical services review. The public campaign against the Health Board's closure of minor injury units highlights the importance of engaging the public about necessary changes in local provision, particularly as services reconfigure with *Clinical Futures*.

175. As mentioned previously, there remains considerable scope to improve work in influencing the way that the public uses and accesses services. Efforts to change the public's behaviour have so far had only limited impact.

176. Whilst ambulance services are not within the remit of the Health Board, they play a major role in the unscheduled care system and ambulance transportations represent significant demand on the emergency department. Currently:

- ambulance demand is increasing with the total number of category A and B calls between January and November 2011 being eight per cent higher than the same period in 2010 and 16 per cent higher than in 2007;
- response time performance in relation to category A calls is generally close to the national target but performance dips significantly in the winter, highlighting the ongoing fragility in the system; and
- performance in the Gwent area is typically worse than the Welsh average in relation to the timeliness of the back-up response to rapid response vehicles, the response time to category B calls and the response to urgent calls from GPs.

177. The Health Board and the Welsh Ambulance Services NHS Trust (WAST) have been concerned about the number of patients being unnecessarily transported to hospital by ambulance, resulting in continuous audits of the volume and outcomes from emergency ambulance journeys. As stated earlier in the report, during 2010-11, 32 per cent of patients arriving by ambulance at RGH and 27 per cent at NHH were discharged without any primary or secondary care follow-up. Whilst this is not direct evidence of patients being brought to hospital unnecessarily, it does suggest more could be done to reduce ambulance use.

178. The Health Board and WAST continue to work together to effect changes to the way that ambulance services are used and delivered. Recent changes include:

- locating a GP, nurse and advanced paramedic practitioner in ambulance control to support journey and care option decisions; and
- providing a phone line for crews to speak to emergency medicine consultants.

179. Whilst we note these as positive developments, we have been told that there were considerable delays in getting these services off the ground and that the services are not being used anywhere near as often as they could be.

180. The Health Board and WAST have also worked together on reducing demand from care homes. The ambulance service has identified the 10 care homes that most frequently call for an emergency ambulance. The Health Board then used this information to carry out targeted visits by the CRTs and provide training packages to the homes' staff. GPs and clinicians have flagged that care and residential homes often needed more support with end of life decisions. Sometimes because of family pressure and concern, elderly people had been transported to hospital by ambulance for the last few hours of their life, when staying in their place of residence would probably have been their preferred choice if they had been able to put arrangements in place to make that decision.

The Health Board's recent engagement with the housing sector provides opportunities to address the impact of poor housing on health

181. There is a clear and widely accepted link to poor housing and poor health and there are clear opportunities for health boards to work collaboratively with social care, housing and housing associations. This is important in moving the focus towards communities and supporting people to stay in their own homes longer, contributing to admission avoidance and rapid discharge.

182. In the first steps to develop a joined approach organisations in Gwent held a Healthy Homes – Healthy Lives conference for the NHS, local authorities and housing associations in November 2011. This conference identified the need to establish a multiagency health and housing partnership forum, including housing professionals in the NCN teams, and developing a closer working relationship between CRTs and housing associations. These proposals were taken to the Health Board's public Board meeting in January to develop the approach further.

Appendix 1

Medical staffing in the emergency department

The figure shows the level of consultant, middle grade and junior medical staffing at the Health Board's emergency departments.

	Consultant (WTE establishment)	Middle grade (WTE establishment)	Junior (WTE establishment)
Royal Gwent (end March 2008)	5.6	21.8	12
Royal Gwent (end November 2011)	9.4	12.5	16
Nevill Hall (end of March 2008)	3	7.8	7
Nevill Hall (end of November 2011)	4	4.5	10

Source: Wales Audit Office, Emergency department surveys, 2009 and 2011.

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

Hospital	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	4
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	1
Glangwili General	2	0	4	1	3	0
Withybush General	0 (+2)	2.87	3.8 (+2.2)	3.2	7	0

(+ 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.

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

Appendix 2

Working hours of A&E consultants

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	9 am to 5 pm	9 am to 4 pm
	Princess of Wales Hospital	9 am to 9 pm	9 am to 9 pm
Aneurin Bevan LHB	Nevill Hall Hospital	9 am to 11 pm	Up to six hours
	Royal Gwent Hospital	8 am to 8 pm	9 am to 4 pm
Betsi Cadwaladr University LHB	Wrexham Maelor	8 am to 10 pm	9 am to midnight
	Ysbyty Glan Clwyd	9 am to 9 pm	9 am to 5 pm
	Ysbyty Gwynedd	9 am to 8 pm	12 pm to 3 pm*
Cwm Taf LHB	Prince Charles Hospital	9 am to 5 pm	*N/A*
	Royal Glamorgan Hospital	9 am to 5 pm	*N/A*
Hywel Dda LHB	Bronglais General Hospital	9 am to 5 pm	On-call plus Hospital at Night team
	Glangwili General Hospital	9 am to 5 pm 9am-7:30pm (Mon & Wed)	9 am to 3 pm
	Withybush Hospital	9 am to 10 pm	1 pm to 9 pm

**Hours longer in practice*

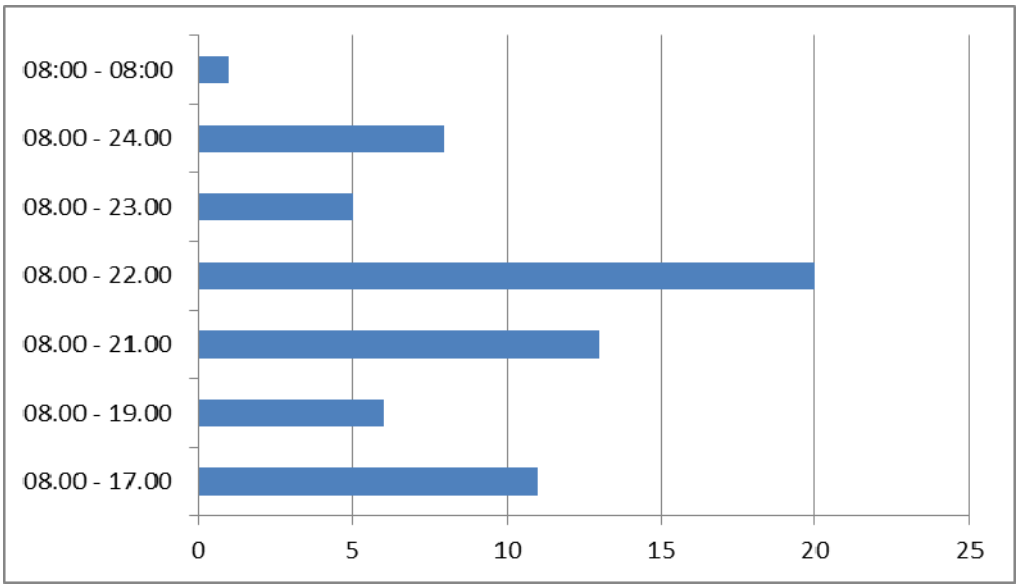
NA – not available

Data for University Hospital of Wales are not available

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

Hours of weekday consultant shop floor cover at English emergency departments

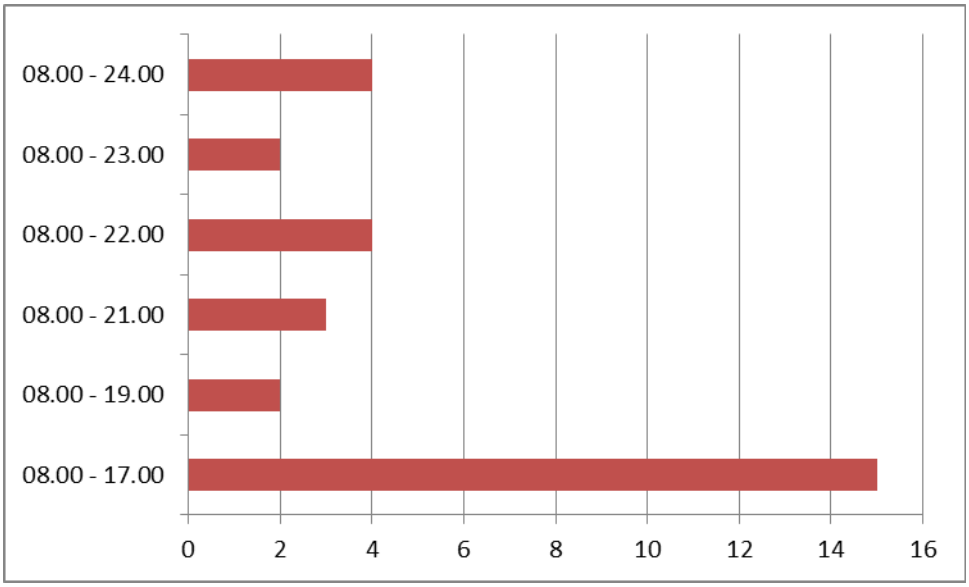
The chart shows the number of emergency departments that take part in benchmarking by the College of Emergency Medicine that have consultant cover during specific weekday hours.



Source: College of Emergency Medicine

Hours of weekend consultant shop floor cover at English emergency departments

The chart shows the number of emergency departments that take part in benchmarking by the College of Emergency Medicine that have consultant cover during specific weekend hours.



Source: College of Emergency Medicine

Appendix 3

Surveys

Survey of GP Practices

Twenty-eight out of 93 GP practices in the Aneurin Bevan area responded to our survey. This was more than other health board areas and although the response rate does not constitute a fully representative picture, it does provide a useful insight into GP practice.

The following is a summary of the survey responses that indicate how practices are supporting unscheduled care services and provides information on their perceptions of these services:

- Half had sought patients' views on how to improve access (across Wales 59 per cent).
- Two-thirds (18) had used the GP Access Survey to review access issues, as well as reviewing issues around same day and urgent access (compared with 70 per cent across Wales). Practices listed changes they have implemented as a result.
  - highlighting the available services and how to access them via posters;
  - introducing the ability to book appointments online;
  - providing/adjusting a mix of book-ahead and same-day to suit patients' needs;
  - introducing extra appointments in the afternoon/on identified busier days/by not closing at lunchtime;
  - providing nurse/GP triage/establishing a nurse-led minor illness morning clinic together with a GP morning clinic for patients with urgent and more serious medical conditions between 8.30 am and 10.30 am Monday to Friday; and
  - introducing a same-day express clinic for minor problems presented.
- Other work that practices have undertaken to review the way they provide same day/ urgent/unscheduled care includes:
  - monitoring and auditing waiting times/reviewing responses from patient questionnaires;
  - keeping and reviewing a log of patient suggestions and minor complaints to identify patterns emerging;
  - introducing telephone triage;
  - working towards the Extended Hours Enhanced Service; and
  - ensuring all patients who think they have an urgent medical condition are seen on the same day.

- Nine practices have used the Primary Care Foundation report to review arrangements for providing same day/urgent/unscheduled care (13 per cent across Wales). Practices has used the report to:
  - ‘We took on board what was expected and even though we had a same day system in place we expanded the availability of clinical staff on a daily basis’; and
  - ‘Practice Manager is producing a Business Plan to recommend improvements to the Partners’.
- Reported barriers to improving same day/urgent access included:
  - DNAs;
  - time constraints/heavy patient demand whilst still providing urgent same day appointments irrespective if a slot is available;
  - lack of information for patients about self-management of minor ailments;
  - practice too small to provide a full range of appointment options/capacity/lack of funding for increases resources;
  - behind the scenes workloads;
  - application for extended hours refused;
  - patients now expect to be given same day appointments/misuse of some same-day appointments by patients;
  - too many non-urgent patients – caused by access to free prescriptions/people demanding a prescription when the item could be bought;
  - lack of support from community and secondary care services; and
  - a higher prevalence of disease than the rest of the UK – this not taken into account in regard to funding.
- Just over half of practices that responded to this question (compared with 41 per cent across Wales) had analysed the number and pattern of telephone calls to the practice but for those that did the changes made included:
  - providing extra receptionists to cope with high demand times;
  - staff rotas changed to manage the increased demand;
  - investing in a new telephone system and ensuring staff available to answer calls at peak times;
  - installing more telephone lines;
  - more information is now taken from the front line staff to see if they can deal with the issue before speaking to the GP; and
  - adjusting the ratio of book-ahead and same-day appointments to suit patient needs.

- Just under half of appointments provided by practices were for the same day although this did vary from two per cent to 80 per cent. (NB: This is not a weighted average.)
- The DNA rate was eight per cent, ranging from two per cent to 20 per cent irrespective of appointment type. (NB: This is not a weighted average.) In tackling DNAs, practices reported that:
  - they are increasing the number of appointments available within 24 hours, and telephone advice to help reduce DNAs;
  - they have implemented a removal policy for repeated offenders; and
  - they telephone or write to patients that did not attend displaying DNA rates and information in the practice premises.
- Most consultations are carried out face-to-face
- Over the last two years: 19 practices had reviewed their systems for home visits (compared with 59 per cent across Wales); 23 practices had systems in place for facilitating home visits; 12 have protocols for responding to home visits; and 27 offer initial telephone assessments by a clinician.
- Eighteen out of 28 practices have formal protocols in place to deal with requests for appointments (compared with 55 per cent across Wales). Receptionists in 26 out of 28 practices receive training on induction, and 19 out of 28 subsequently receive refresher training, on identifying urgent and emergency calls (compared to 88 per cent and 75 per cent respectively in Wales).
- Over the last two years, 15 practices had reviewed receptionist's effectiveness in identifying emergency/urgent calls and as a consequence:
  - one practice said that whilst receptionists are trained on what is not an 'emergency' appointment, but it should be a clinician who decides on the level of urgency, not receptionists;
  - have implemented a script for receptionists to use; and
  - have updated training and protocols for dealing with patients and assessing the degree of urgency required.
- Roughly 13 per cent of appointments are used for patients with non-clinical needs in a week, these ranges from 0 per cent to 50 per cent across the practices. (NB: This is not a weighted average.)
- Eighteen of the practices perceived out-of-hours services to be very good or good at meeting the needs of patients out of hours while two others perceived them to be poor or very poor (across Wales 76 per cent of practices reported that OOH services were good or very good). Ten practices, less than half, reported receiving information about frequent attenders of out-of-hours services (this is lower than the rate of 62 per cent across Wales). Main opinions expressed included:
  - one practice said clinical feedback received, good communication , minimal patient complaints;
  - good lines of communication between primary care and out of hours; and

  - generally good service, however, there are occasions when the patient has been told to wait until they are open.
- Perceptions about practice involvement in the planning or redesign of USC/CCM services:
  - the Health Board's practices were more positive about their involvement in planning and redesign that practices across Wales, with 11 agreeing or strongly agreeing that they were involved with planning (31 per cent across Wales) and agreeing or strongly agreeing that they were involved with redesigning (21 per cent across Wales);
  - most practices did not perceive the Health Board as providing support to become involved in the planning and redesign of USC services however, two-fifths of practices in the Health Board did feel adequately informed of plans for USC services (this is similar to the percentage across Wales, 43 per cent); and
  - more positive response in relation to the planning and redesign of services for chronic conditions, nearly half of practices in the Health Board perceived to be actively involved in planning and redesigning CCM services (compared with 45 per cent of practices across Wales).
- Two-thirds of practices believe the data on emergency admissions introduced as part of the QOF framework are helpful (38 per cent across Wales); three quarters believe the data are used by the practice (44 per cent across Wales), more than half believe the data will lead to changes in the way practices provide services (25 per cent across Wales). Views expressed on how to improve the quality of the data include:
  - Make it accurate, include cross-border (English) residents who are registered with the Practice.
  - Secondary care should give practice data regarding inappropriate hospital admissions so the problem may be defined and action plans put in place. At the moment we are given numbers of hospital admissions but no quality data regarding inappropriate admissions. More information and audits from secondary care would be helpful.
  - It would be helpful to know details of the practice emergency admissions rates (excluding patients referred by the out-of-hours service).
  - We need to have individual patient names and diagnoses as soon as possible after the event so that we can review what happened.
  - Breakdown of Surgery emergency admissions, out-of-hours admissions for the Practice, admissions from A&E attendance for the Practice to see a clearer picture.
- Ten practices have undertaken work themselves or had work undertaken by the HB, or to identify patients who are repeatedly attending the emergency department or other unscheduled care services in the hospital.
- The majority of practices are routinely notified when their patients access the emergency department (three of those that responded to this question said they were not), but all indicated that they are not informed of the frequency of access.

- In respect of support practices are given to help avoid emergency admissions, hospital attendances and A&E attendances:
  - fourteen practices perceived that they have 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 A&E attendance when appropriate (compared with 32 per cent across Wales);
  - thirteen practices perceived that they have good access to 'rapid access clinics' or 'hot clinics' to help avoid emergency admissions/hospital attendances and A&E attendances when appropriate (compared with 34 per cent across Wales);
  - twelve practices perceived that they had good access to diagnostic services to help avoid emergency admissions/hospital attendances and A&E attendances when appropriate (compared with 32 per cent across Wales);
  - fifteen practices perceived that they can refer patients to a good range of community services to avoid emergency admissions/hospital attendances and A&E attendances when appropriate (compared with 36 per cent across Wales);
  - eleven practices agreed that they had enough information about the range of community services available to prevent avoidable admissions (compared with 42 per cent across Wales).
- In the final comments box, practices indicated:
  - 'We would like to receive regular (monthly or quarterly) information relating to patients who frequently attend A&E.'
  - Since the opening of the new Hospital (YAB) the Practice has not been updated about the services offered locally and which we should continue to refer to NHH. Also, periodically we used to receive Dept and Consultant contact details. These were particularly useful for keeping us up to date with who had left, currently worked where and their telephone/fax numbers – saves endless phone calls to the hospitals to confirm.

Newport City Council's Newport Citizens' Panel August 2011 results

Newport City Council's Involve Newport Citizens' Panel was also surveyed in August 2011 regarding access to primary care. The results showed:

- nearly 30 per cent of responders stated they were unable to get an urgent appointment with their GP within 24 hours;
- thirty-four per cent of people said it 'wasn't easy' to book a GP appointment in advance;
- nearly 24 per cent reported it 'wasn't very easy' or 'not at all easy' to get through to their GP surgery by phone;
- forty-three per cent reported it was 'not very easy' or 'not at all easy' to book a convenient GP appointment; and
- nearly 43 per cent said it was 'not very easy' or 'not at all easy' to speak to their GP if they needed advice – conversely only around 38 per cent said this was 'very or fairly easy'.

Appendix 4

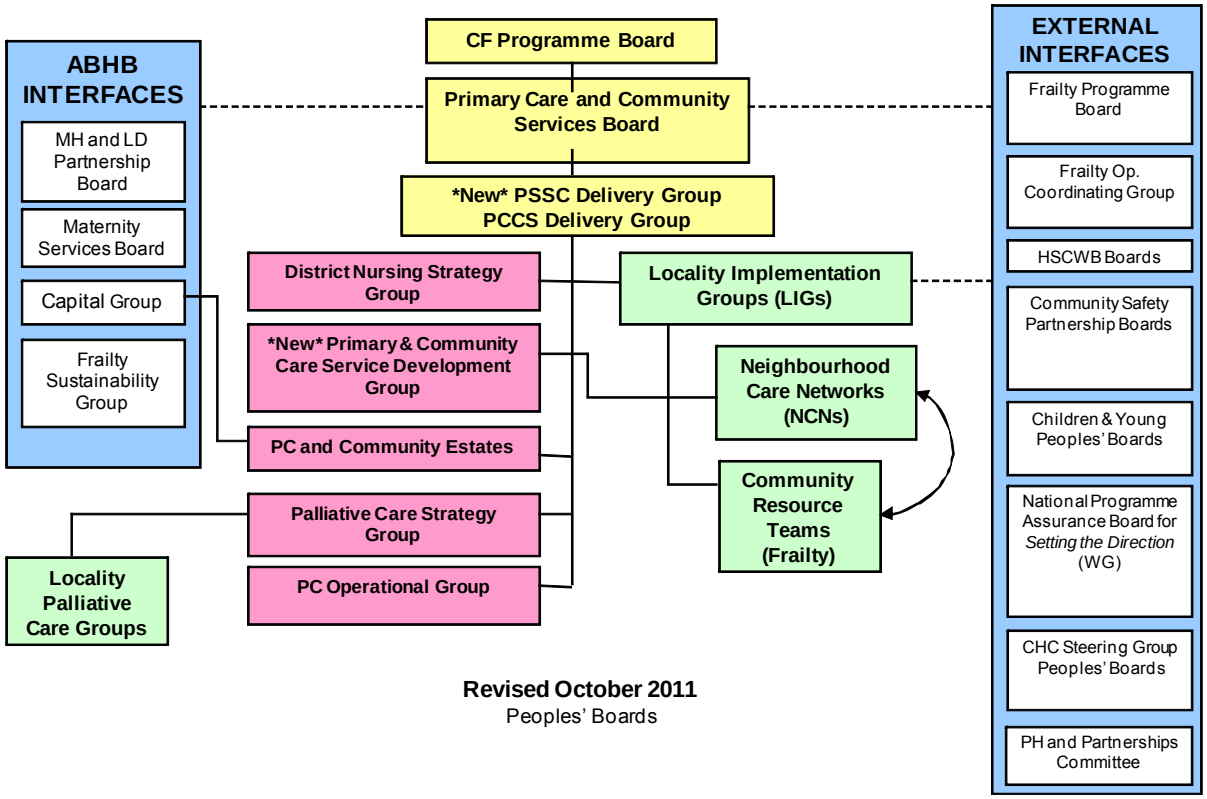
Chronic condition prevalence by locality 2011

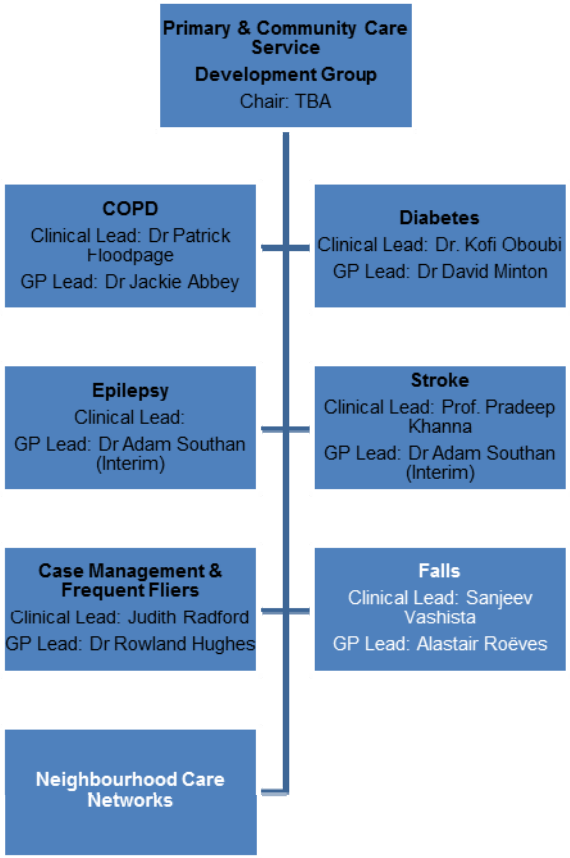
Condition	All Wales Ave (%)	Blaenau Gwent		Caerphilly		Monmouthshire		Newport		Torfaen	
		No. on Disease Register	% Prev.	No. on Disease Register	% Prev.	No. on Disease Register	% Prev.	No. on Disease Register	% Prev.	No. on Disease Register	% Prev.
AF	1.69	1,132	1.44	2,786	1.52	1,882	1.95	2,146	1.47	1,540	1.64
ASTHMA	6.70	4,839	6.17	11,879	6.47	6,092	6.30	9,626	6.58	6,847	7.30
BP	15.17	13,153	16.77	30,081	16.37	14,418	14.90	20,859	14.25	15,144	16.15
CHD	4.10	3,498	4.46	7,846	4.27	3,845	3.97	5,597	3.82	4,025	4.29
CKD	3.29	2,879	3.67	6,740	3.67	3,962	4.10	4,931	3.37	3,025	3.23
COPD	1.99	2,190	2.79	3,975	2.16	1,407	1.45	2,575	1.76	1,746	1.86
DIABETES	4.86	4,566	5.82	10,003	5.45	4,780	4.94	7,505	5.13	5,318	5.67
EPILEPSY	0.73	607	0.77	1,408	0.77	567	0.59	1,061	0.72	748	0.80
HF (1)	0.91	881	1.12	1,591	0.87	919	0.95	1,263	0.86	887	0.95
HF (3)	0.51	490	0.62	843	0.46	506	0.52	494	0.34	535	0.57
OBESITY	10.11	9,782	12.47	22,169	12.07	8,993	9.30	15,453	10.56	10,404	11.10
SMOKING		21,119	26.92	48,522	26.41	24,291	25.11	36,082	24.65	25,268	26.95
STROKE	2.04	1,393	1.78	3,446	1.88	2,117	2.19	2,792	1.91	1,814	1.93

Source: Aneurin Bevan Health Board

Appendix 5

Primary Care and Community Services Reporting Structure




Primary & Community Care Service
Development Group
Chair: TBA
COPD
Clinical Lead: Dr Patrick Hoodpage
GP Lead: Dr Jackie Abbey
Diabetes
Clinical Lead: Dr. Kofi Oboubi
GP Lead: Dr David Minton
Epilepsy
Clinical Lead:
GP Lead: Dr Adam Southan (Interim)
Stroke
Clinical Lead: Prof. Pradeep Khanna
GP Lead: Dr Adam Southan (Interim)
Case Management & Frequent Fliers
Clinical Lead: Judith Radford
GP Lead: Dr Rowland Hughes
Falls
Clinical Lead: Sanjeev Vashista
GP Lead: Alastair Roëves
Neighbourhood Care Networks

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