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Transforming Unscheduled Care and Chronic Conditions Management

Betsi Cadwaladr University Health Board

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Context

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

2. The need for change has been apparent for some time. In 2003, the *Review of Health and Social Care Services in Wales* (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 in NHS Wales. It describes the pressures that Welsh hospitals experience which include the large number of emergency admissions and delays in discharging patients who are ready to leave hospital. The programme states that one of the causes of elevated pressures in hospital is that historically, the health service has gravitated services and patients towards hospital, thus restricting the sustainability and effectiveness of community services.

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

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

    *   **The considerable impact of chronic conditions is growing in Wales.** One-third of the adult population in Wales, an estimated 800,000 people, report having at least one chronic condition, such as diabetes, chronic obstructive pulmonary disease (COPD) or heart disease. This proportion is higher in Wales than other constituent countries 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.

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

- **Unscheduled care services are some of the most pressurised parts of the health and social care system.** The Welsh Government's 2008 *Delivering Emergency Care Services* strategy stated that Unscheduled Care services face ever-increasing demand. We estimate that there are more than eight million contacts[2] with Unscheduled Care services in Wales every year, with associated use of resources implications.

- **The areas of chronic conditions management and unscheduled care are crucially interrelated**. People with chronic conditions tend to be frequent users of the Unscheduled Care system because when their conditions exacerbate, they often need to access services in an urgent and unplanned way. Moreover, people with chronic conditions are twice as likely to be admitted to hospital than patients without such conditions. Transforming chronic conditions services and helping more individuals to self-care has huge potential benefits for Unscheduled Care services.

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

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[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 EDs, 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. Betsi Cadwaladr University Health Board (the Health Board) covers the whole population of North Wales, providing three Emergency Departments (EDs), previously called Accident and Emergency departments in Ysbyty Gwynedd, Ysbyty Glan Clwyd and Wrexham Maelor Hospital. A range of community hospitals provide minor injuries services (MIU). Chronic conditions are either managed in the primary and community care sector, for example patients' own homes, GP practices and community hospitals, or in secondary care within acute hospitals. The Health Board, established in October 2009, is structured around Clinical Programme Groups (CPG), led by clinically qualified healthcare professionals and organised around broad medical specialities. Both Unscheduled Care and Chronic Conditions Management services are primarily managed through the Primary, Community and Specialist Medicine CPG, although other CPGs have important contributions to make for the care of these patients.

9. Our preliminary follow up work at the Health Board in mid-2011 found that it had started to implement a whole systems approach to Unscheduled Care but this was not yet resulting in improved performance. The Health Board set out the need for three major EDs in North Wales in *Our Strategic Direction,* which it published in October 2009. The Health Board had also produced a draft *Blueprint* for a whole systems approach to Unscheduled Care. However, organisational re-structuring was still underway at the time of our preliminary follow-up work following the NHS reforms in 2009. Although the *Blueprint* was promising, implementation is yet to start.

10. The financial position of the Health Board is very challenging, and although the Health Board broke-even at the 2011-12 year end, a structural deficit remains. Cost improvement programmes are in place but not achieving targets, and stringent financial controls are in place around vacancies and other expenditure. The Health Board reports that it will start 2012-13 with a £65 million deficit on a budget of around £1.2 billion. Consequently, the financial pressure is significant and still increasing. Further pressure comes from the Health Board's failure to achieve the Welsh Government's tier one targets for Unscheduled Care in Ysbyty Glan Clwyd, which led to Delivery and Support Unit (DSU) intervention over the winter of 2011-12.

11. Our fieldwork was conducted in the first six months of 2012, and subsequently the Health Board started consultation on *Healthcare in North Wales is Changing.* Where applicable we have added references to these proposals throughout this report, but we have not updated other findings to reflect the impact of other initiatives underway in the Health Board on these services, as we have not been able to independently assess their impact. We expect the Health Board to publish a management response alongside this report, where it will outline both the progress it has made since our fieldwork, and the actions it plans to take to address our findings.

Our main findings

12. Our review, which was carried out between January 2012 and April 2012, 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?'

13. Our main conclusion is unscheduled care services remain under pressure while chronic condition services are still fragmented and underdeveloped: progress in implementing a whole-system approach is hampered by the complexity of internal structures and partnerships, insufficient clinical engagement and underdeveloped plans to implement a comprehensive model.

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

> **Part 1 - The Health Board is struggling to improve unscheduled care performance because acute capacity is stretched and the shift of services into the community has been slow, resulting in only limited reduction in demand on acute services.**

1a. Slow improvements to patient flow combined with small reductions in bed capacity mean that EDs are under significant pressure, which increases risks to patient care

- Numbers of ED attendances have slowly increased but planned increases to medical staffing are only partially in place.
- Emergency department performance is consistently below national targets and performance against the eight-hour target is deteriorating.
- In Ysbyty Glan Clwyd a relatively high proportion of patients arrive by ambulance, and across the Health Board many wait too long to be handed over to the care of hospital staff.
- Bed capacity has reduced, and a range of actions to improve patient flow to increase bed availability, are only just starting to produce results.
- Despite progress on Coronary Heart Disease and Diabetes, admissions for chronic conditions continue to create high demand on acute services, particularly in respect of COPD.
- Actions to tackle delayed transfers of care have had a positive impact.
- Limited information is provided to GPs to help them understand their admission profile to help divert emergency demand.

1b. There has been limited progress developing effective chronic conditions management programmes that cover the whole North Wales population

- The Health Board has not fully capitalised on the demonstrator site legacy to improve Chronic Conditions Management services.
- Little progress has been made to further develop the community resource model.
- Community hospitals are not uniformly fulfilling their potential role.
- Limited use is made of primary care contracts to support patients with chronic conditions and Unscheduled Care needs.
- Primary care access measures are contradictory, with poor opening hours indicating scope to improve access.

1c. Limited progress has been made to influence the way the public uses services and to improve self-care

- Considerable scope remains to improve the utilisation of public marketing to help citizens make informed choices about where to seek care in emergencies.
- The Health Board was the first in Wales to implement 'Choose well'.
- Progress on single points of access and communication hubs has been slow.
- The Health Board has yet to see the benefits from the self-care agenda.

Part 2 - The Health Board has a vision for both unscheduled care and chronic conditions management services, but plans to implement the vision are vague, high level and threatened by a number of challenges made harder by complexity

2a. The Health Board has a strategic vision articulated in a number of documents but a lack of overall cohesion between the documents hinders clarity.

2b. The Health Board's vision for Unscheduled Care and Chronic Conditions Management services is not supported by appropriate and detailed transformation plans.

2c. Complex organisational structures are not yet fully staffed, impacting on the pace of change.

2d. Accountability and performance management arrangements for Unscheduled Care and Chronic Conditions Management are complex, and are not supported by comprehensive performance information.

2e The clinical leadership model is not yet delivering sufficient clinical engagement to drive successful change.

2f. The complexity of Health Board structures and partnerships makes engagement with key partners harder.

Recommendations

15. The table below summarises our recommendations, which are intended to complement the detailed action plan which the Health Board developed following the DSU report on Glan Clwyd. Further iterations of this consolidated action plan must address the wider issues raised in our report. Our recommendations are below.

At Health Board level

R1   The lack of detailed implementation plans for whole system service modernisation is a key finding of our work. Once consultation on *Healthcare in North Wales is Changing* is complete, the Health Board must move quickly to ensure strategic plans are finalised and move quickly through implementation plans into detailed implementation. Specifically:

- Ensure formal adoption of the *Unscheduled Care Blueprint* by the Board.

- The implementation plans must:
  - take account of Setting The Direction, and the Unscheduled Care Blueprint model;
  - build on learning from demonstrator sites on 'what works' locally;
  - be fully costed, including both full financial and staffing requirements;
  - provide clear steps to move to the new service configuration(s);
  - ensure all of the MIUs are clinically sustainable, provide an environment suitable for modern healthcare provision, with sufficient volumes to maintain staff competency levels, and fit a pattern of provision which supports a whole-system service model for Unscheduled Care; and
  - ensure all community hospitals are fully utilised, and enabled to play their role in step up/step down care for people with both Unscheduled Care needs and chronic conditions.

R2   The incomplete internal organisational change process is hampering decision making, and operational effectiveness. The Health Board must complete its organisation change process by the end of 2012-13, and ensure that this provides strengthened:

- operational site management to strengthen operational co-ordination between CPGs;

- senior operational management capacity to free up clinical leaders to lead; and

- day to day site management arrangements, to improve co-ordination of bed management, and clearly communicate these to all staff.

R3   Although developing, the Health Board's performance information reports have not provided a tiered holistic, whole system view of chronic conditions and Unschedule Care services. A consistent hierarchy of information should be monitored by the Board through its sub-committees, and at CPG, area, site, locality and department level. Specifically this information suite must also include:

- progress reports on the implementation of *Setting the Direction*;

- both community and primary care measures, for example Home Enhanced Care Service (HECS) care packages and local enhanced services (LES) performance;

- acuity and safety measures alongside access performance measures to ensure patients are managed safely in EDs, such as standardised clinical incidents;

- Chronic Conditions Management measures, such as 12 month rolling average length of stay for key conditions, or standardised admission rates by locality; and

- outcome measures for unscheduled care and chronic conditions, for example patients returned to usual place of residence, supported at home, or re-admitted within 28 days.

R4   The current information systems do not provide sufficiently detailed and comparable information to co-ordinate services, diagnose issues and develop alternative pathways. This must be rectified quickly. Specifically:

- Emergency departments and MIUs should all use compatible triage and information systems, able to provide consistent management information.

- The Health Board must routinely capture and analyse emergency admissions by GP practice or look for trends by GP practice or locality and working with the GPs to understand and reduce this demand where appropriate.

- Clinical risk management systems still vary between sites, and must rapidly move onto the Health Board's standardised risk management arrangements from their legacy systems. This must include:
    – quickly implementing the new incident reporting and risk management systems to standardise recording across the Health Board;
    – incident reporting must include contributory factors, such as delay;
    – ED staff must contribute by reporting incidents and near misses consistently and proactively; and
    – at CPG and operational levels, monitor clinical incidents and outcomes alongside ED waiting time by categories susceptible to pressure, such as medication administration (when patients are waiting for admission), delay in assessment.

Managing Unscheduled care

R5   A public health information campaign utilising the Choose Well message to help patients choose the appropriate route for their Unscheduled Care needs, improve the efficient use of MIU resources, and relieve pressure on EDs. Rapid introduction of a 'single point of access' should support patients choosing where and how to access services.

R6   Post consultation the Health Board needs to publicise MIU services and their opening times effectively, and agree protocols with the Welsh Ambulance Service Trust for diversion of appropriate cases to MIUs.

R7   Work with primary care to reduce demand on EDs by working in partnership to identify how demand can be reduced and sustained to:

- develop and implement a policy whereby patients can be referred back to their GP provided the triage score is low and the physical parameters, such as temperature and pulse, are within normal range; and

- ensure GP practices across the Health Board are open for all of their hours, allowing more patients to be seen in primary care.

R8   To strengthen capacity within the EDs, and ensure patients are able to be admitted to a suitable bed in a timely manner, the Health Board must ensure it urgently implements and sustains all of the recommendations around flow and working practices in the DSU action plan across all three sites, but in Ysbyty Glan Clwyd in particular. In addition:

- whilst waiting to recruit to vacant posts in a time of UK-wide difficulties in recruiting Emergency Department Medical staff, the Health Board should audit the availability of consultants in post, and consider what can be done to support consultants with their other tasks to maximise their actual availability on the 'shop floor';

- ensure that all ED staff are not covering additional duties, and have suitable skills;

- ensure that plans for the new and revamped departments ensure efficient flow, and allow sufficient flexibility for predictable changes in workload and services across north Wales.

- integrate triage for EDs and OOH services;

- improve co-ordination with primary care by ensuring that CPGs and primary care work together to ensure rapid access through alternative routes for suitable patients such as hot clinics and diagnostics; and

- optimise ways to develop extra peak capacity, such as the 'Elastic Ward' concept.

Transforming care for chronic conditions

R9   Services for Chronic Conditions Management were at the time of review fragmented, and underdeveloped. Using the Welsh Government's Chronic Conditions Management model, and through *Healthcare in North Wales is Changing* the Health Board should ensure that:

- All patients who may benefit have access to and complete education and rehabilitation programmes.

- Community pharmacy contracts are effectively utilised to support patients with chronic conditions.

- All CPGs co-operate with proposed new enhanced community services to allow them to operate as intended; the community resource team model is embedded across all localities; and work with locality teams and primary care to identify and understand why acute admission is the default pathway for many patients. Then use this information within localities to develop alternative patient pathways.

- Telehealth is used effectively to support primary care management of appropriate patients.

- Single points of access must be implemented.

Detailed Report

The Health Board is struggling to improve unscheduled care performance because acute capacity is stretched and the shift of services into the community has been slow, resulting in only limited reduction in demand on acute services

16. Across Wales, demand for hospital services is high with increasing numbers of ED 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 demand on the acute sector by developing out-of-hospital services, supporting self-care and helping signpost patients to the services which are most appropriate to their needs.

Slow improvements to patient flow combined with small reductions in bed capacity mean that Emergency Departments are under significant pressure, which increases risks to patient care

Numbers of emergency department attendances have slowly increased, but planned increases to medical staffing are only partially in place

17. The Welsh Government's *Delivering Emergency Care Service*s strategy highlighted a year-on-year increase in the number of patients attending hospital EDs. As well as the general upwards trend in demand, EDs 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.

18. Between 2010 and 2011, there was a small rise (1.6 per cent) in the total number of attendances at major ED departments across Wales (Appendix 1). The Health Board has experienced a rise of 2.9 per cent, with more than 4,700 extra attendances per year. Exhibit 1 shows the percentage change in attendances at each major ED department in Wales. At Wrexham Maelor, the number of ED attendances increased by 5.1 per cent from 63,703 in 2010 to 66,940, the equivalent of nine more attendances each day. At Ysbyty Gwynedd ED attendances increased by 3.6 per cent from 44,887 to 46,518, or just over four additional attendances per day. Attendances at Ysbyty Glan Clwyd remained relatively unchanged.

Exhibit 1: Percentage change in the number of attendances at major ED departments between 2010 and 2011
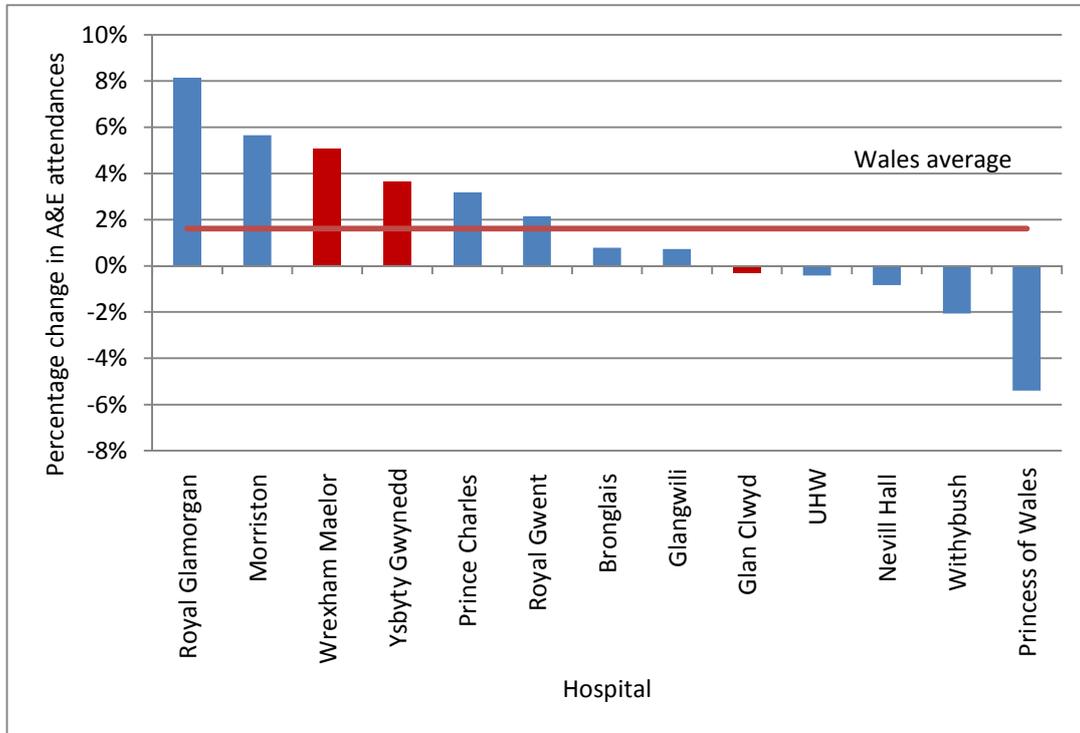
Source: Wales Audit Office analysis of ED attendances derived from StatsWales [statswales.wales.gov.uk]

19. The pattern of attendance at the three EDs is broadly similar year on year, except for a drop in the winter of 2009-10 during a period of severe cold weather (Exhibit 2). Our interviews suggest that this was mainly a reduction in minor injuries and illnesses, supporting DSU findings that substantial elements of workload in Ysbyty Glan Clwyd are for minor injuries.

Exhibit 2: Trend in monthly attendances at major accident and emergency departments at Betsi Cadwaladr University Health Board, October 2009 to May 2011
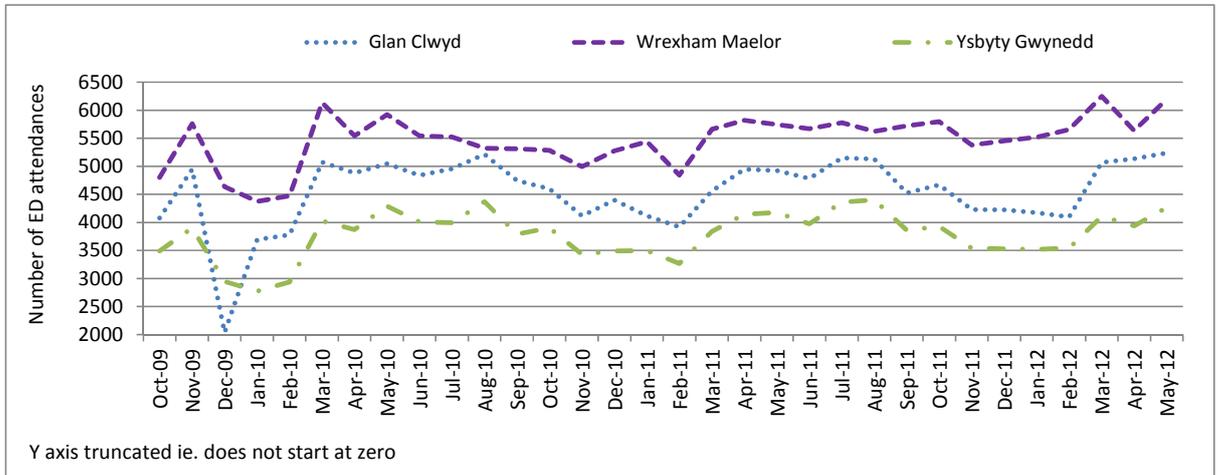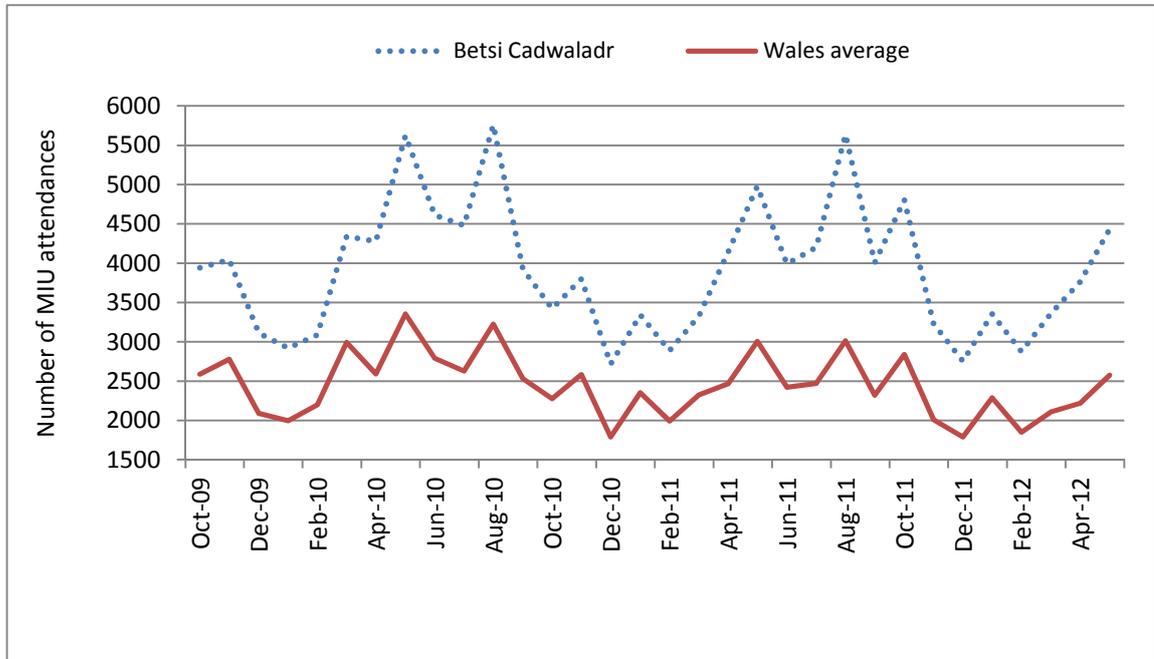
Source: Wales Audit Office analysis of data on ED attendances derived from StatsWales [statswales.wales.gov.uk]

20. The Health Board has 15 MIUs which provide care for injuries that are non-life threatening, such as lacerations that require simple suturing and sprained ankles. Seasonality influences the pattern of attendances at the Health Board's MIUs, with peaks in activity during public and school holidays (Exhibit 3).

Source: Wales Audit Office analysis of data on ED attendances derived from StatsWales [statswales.wales.gov.uk][3]

21. Whilst an MIU service in each locality will ease accessibility in rural areas, and if used properly allow triage and rapid transfer direct to acute services for more serious walk-in cases, this needs to form part of the wider whole-system provision of Unscheduled Care services. If patients attend a MIU this can help to ease the pressure on ED departments, allowing them to concentrate on patients with more serious illnesses and injuries, therefore the provision of planned MIU services is an important part of the whole system. The provision of MIUs across North Wales has been based on historical provision and not necessarily part of a clear whole system plan. Since our fieldwork the Health Board consultation on *Healthcare in North Wales is Changing*[4] sets out plans to allow standardisation and clarity of hours and practice to increase clarity for the public, and concentrate demand to support maintenance of skills within the MIUs.

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[3] We compared the StatsWales data returns with the information that health boards provided. The data are correct, but the average is low because the overall number of attendances at MIUs in one health board are extremely low in comparison with the other health boards.

[4] *Healthcare in North Wales is Changing*: Report on service change proposals to Board published 19 July 2012.

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22. The MIUs should use triage systems that are consistent with the main EDs they are associated with as this increases consistency of patient assessment and makes cross referral more efficient and safer. Only six of the Health Board's 15 MIUs reported using a triage system, and only three of these used a triage system consistent with the main EDs.

23. Across the Health Board's MIUs there are significant variations in the number of attendances each year and differences in workload (Appendices 2 and 3). Not all the variation is related to seasonality. Neither is it clear how staff maintain their skills when some units assess and treat such small numbers of patients each year, particularly as rotation between MIUs and EDs is not routine.

24. Between 2010 and 2011, attendance at the Health Board's MIUs fell by three per cent compared with a six per cent reduction across Wales (Exhibit 4). Data for six of the MIUs[5] shows that there have been bigger reductions over the longer term. Between 2007-08 and 2010-11, MIU attendances reduced by nine per cent. The fall in the number of attendances is unrelated to, and predates, the reduced opening hours at some MIUs, and the temporary emergency closures of some other MIUs in December 2011.

25. In December 2011, the Health Board initiated a number of urgent temporary service changes, including temporary movements of nursing staff from community hospitals to acute sites and between community hospitals. This temporary measure resulted in MIUs closing, for example in Bryn Beryl and Colwyn Bay. Emergency Nurse Practitioners moved to Ysbyty Glan Clwyd from Colwyn Bay, and some ward nursing staff moved to cover other community hospitals (Eryri) or acute wards, allowing beds in these areas to remain open for acute admissions and step-down. This measure was to maintain safe staffing levels at a time of peak demand on acute sites. The Health Board reopened MIUs on 1 April 2012, in time for the Easter school holidays.

26. Good public knowledge about the services that MIUs provide, allows health boards to maximise the benefit of MIU services. If minor injuries patients are not diverted to MIUs then EDs may struggle to deliver efficient services. Interviews with staff revealed that not all MIU services are well publicised or efficiently used by members of the public, with patients arriving when units are closed, or defaulting straight to EDs having driven past an MIU. Our discussions with ambulance staff also indicate that there is some scope for ambulances to divert to MIUs for minor injuries patients following triage by paramedics. This happens at times of peak demand but this alternative is not consistently used.

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[5] Bryn Beryl, Dolgellau and Barmouth, Ffestiniog, Llandudno, Tywyn, and Ysbyty Penrhos Stanley.

Exhibit 4: Percentage change in number of attendances at MIUs between 2010 and 2011
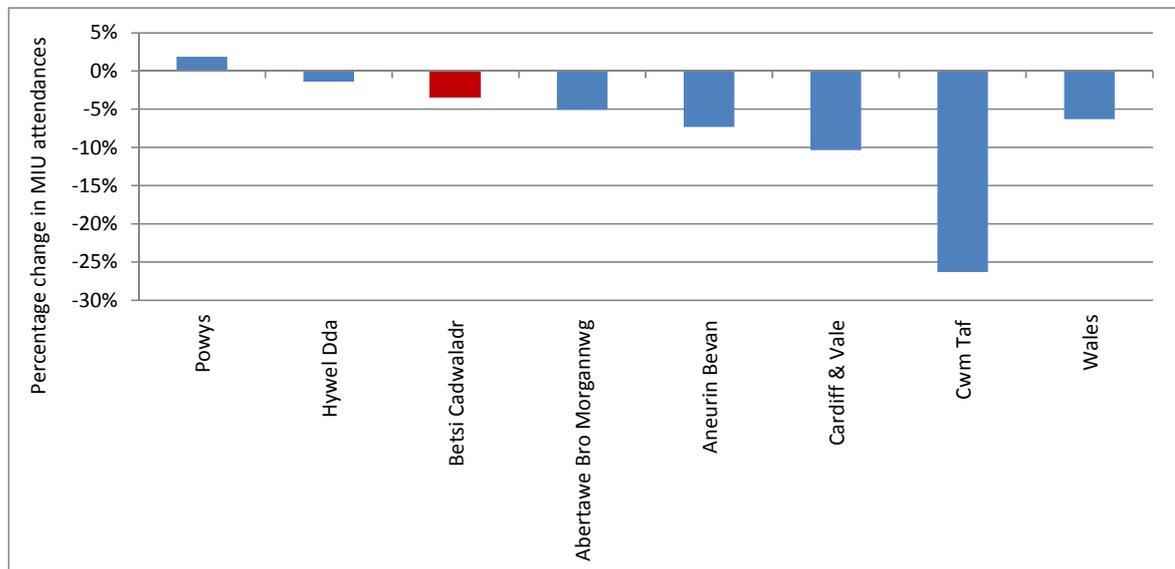
Source: Wales Audit Office analysis of data on ED attendances derived from StatsWales [statswales.wales.gov.uk]

27. The College of Emergency Medicine now recommends that 'every major ED should have at least 10 emergency consultants to provide up to 16 hours of on-site 'shop floor' cover seven days a week[6]. The Health Board has consultants available at all three EDs for 10-14 hours on weekdays (see Appendix 4). However, at weekends there are marked differences in consultants' working hours across the three sites, ranging from three hours at Ysbyty Gwynedd, to eight hours at Ysbyty Glan Clwyd and 15 hours at Wrexham Maelor per weekend day.

28. The number of medical staff varies across the three EDs reflecting the arrangements in place prior to the NHS reforms in 2009. The Health Board has plans to increase senior cover to ensure sufficient senior decision-making capacity at peak times of demand, but is still considerably short of its own aims in Ysbyty Glan Clwyd, and slightly short in Ysbyty Gwynedd. Wrexham Maelor has eight consultant posts and sufficient senior decision-making capacity to cover peak times, which probably contributes to better performance against the four hour waiting time target (paragraph 34).

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

29. Like other health boards, Betsi Cadwaladr has a shortfall in the overall number of consultants and middle-grade doctors working in the EDs due to long-standing recruitment difficulties. These difficulties reflect UK-Wide shortages of ED medical staff. The Health Board has taken the opportunity to try and make middle grade posts more attractive by introducing Clinical Fellows, GP Registrars and medical staff from the Royal Air Force to provide varied training and experience opportunities which has attracted staff to these posts.

30. In April 2012, there were 4.5 whole-time equivalent (WTE) consultant vacancies and six WTE middle-grade vacancies (Appendix 5). These vacancies are concentrated at Ysbyty Glan Clwyd (because of long-standing recruitment problems), and Ysbyty Gwynedd (because of the retirement of their fourth consultant post). Multiple campaigns to attract ED consultants have only recently attracted a suitable candidate for appointment at Ysbyty Gwynedd, who was appointed on a locum contract in June 2012.

31. Steps are also being taken to encourage movement of consultants across the three EDs, with consultants from Wrexham Maelor and Ysbyty Gwynedd working shifts in Ysbyty Glan Clwyd. In the meantime, the Health Board continues to rely on locum consultants, both to fill slots in the rotas, and to back-fill posts. This situation is not sustainable in the long term because the locums are former ED consultants, who have retired and may choose to stop working at any time.

32. The Health Board moved staff resources from community services to its acute sites as part of its emergency changes over the past winter. Some Emergency Nurse Practitioners were asked to work in the EDs. The impact of these changes on acute services is difficult to assess. It does show the perceived level of pressure in the acute units and an attempt by both the CPG and Health Board to maintain the safety of acute services.

33. In our interviews, staff reported feeling under pressure, but Exhibit 5 shows that in November 2011, workload pressure, measured as attendances per WTE staff, was at or below the Wales average (58 attendances per WTE staff). Attendances per WTE staff at the Wrexham Maelor, Ysbyty Glan Clwyd and Ysbyty Gwynedd were 58.8, 54.3 and 46.8 respectively. Further analysis (Appendices 5, 6 and 7) show the number of attendance per WTE medical or nursing staff shows that the attendances per WTE medical staff is higher than the Wales average at Ysbyty Glan Clwyd while numbers of attendances per WTE nursing staff were lower than the Wales average at Ysbyty Gwynedd. This information does not take into account patient acuity (severity), or whether staff are covering additional duties, such as caring for patients waiting for beds elsewhere or in the Clinical Decision Units (CDUs), or vacancies for maternity or long-term sickness absence. All of these factors will increase the apparent intensity of workload and perceived ability to cope with demand safely.

Exhibit 5: Number of attendances at major ED departments in Wales per WTE ED staff (including locum medical staff) in November 2011
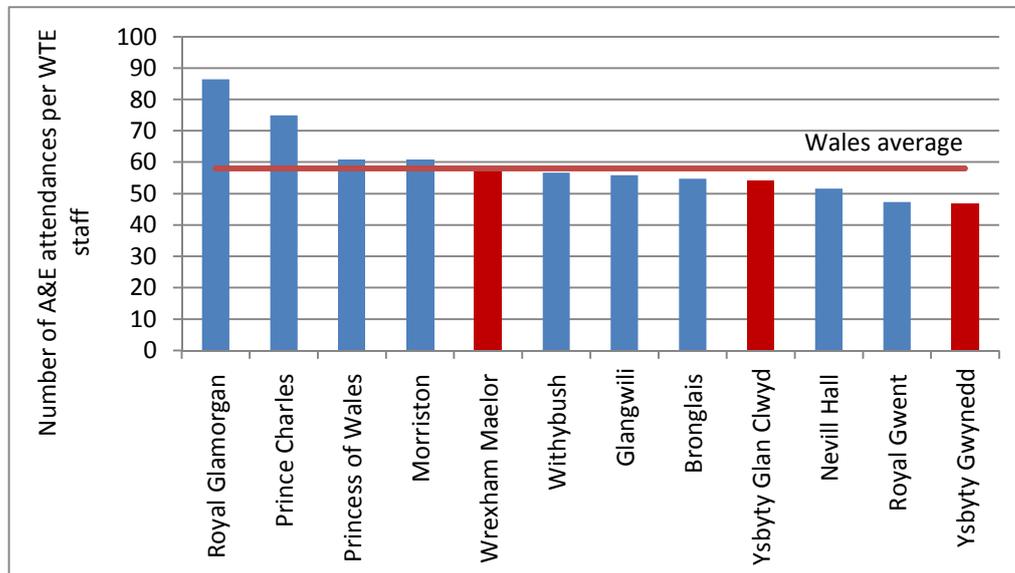
Data for University Hospital of Wales not available.

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

34. The whole acute system is under significant perceived pressure. Patients are being managed for long periods in crowded and busy EDs (see paragraphs 37 and 38), or in ambulances while waiting for space in the ED (see paragraph 45). In our interviews, many clinicians expressed concerns that patients were waiting too long for transfer to more suitable ward environments, and that this was causing back-logs in assessment of new patients. In addition, the EDs in Ysbyty Gwynedd and Ysbyty Glan Clwyd are old, and their layouts may be contributing to workload pressures. In particular, related work areas may be separated making work flow less efficient. The Health Board has made some improvements in Ysbyty Gwynedd and progressed plans for capital investment on an expanded and re-modelled ED, as well as a completely new Emergency Quadrant for Ysbyty Glan Clwyd. These will take time to build and commission but new facilities alone will not solve the issues around good patient flows.

35.   The impact on clinical risks is hard to quantify, as the EDs use three different incident reporting frameworks, part of their legacy arrangements, and had not yet moved to the Health Board's new risk management framework. These legacy frameworks are not consistent and are influenced by the different tolerance to risk, and reporting cultures within the EDs. The total numbers of incidents recorded in EDs has remained stable since 2009, and contributory factors are not fully recorded. However, the PCSM CPG has analysed incidents for trends and shared this learning through its internal structures. Other acuity or proxy safety measures such as SAPhTE[7] scores - a measure of workload intensity and overall safety in EDs - show high scores (red or orange) for long periods of time across the Health Board - indicating high levels of workload acuity. These scores have been consistently monitored weekly at PCSM CPG level and through the Unscheduled Care Board, and form the basis of the perceived high workload pressure consistently reported through our fieldwork.

36.   Although relative workload was at or below the Wales average, perceived workload pressures may increase the risk of errors if staff work under sustained pressure for long periods of time. However, at the time of our fieldwork the Health Board could not assure itself that patient outcomes are not adversely affected by perceived pressure on EDs. The Health Board had tried to monitor patient outcomes by reviewing mortality data at Board Committee level, and recognised that it needed to step up routine monitoring of unscheduled care pressures. From July 2012, the Quality and Safety Committee requested additional monthly unscheduled care reports, and this is a positive step forward. These new reports include information on workload intensity and actions underway, although there is scope to expand these further to include patient safety and outcome metrics or measures. This would help the Health Board to regularly monitor and assess the impact of acute service pressures on service quality and patient outcomes.

Emergency department performance is consistently below national targets and performance against the eight hour target is deteriorating

37.   People accessing hospital EDs are, in the majority of cases, in need of rapid assessment and treatment. For this reason, hospital EDs have been set a national target of ensuring at least 95 per cent of their patients spend no longer than four hours in the department from arrival until admission, transfer or discharge and that 99 per cent spend no longer than eight hours.

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[7] SAPhTE scores aim to measure the pressures being faced by EDs across Wales. **Green**: There is an acceptable level of risk within the department, and continuous monitoring is taking place. **Yellow**: The situation within the department is potentially unsafe, and the bed/duty manager has been informed, with action where appropriate. **Orange**: The situation within the department is dangerous, requiring action to improve safety within 30 minutes. In some instances patients may be held in an ambulance. **Red**: The situation within the department is critical, requiring immediate action to improve safety. In some instances the department may be closed and ambulances diverted.

38. The Health Board's performance in relation to the four-hour ED target has been consistently below the 95 per cent target since the Health Board was established in October 2009, with the exception of Wrexham Maelor's ED (Exhibit 6). At the time of our fieldwork, around 20 per cent of patients spent more than four hours in the EDs at Ysbyty Gwynedd and Ysbyty Glan Clwyd. The performance at Wrexham Maelor is comparatively better than the Wales average, but still below the 95 per cent target.

39. Prior to the Health Board's establishment, performance against the four-hour waiting time target at the three EDs was generally above 90 per cent. A number of changes are likely to have impacted on performance, not least the loss of direct admissions to Llandudno General Hospital (paragraph 51). Our work suggests the deterioration in performance may also be related to other more challenging cultural factors. In particular, legacy cultures, whereby in some of the predecessor organisations the executive managers were extensively actively involved in sorting out problems, hence the Health Board inherited unrealistic expectations from front-line staff. In addition, deterioration in performance may also be related to management capacity to support clinical leaders given the Health Board has reduced management costs (and posts) by a fifth. As a result, senior clinical staff and Assistant Directors are being diverted to provide day-to-day operational site-management.

Exhibit 6: Trend in proportion of patients who spend less than four hours in the emergency department
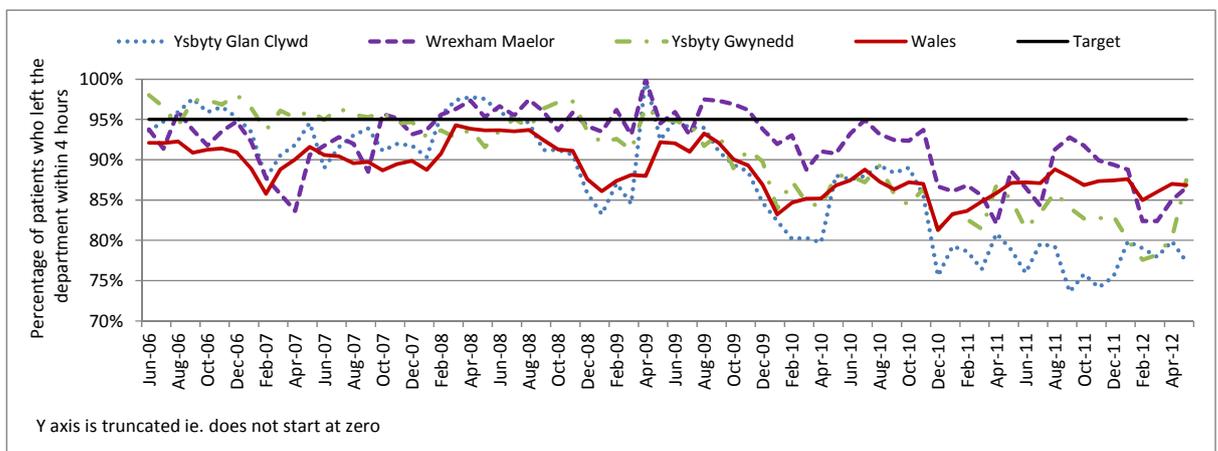
Y axis is truncated ie. does not start at zero

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

40. From December 2011, the Welsh Government changed the way in which breaches to the waiting time targets are counted. This means that data for December 2011 are not strictly comparable with data for the previous months. If a clinician decides that the safest place for a patient is the ED, the patient should remain there until it is safe to be moved. This means that these patients are no longer counted as a breach. It is thought that these exclusions may give rise to a small increase in the proportion of patients waiting less than four (and eight) hours, which may explain some of the improvement in performance at Wrexham Maelor and Ysbyty Gwynedd hospitals. However, until March 2012, the three North Wales EDs were unable to fully apply the guidance in relation to the way in which breaches are counted.

41. The time that individuals spend in EDs from arrival to departure appears to be increasing across EDs in Wales (Appendix 8). At Ysbyty Gwynedd, the average time patients spend in the ED increased from 106 minutes in 2007-08 to 147 minutes in 2010-11. At the Wrexham Maelor, waiting times remained relatively constant with patients spending on average 124 minutes in the ED during 2010-11 compared with 127 minutes in 2007-08. Comparable data were not available for Ysbyty Glan Clwyd but in 2010-11, patients spent, on average, 156 minutes in the ED.

42. Whilst performance against the four-hour waiting times has deteriorated, of more concern is the decreasing proportion of patients admitted within eight hours in the Health Board's EDs (Exhibit 7). The number of patients spending longer than eight hours in EDs has risen four-fold since 2009 from 528 to 2676 in 2011. In most cases such patients require a bed and on-going medical care. The EDs are not set up to care for patients over long periods, and drug rounds and patient meals particularly are not normal procedures. These long waits in EDs present a potential risk to patient care.

Exhibit 7: Trend in the proportion of patients who spend less than eight hours in the emergency department
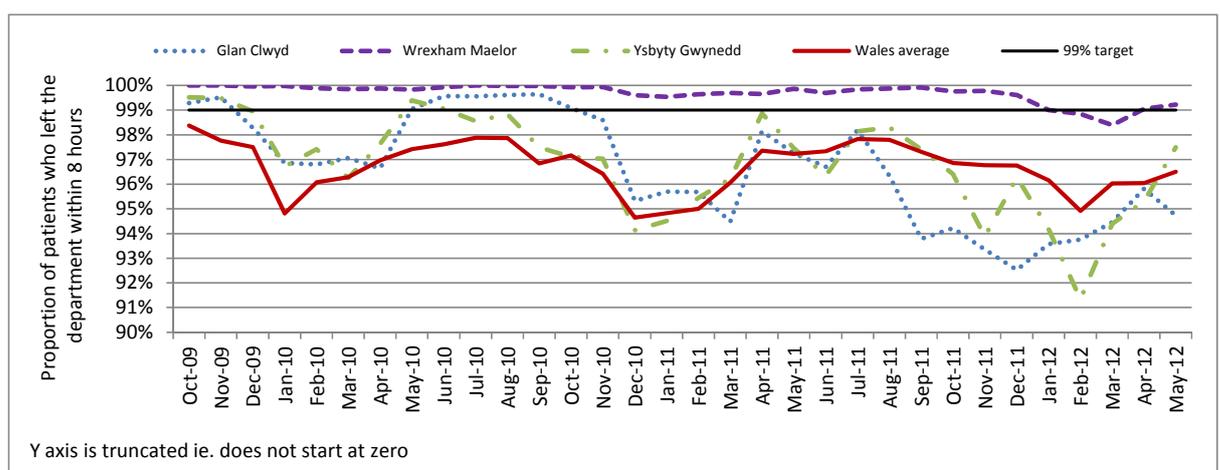
Source: Wales Audit Office analysis of data on ED attendances derived from StatsWales [statswales.wales.gov.uk]

43. The Health Board has failed to achieve the Tier 1 priority for delivery of the Unscheduled Care target at Ysbyty Glan Clwyd. This poor performance has meant intervention by the Welsh Government's DSU. This is the third such intervention in this hospital in the past seven years. The DSU have highlighted a number of areas where they are concerned, which include:

- issues with low levels of ED staffing;

- poor discharge planning;

- the Health Boards' lack of understanding of demand;

- poor root cause analysis of breaches ie, why the department is not achieving targets in relation to waiting times and patient handovers; and

- failure to grasp opportunities to expand the case mix of patients accessing CDU and ambulatory care areas, and changing the model of provision within the Ysbyty Glan Clwyd ED.

44. The Health Board has responded by developing an action plan and appointing a project manager to oversee the implementation of the plan. The Health Board has extended tailored action plans to all three acute sites. It is too soon to evaluate the impact of this work, as the management arrangements were only put in place in January 2012. However, the Health Board were not happy with the pace of progress in Ysbyty Glan Clwyd, and put a senior intervention team based on improvement methodology on site in October. October performance figures from recent Board reports show a sustained improvement in four hour waits in Ysbyty Gwynedd, and maintained performance in Wrexham Maelor, and for the first time substantially improved progress in Ysbyty Glan Clwyd to 88 per cent compliance with the four hour target.

In Ysbyty Glan Clwyd a relatively high proportion of patients arrive by ambulance, and across the Health Board many wait too long to be handed over to the care of hospital staff

45. When the ED and the rest of the acute hospital experiences increased demand, throughput of patients slows. Patients awaiting admission can be delayed in the ED while waiting for a bed. This 'flow' delay not only means that EDs become full, but also can delay the handover of patients from ambulance crews to hospital staff. Such delays have detrimental impacts on patients, who can often await medical attention in the back of an ambulance, on a trolley in the ED, CDUs or short stay ward. These delays have a detrimental impact on the ambulance service's ability to react quickly to emergencies because when crews are delayed at hospital they are prevented from responding to other emergency calls. There is also a potential impact on individual patients waiting for assessment and treatment away from the main ED.

46. A high proportion of patients attending the Health Boards' EDs arrive by ambulance (see Appendix 9). One-third (33 per cent) of attendances at Ysbyty Glan Clwyd arrive by ambulance compared with 26 per cent at Ysbyty Gwynedd and 20 per cent at the Wrexham Maelor. During interviews, ambulance staff discussed calls and the level of discretion they exercised in how they respond. Only at times of pressure are alternatives to conveying patients to EDs considered. The new 'clinical desk'[8] may allow paramedics to re-direct patients after face-to-face paramedic triage to MIUs or other clinically appropriate destinations. The Health Board should collaborate with the ambulance service to look at developing alternatives to conveying patients to EDs where it is appropriate to do so.

47. The Welsh Government introduced a mandatory 15-minute handover target in April 2008 to improve the timeliness of handovers between ambulance crews and EDs. More recently, the Welsh Government's *Delivery Framework for NHS Wales for 2011-12* sets out the minimum expectation that 95 per cent of all cardiac arrest, stroke and major trauma patients will be handed over within 15 minutes while continuous improvement in handover performance is expected for all patients.

48. The handover period starts from when ambulance crews notify the ED staff they have arrived with a patient who needs their care (logged on the data terminal). The period ends when the ambulance crew transfer the patient's clinical care to the ED staff and are free to return to the ambulance (again logged on the data terminal). The Health Board is currently a long way from achieving the 15-minute handover for all patients (Exhibit 8). Performance varies across the three EDs. Wrexham Maelor performed better than the Welsh average while performance at Ysbyty Gwynedd mirrored the Welsh average until the early part of 2011 when it dropped below. Performance at Ysbyty Glan Clwyd was better than Wales average until March 2011 when it moved closer to the Wales average then fell further throughout the summer and autumn.

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[8] A clinical model of triage, the 'Clinical Desk'. The Clinical Desk aims to manage the high number of 'inappropriate' emergency ambulance responses to 999 calls from people with neither life-threatening nor serious conditions. For low acuity calls, the aim is to ensure callers get the appropriate advice or were effectively signposted to healthcare services. The Clinical Desk uses the skills of NHS Direct Wales nurses to assess or triage low acuity 999 calls, and in some instances where calls are serious but a full emergency ambulance response is not necessary. Nurse advisers assess callers using the same computer decision software (CAS) (CDS)? utilised by NHS Direct Wales so that callers receive the most appropriate advice and support for their needs.

Exhibit 8: Trend in proportion of patients handed over within 15 minutes of arrival in the ED
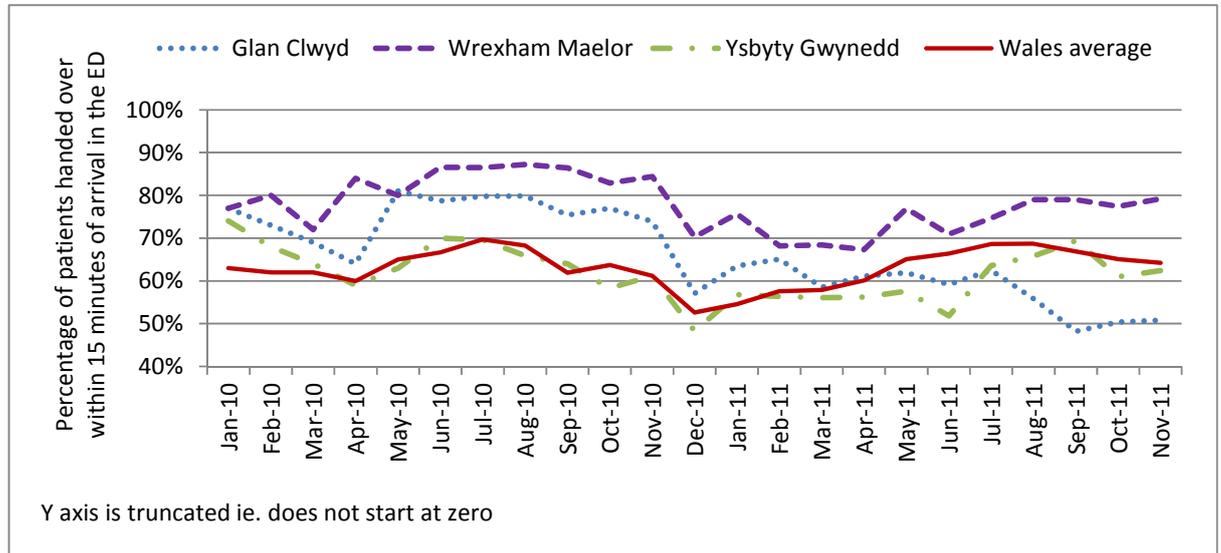
Source: Wales Audit Office analysis of data provided by Welsh Ambulance Services NHS Trust

49. The majority of ambulance staff we interviewed felt that since the data terminals had been introduced they had seen little data or information on whether handover targets were being met, nor had they seen any improvements in the way handovers were carried out. This lack of feedback will affect the ambulance staff engagement with the data process, and should be explored further with the Welsh Ambulance Service.

Bed capacity has reduced slightly, and a range of actions to improve patient flow and intended to increase bed availability are just starting to produce results

50. Hospitals are frequently at capacity, which leads to problems admitting patients and back-logs within both EDs and in ambulances. This is a result of two inter-related issues, the number of beds available for patients awaiting admission and the management of patient flows once a patient is admitted to a bed. This means if patient flow is good, then a bed will be freed up more quickly for the next patient who needs it, and fewer beds will be needed for the same or greater number of patients.

51. Data published by the Welsh Government shows that across Wales the average number of daily staffed beds reduced by 5.5 per cent between 2009-10 and 2010-11. Across Betsi Cadwaladr hospitals, the reduction was four per cent with the biggest reductions at Ysbyty Gwynedd where total bed numbers reduced by 15 per cent from 577 to 490, if the former acute medical admissions ward in Llandudno General Hospital is included. The ward in Llandudno was closed for clinical reasons as part of planned shift in care and change in the nature of capacity and the nurses transferred to staff the Clinical Decision Unit in Ysbyty Gwynedd. Further analysis shows that beds for general medicine and geriatric medicine reduced by four per cent (30 beds) across all hospitals between 2009-10 and 2010-11. The biggest reductions were for surgical beds (13 per cent or 32 beds), in line with increasing day case surgery. In addition, the number of community hospital beds classified as GP reduced by 13 per cent (30 beds). In total, this amounts to an official reduction of 87 beds since the Health Board began. However, some of the apparent reduction is due to inaccuracies in Welsh Government data prior to October 2009, as the Health Board inherited less beds in the West than official figures would indicate. The Health Board's own analysis suggests that the actual bed reduction was less but they have not provided us with the exact numbers.

52. The Health Board lacks 'surge' capacity for emergency medical beds – where bays with beds can be opened in times of high demand. This means that the whole system is vulnerable to peaks in demand. The only surge capacity sits in other CPGs, which means that operations or other activity will be cancelled if patients with Unscheduled Care needs are admitted to these beds. The Health Board recognised this lack of capacity on acute sites, and the bed rebalancing (Box 1) was one of the measures designed to address it.

53. The Norovirus outbreak in early 2012 compounded the pressure on beds. It led to the closure of some wards to new admissions, and restricted the movement of patients on those wards affected by the Norovirus outbreak. To reduce the risk of cross infection, staff on infected wards were correctly not allowed to open beds on uninfected wards, which reduced capacity further. The Health Board estimates that 335 bed days were lost in January 2012, the equivalent of 10 beds per day, which significantly affected its ability to effectively manage demand.

54. Bed occupancy in medicine is over 100 per cent at Ysbyty Glan Clwyd. This means that beds are always occupied and in some cases, new patients will be waiting on the ward to be admitted to a bed before the previous bed occupant has been moved or discharged. Occupancy rates are also nearing 100 per cent at Wrexham Maelor and Ysbyty Gwynedd. Demand for beds is exceeding supply with patients waiting longer for a bed. When patients with medical conditions are finally admitted, they may be on a ward for patients with non-medical conditions, such as a surgical ward. This can have a negative impact with patients reviewed less frequently and lead to inefficiencies as medical staff move around the hospital to review patients.

55. Effective patient flow means that patients are safely discharged in a timely fashion, and this is generally measured by length of stay. Length of stay for acute medical and care of the elderly patients is high, exceeding both the target set by Welsh Government, and comparable hospitals in other parts of the UK. (11.1 in BCU compared to a Welsh target of 9.3). If length of stay matched targets then beds would be available sooner for patient admissions, amounting to roughly an additional 57 beds[9] per day, which if these patients achieved the target length of stay of 9.3 days, would amount to a potential additional six admissions per day.

56. The Health Board has taken a number of actions to address the pressures within its emergency services and improve patient flow through the acute sites. However, a number of these actions were not fully implemented at the time of our fieldwork, and had not, therefore, achieved the results planned by the Health Board. Box 1 sets out some of the actions taken and their impact. A further iteration of the action plan for Ysbyty Gwynedd shows some limited further progress on patient flow through the hospital in July 2012. However, not all of the actions were complete, at the time of reporting.

57. The Health Board is actively managing Unscheduled Care performance, using the four and eight hour waiting time targets as indicators for pressure on services and monitoring of progress through the Unscheduled Care Modernisation Board and the CPG structure. The Health Board has taken a number of additional actions to tackle the challenges, which include: the Unscheduled Care Modernisation Board which meets monthly, and is supported by weekly meetings chaired by the Director of Improvement and Business Support (IBS). Weekly reports to the Executive Management Team and regular discussion at Board of Directors all indicate the priority the Health Board is giving to improving Unscheduled Care services. The Director of IBS has in effect set-up a support structure to the CPGs to drive improvement in Unscheduled Care services. This is explored further in section two (paragraph 132).

[9] Multiply the average number of days over the target, in this case 1.8, by the number of emergency admissions for patients during the year (11,670 in 2010-11) to give the total number of excess bed days then divide by 365 to give the daily bed number (this assumes full occupancy).

Box 1: Health Board actions to address pressures in emergency services

Actions taken	Impact of actions taken
Co-locating GP out-of-hours services and EDs	Although GP out-of-hours services are co-located with EDs, there is no integrated triage and processes are not in place to routinely redirect people to GP out-of-hours services.
Formal weekly clinical site meetings to monitor EDs	Weekly clinical site meetings take place. Meetings focused on explaining performance over the past week, and discussing approaches to drive future performance improvement. In addition, our review of meeting minutes and attendance at one meeting indicate that other CPGs and wider partners (eg, WAST) do not always attend, losing an opportunity to proactively discuss and address pathway blockages, and whole system issues.
Opening of CDUs	The CDUs have helped the Health Board to manage patient flow, by providing a safe place to manage patients who cannot be transferred to a ward. However, in Ysbyty Gwynedd and Ysbyty Glan Clwyd, these areas are currently being used for surge capacity to safely hold patients, and in effect as a short stay ward. Only the Wrexham CDU is being used as it should be for the diagnosis, assessment and stabilisation of patients who do not need to be admitted as an inpatient.
Bed rebalancing from surgery to increase beds available to medical admissions	Excess surgical ward capacity was transferred to the Primary, Community and Medicines CPG. The opening of additional medical beds (for example in Aran ward, Ysbyty Gwynedd) was slowed by the inability to recruit to vacant nurses posts; initially the CPG tried unsuccessfully to fill nursing posts by internal recruitment. This was not possible, and also had the impact of leaving vacancies on other wards, which resulted in bay closures. In January 2012, approximately half of the extra 25 medical beds per site were open for admissions. In May 2012 the Health Board reported that all medical beds were staffed and open.
Opening of additional unfunded beds (a closed Wrexham rehabilitation ward opened as a 'surge ward')	The opening of additional beds has been affected by the inability to fully recruit to additional nursing posts at short notice; although beds have opened, others have closed or their use restricted due to staffing shortages, Norovirus outbreaks, or other 'safety' reasons.
Daily bed management meetings	These meetings have helped to improve patient flow through the hospitals; and recent clarification of the role of site based Assistant Directors of Nursing and Medicine (the Hospital Management Team) has helped to start to drive improvement.

Actions taken	Impact of actions taken
Actions to optimise patient flow through the acute sites, including recommending daily early morning ward rounds, and nurse-led discharge, and progress-chasers.	Ward rounds are starting to be optimised to improve patient flow. Variation in practice between consultants means that ward rounds are not always carried out every day on each ward. Meanwhile, the expected date of discharge is not always recorded and nurse-led discharge is not consistently applied across the whole Health Board, which means patients may stay in hospital longer than necessary. Progress-chasers (more generally called discharge facilitators) are reportedly having a positive impact in the Centre and West, but these relatively new posts are still embedding. Our interviews also suggest that some patients are admitted for diagnostic reasons to by-pass waiting lists, or for rapid access for conditions that can be managed in primary care and the community.

However, the DSU report also indicates more scope to improve utilisation of discharge lounges and work with consultants, to embed good practice within job plans and routine working practices. |

Source: Wales Audit Office interviews and review of action plans

58. The Health Board is only part-way through implementing its action plans on each acute site, but our analysis suggests that its focus on resolving capacity issues in EDs and improving patient flows is the first part of the solution. The Health Board's focus on making the acute system operate more efficiently by opening extra beds and improving patient flows once patients are admitted is a positive step. The next step is to reduce demand by re-directing from EDs to other appropriate services. Opening more beds alone is unlikely to ease pressure in the medium term, it is a temporary and costly fix, and until flow issues are resolved they will simply fill up again.

59. This analysis is supported by the Health Board's more recent performance data (October 2012), which shows that performance against four hour waiting time targets in the ED at Ysbyty Gwynedd has substantially improved over the past few months to around 91 per cent, with a substantial reduction in eight hour waits. Whilst Wrexham Maelor performance remains stable at around 92 per cent against the four hour waiting time target with a further reduction in eight hour waits. However, performance at the Glan Clwyd ED is only now showing improvement following the intensive 'intervention', despite DSU intervention and management action over the past few years.

Despite progress on Coronary Heart Disease and Diabetes admissions for chronic conditions continue to create high demand on acute services, particularly in respect of Chronic Obstructive Pulmonary Disease

60. The Welsh Government's Chronic Conditions Management model and framework signalled a need to rebalance services on a whole system basis and providing more care in community settings. One of the key aims 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.

61. Since 2007-08, NHS bodies have been expected to achieve reductions for COPD, coronary heart disease (CHD) and diabetes. These three conditions accounted for eight per cent of all emergency admissions to the Health Board that year, which was the same as the Wales average. In 2010-11, these proportions were unchanged from the baseline position.

62. Over the last five years, the number of emergency admission for COPD and CHD fell across the NHS in Wales by six per cent and nine per cent respectively while the number of emergency admissions for diabetes increased by six per cent (Exhibit 9). Unlike most other health boards, emergency admissions for COPD increased by 28 per cent) while admissions for CHD and diabetes decreased by eight per cent and one per cent respectively.

Exhibit 9: Percentage change in the number of emergency admissions for Welsh residents due to chronic conditions between 2006-07 and 2010-11
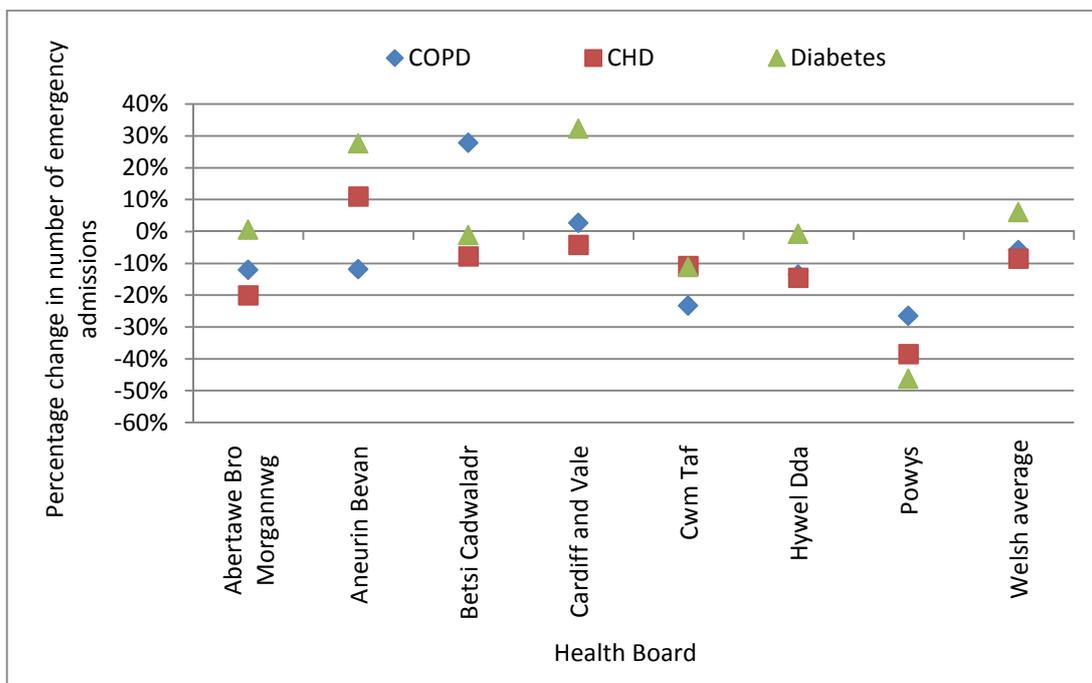
Source: Wales Audit Office analysis of data derived from the Patient Episode Database for Wales and provided by NHS Wales Informatics Service (NWIS)

63. NHS bodies are expected to reduce the multiple admission rate ie, the proportion of repeat admissions, to 14.6 per cent or less and the average length of stay to 5.7 days or less for these three conditions. Performance against these targets is measured on a rolling 12-month basis (the performance reported for any single month therefore representing the average over the previous 12 months rather than the in-month performance). Appendices 10 and 11 show that the Health Board's performance over the last five years has been mixed. Exhibits 10 and 11 show that during this period (April 2006 to July 2011) the Health Board's mean rolling average performance was marginally better than the average for Wales. In summary, the 2010-11 data shows:

- the COPD rolling 12-month average multiple admission is relatively unchanged and remains above target at 30 per cent while the rolling average length of stay is still above target but has fallen more steadily to 8.6 days;

- the CHD rolling 12-month average multiple admission rate is below target and remains stable around 12 per cent while the rolling 12-month average length of stay steadily decreased to 4.7 days; and

- the diabetes rolling 12-month average multiple admission rate remains on target despite fluctuations over the five years, while the rolling average length of stay fluctuates between six to seven days.

Exhibit 10: Mean rolling emergency multiple admission rate between April 2006 and July 2011
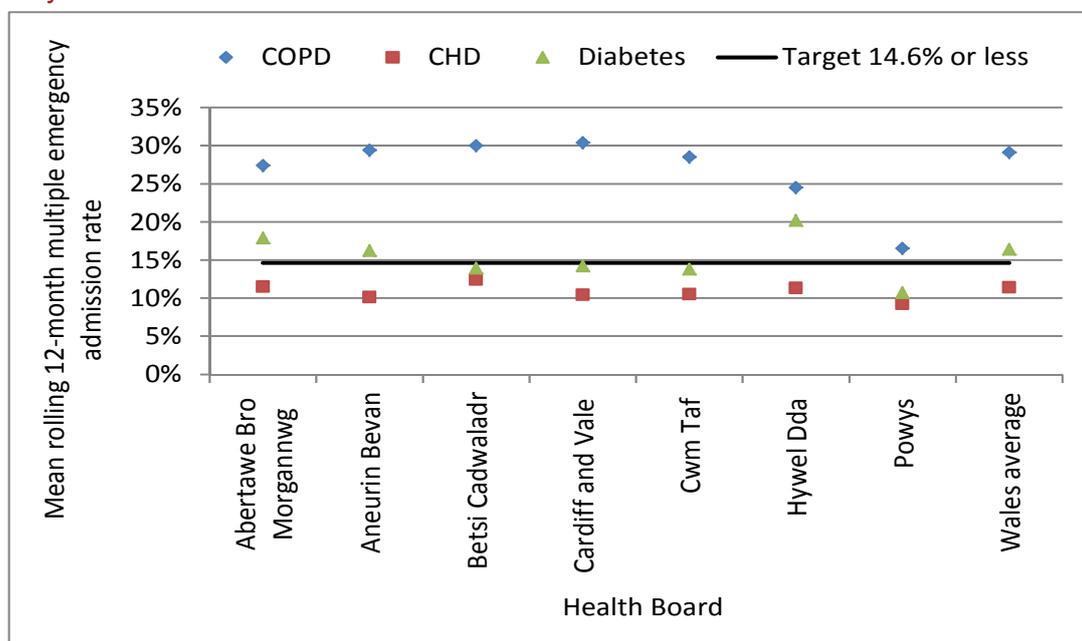
Source: Wales Audit Office analysis of data extracted from NLIAH's report 'Progress Report on the Chronic Conditions Management Service Improvement Plan as measured through the Chronic Conditions Management Maturity Matrix', October 2011

Exhibit 11: Mean rolling average length of stay for chronic conditions between April 2006 and July 2011
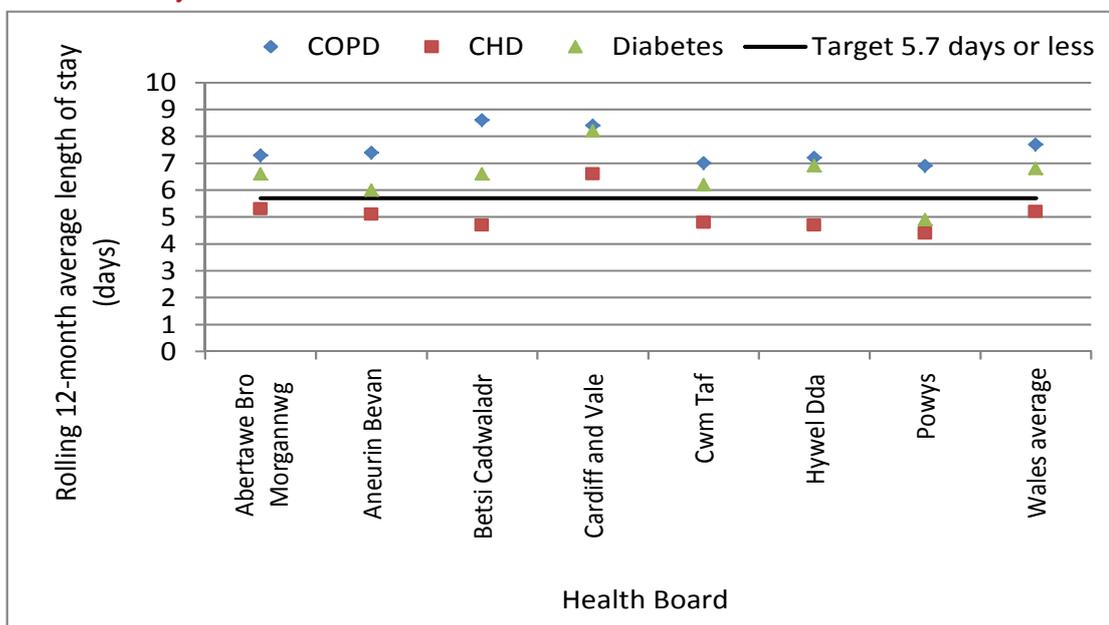
Source: Wales Audit Office analysis of data extracted from NLIAH's report 'Progress Report on the Chronic Conditions Management Service Improvement Plan as measured through the Chronic Conditions Management Maturity Matrix', October 2011

Actions to tackle delayed transfers of care have made a positive impact

64. Efficient discharge processes are another key determinant of good hospital flow. If discharge processes do not work well, patients may spend too long in hospital, which can pose risks to their independence, as well as prevent the flow of patients from the ED to the wards. The Welsh Government's *Delivery Framework for NHS Wales for 2011/2012*, includes a Tier 2 target of continuing to improve performance in relation to delayed transfers of care.

65. The Health Board has started a number of actions in recent years to improve the flow of patients through its hospitals for example:

- expanding a planned date of discharge system, already in place in Wrexham, into Ysbyty Gwynedd and Glan Clwyd, so when patients are admitted their date of discharge is estimated to enable improved discharge planning such as ensuring that care packages are in place; and

- inclusion of social care representatives in discharge planning meetings.

66. The actions to reduce delayed transfers of care seem to have had a positive impact. Over the past five years, the number of patients experiencing a delayed transfer of care reduced by a third from 1,269 in 2005-06 to 805 in 2010-11. The number of bed days lost as a result of delays reduced by nearly half (Exhibit 12). The Health Board needs to continue its work to tackle delayed transfers of care to free up capacity and improve patients' experience. We estimate that lost bed days in 2010-11 were the equivalent of 2,300 admissions[10] forgone.

Exhibit 12: Trend in the number of patients experiencing a delayed transfer of care from acute and community facilities (excluding mental health facilities) at Betsi Cadwaladr University Health Board and lost bed days as result of delays

	Number of patients experiencing a delayed transfer of care	Number of lost bed days	Average lost bed days per patient
2005-06	1,269	31,065	24.5
2006-07	1,050	23,856	22.7
2007-08	1,060	21,869	20.6
2008-09	899	18,350	20.4
2009-10	813	19,259	23.7
2010-11	805	16,879	21.0

Source: Data provided by NHS Wales Informatics Service

Limited information is provided to GPs to help them understand their admission profile to help divert emergency demand

67. 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.

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[10] This estimate is based on the Health Board's average length of stay of 7.2 days.

68. We undertook a survey of GP practices to understand how involved GPs are with the Health Board in managing demand on acute services, and what, if any, information they receive about admission rates for their practice population.[11] Twenty-five of the thirty practices responding to our survey told us that they were routinely notified when patients accessed the ED. However, only nine practices were informed of the frequency of access by their patients. This means that GPs were not made aware of patients who regularly sought emergency care nor did practices have systems to identify these patients. Therefore patients with health needs that regularly become severe enough to warrant emergency hospital care, are not being systematically identified so their health problems can be addressed.

69. In the past, the Health Board did not routinely analyse emergency admissions by GP practice or look for trends by GP practice or locality. Instead the Health Board focused its data analysis on the acute setting, thereby missing important information on the underlying causes of the demand. At the time of our fieldwork the Health Board was developing this type of data to support its locality stakeholder work, and help localities develop and implement community services to effectively divert patients from acute settings, by providing them with treatment sooner, before their condition deteriorates.

70. Primary care contractors have a vital role to play in community services. Currently 90 per cent of patient contacts with NHS Wales take place in primary care. Historically, the use of primary care contracts in creating capacity to care and support patients in the right place has been patchy. The careful use of primary care contracts can support community services, and the transformation of care for critical groups both with chronic conditions and Unscheduled Care needs.

There has been limited progress developing effective chronic conditions management programmes that cover of the whole North Wales population

71. As a result of the slow pace of change in Chronic Conditions Management services in North Wales, the Health Board is unable to effectively utilise Chronic Conditions Management services to support patients, and manage demand more effectively in the community. This contributes to pressures on Unscheduled Care services. The model contained in Healthcare in the North Wales is Changing consultation should address many of the issues explored below, if implemented.

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[11] As part of the audit, we emailed a questionnaire survey to general practice managers at the 498 GP practices in Wales. Practice Managers were asked to complete the survey on behalf of the practice. The overall response rate across Wales was poor with only 26 per cent of practices responding. At the Health Board, only 30 of the 135 practices surveyed (22 per cent) responded. While unlikely to be representative of all Betsi Cadwaladr practices, we have used these responses to illustrate particular issues.

The Health Board has not fully capitalised on the demonstrator site legacy to secure wider improvements in chronic conditions management services

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

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

74. Delivery of the proposed model relies on health boards identifying the needs of their communities and stratifying practice populations according to levels of risk of unplanned hospital admissions. Those individuals identified at greatest risk of unplanned admissions, particularly the frail elderly and those with chronic conditions, should be actively managed to ensure they receive the right care in the most appropriate place. However, the all-Wales risk stratification tool (PRISM) piloted over the course of the last three years is unlikely to be available to health boards until at least 2013. The HECS puts an alternative model in place. Consequently, the focus on identifying patients at risk of an unplanned admission, which affects the Health Board's ability to manage demand, and plan services to divert patients from acute care settings and to manage them more effectively in the community is limited to those localities with HECS.

75. Gwynedd and South Wrexham piloted the Welsh Government's Chronic Conditions Management demonstrator programme between 2007 and March 2011. These localities made some improvements in service development and innovation, prevention and promotion, independence and self-care, primary care, and professional skills development, as well as information and communication. Gwynedd also made significant improvements in relation to their local vision and priorities and partnership working. The learning from these demonstrators underpins the Health Board's plans for locality working and community services going forward, but the slow development of locality structures means that limited progress has been made so far.

76. The Health Board has introduced new community services for people with enhanced care needs, such as an acute exacerbation of a chronic condition - the HECS pilot in North Denbighshire. This service aims to prevent patients being admitted to an acute bed, or to help facilitate their early discharge. This service has received positive feedback from patients and carers, and a positive internal evaluation of its effectiveness. Under *Healthcare in North Wales is Changing* the Health Board puts forward plans to roll this service out across all localities, and this is an encouraging step forward.

77. Many of the services that were in place in the previous LHBs have been continued and retain their original geographical footprint providing services to a small cohort of patients. Examples include:

- acute stroke services in the West;
- cardiac rehabilitation in Gwynedd and Ynys Môn, and Wrexham;
- kidney dialysis in the home in Gwynedd; and
- intermediate care teams, which continue to facilitate early discharge from hospital, provide rehabilitation, and prevent avoidable admissions, but these teams are not available in all parts of the Health Board.

78. *Setting the Direction* and the Chronic Conditions Management model and framework both advocate the need for an integrated multidisciplinary team that focuses on co-ordinating community services across geographical localities for individuals with complex health and social care needs. These Community Resource Teams (CRTs) will target care and support to help individuals identified as at greatest risk of hospital admission to maintain independence in their own communities. The Health Board has formally adopted the CRT model through its Primary and Community Implementation Board and plans to build upon some legacy services, such as Model Môn in Anglesey. The Health Board expects its locality teams to move this agenda forward.

79. New services that meet strategic priorities are now being developed, and spread to provide equity across North Wales, and include the following:

- Work on advanced care planning for patients in care homes, which is aiming to reduce inappropriate admissions and deliver patient-centred care.
- The End of Life Care Pathway which seeks to enable patients to die in their own home rather than be admitted to an acute hospital.
- A specialist renal nurse in one practice, who sees patients with chronic kidney disease in the central locality.
- Rolling out the SHINE initiative in Cardiology more widely than the Wrexham area. The cardiology consultant provides rapid and easily accessible advice (telephone and email) to enable GPs to manage patients with cardiac conditions in primary care.
- The Changing Care Programme, which is a pilot project looking at five services that can move patient care into the community. The Health Board is also looking at developing new roles for staff to work in the rehabilitation services and the diabetes care teams, and extending the roles of health care advisors, to free up registered nurses for more complex tasks, such as assessments and care co-ordination.

80.   The Health Board established a Primary and Community Implementation Board in November 2011, and at the time of our fieldwork this workstream was just at an early stage. However, the timescales for implementing new Chronic Conditions Management services and expanding existing services remains extended due to a number of factors. The appointment of locality leads took longer than expected with locality matrons only in post from March 2012, and operational plans at a locality level were in their infancy at the time of our fieldwork. This has affected the Health Board's ability to introduce new services or roll out pilot services. Locality teams recognise the need to make faster progress, and there is a developing emphasis on ensuring consistency of local operational plans across the Health Board.

Community hospitals are not uniformly fulfilling their potential role

81.   Our previous work on chronic conditions found that the role of community hospitals in helping to manage chronic conditions was unclear. Community hospitals were not typically used to prevent or divert acute hospital admissions or to facilitate step down from acute care for patients with chronic conditions. Between 2009-10 and 2010-11, the number of community hospital beds reduced by 13 per cent from 1,077 to 936, representing the planned closure of unsuitable facilities, and transfer to new more modern settings by predecessor organisations.

82.   The role community hospitals currently play in helping to manage chronic conditions across the Health Board remains unclear. Recent high demand and lack of staffing in the acute setting has meant that some community hospitals have had their services reduced, and nursing staff temporarily redeployed to the acute sites. Many community hospitals provide diagnostic services, such as radiology and phlebotomy, therapy services and host out-reach outpatient clinics for many medical specialities. However, many of these services are not fully utilised and the recently started outpatient service review is expected to make recommendations on their future use. Without focussing on community hospitals and community services, the Health Board will not be able to manage demand for acute services more effectively.

83.   The number of community hospital beds classified as GP beds reduced by 13 per cent from 239 in 2009-10 to 230 in 2010-11. These beds account for one in 12 of the Health Board's hospital beds. GPs can admit patients to a community hospital bed for care and treatment, preventing an admission to an acute hospital ward. However, accessing these beds out of hours or via EDs can be difficult because of the way in which community hospital beds are managed. Some beds are managed by GPs while other beds are managed by hospital doctors. This affects capacity for step down and step up provision, and in effect reduces the number of beds available in the community. Because, if the bed is managed by some GP practices, or groups of practices, then that bed may only available for patients registered with these practice(s) while beds managed by hospital doctors and other practices are available for any patient.

84.	The Health Board inherited a lack of clarity around the future use of the 22 community hospitals in North Wales. As part of *Healthcare in North Wales is Changing* the Health Board has recently outlined proposals to clarify community hospital services, and give them a clear role in the whole system of care. This means that some community hospitals will change their patterns of service provision, for example by reducing their beds, or moving location so that care will transfer to new more modern settings and more care be provided at home. In the model under consultation, each locality will have access to a hub community hospital within 40 minutes drive, and some localities will have additional community beds and new additional resource centres, and all localities will have enhanced community teams to provide more care at home. These changes are intended to secure the future of community hospitals as local centres where patients can be diagnosed and treated closer to home, and to prevent avoidable admissions.

Limited use is made of primary care contracts to support patients with chronic conditions and unscheduled care needs

85.	The Health Board has a range of legacy LES and Directed Enhanced Services (DES). However, the LES are now being reviewed to bring them into a cohesive system. During 2012-13, the Health Board is planning to develop a COPD LES for the whole of North Wales, building on the legacy Conwy LHB model. This is intended to replace a variety of small inherited LES schemes for a variety of chronic conditions. The detail of the new LES has yet to be agreed with the Local Medical Committee, and likely implementation in the latter half of 2012, means it is unlikely to have the intended impact until winter 2014. Other parts of Wales have made substantially more progress on effective community management of COPD, and consequently seen a reduction in reliance on in-patient stays to manage these patients (paragraph 62).

86.	The Health Board is meeting its chronic conditions targets in terms of Quality and Outcome Framework (QOF), and hence GP practices are likely to be caring for most of their known chronic conditions patients. However, QOF allows practices to exclude patients from QOF points calculations (known as exception reporting), for example because patients fail to attend re-call appointments. This means that good QOF scores do not guarantee that all patients with chronic conditions receive optimal care. Hence LES are important additional levers to improve the quality of care for patients with multiple, or complex needs.

87. Other community services have a part to play in managing chronic conditions in community settings. There are 154 community pharmacies providing services to people living in the Betsi Cadwaladr area with the majority dispensing prescriptions or giving health advice to their local communities. However the Health Board has yet to engage fully with this group and realise the benefits of a partnership approach through the Pharmacy contract by actively commissioning services, such as Smoking Cessation, Weight Management, Medicines reviews and minor ailments. Recent work by the community pharmacies on post discharge medicine management reviews has not been seen as successful due to slow engagement from the Health Board. In particular, community pharmacists have struggled to get the information they need on discharge medication to undertake the post-discharge reviews. As a consequence, many community pharmacies did not meet their target numbers of review in 2011-12.

Primary care access measures show a mixed picture, indicating scope to improve access further

88. 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. Access is also crucial for Chronic Conditions Management, with primary care responsible for identifying, stabilising and maintaining most patients with chronic conditions, and 90 per cent of patient contacts happen in primary care across NHS Wales. When patients are unable to access primary care services urgently, not only do they have a poorer experience but they often default to acute services. Defaulting to acute services, such as ambulance and ED services, is costly and results in increased demand elsewhere in the system.

89. Findings from the 2011 Welsh GP Access Survey suggest that a relatively high proportion of patients were able to see or speak to a GP or other health professional on the same day or the next day (Exhibit 13).

Exhibit 13: Percentage of patients registered with GP practices in Betsi Cadwaladr University Health Board who reported being able to see or speak to a GP or healthcare professional the same or next day
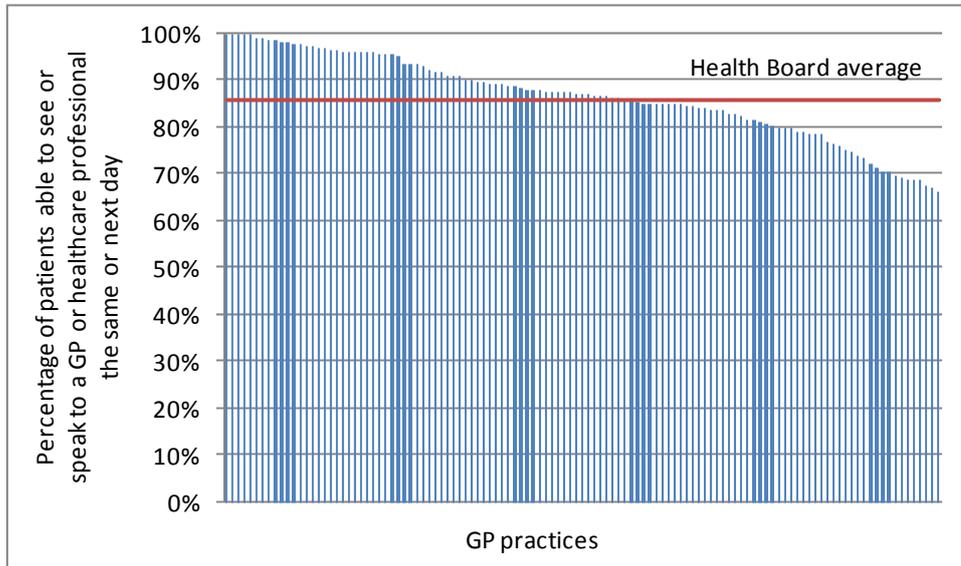
Source: Welsh GP access survey, 2009-10, Welsh Government, SDR 93/2010

90. More than half of practices responding to our survey (compared with 41 per cent across Wales) had analysed the number and pattern of telephone calls to the practice. For those that did, additional staff had been deployed to answer calls during peak periods and telephone lines were open from earlier in the morning, or appointments were available to book via the internet. Most practices told us that they had formal protocols in place to deal with requests for appointments and that practice receptionists received training to identify callers who need an urgent or emergency appointment.

91. Practices themselves are also looking to improve access. Practice managers responding to our survey told us that they had used the GP Access Survey to review access issues and implement changes where appropriate. The types of changes cited by practice managers included:

- providing a daily open access clinic;
- operating a nurse-based triage system all day and reviewing the availability of GPs to take phone calls or make house calls for more urgent calls;
- operating an on-call system to ensure that either a GP or Nurse Practitioner contacts the patient on the day, and saving urgent slots that then can be booked on the day by that team;
- increasing the number of appointment slots available by opening the surgery earlier in the morning or providing appointments later in the evening;
- increasing the number of emergency appointments, operating an open access system so patients are always seen on the same day if required;
- increasing the number of appointments available by increasing hours/sessions of GPs;

- adjusting the mix of book-ahead and same-day appointments ie, ensuring that there is enough of each type of appointment to suit patients need or demand; and

- introducing touch screens for patients to indicate their arrival to free up reception staff during busy periods.

92. All of this demonstrates well-developed capability at the Health Board in respect of primary care. Recent statistics show further opportunity to improve opening hours for GP practices. At the All Wales level, 31 per cent (149 practices) of practices were open for the duration of daily core hours[12] in 2011. This was an increase of 12 percentage points from 2010 when 19 per cent (93 practices) of practices fell into this category, and is probably due the widespread use of the Gwent access criteria. However, the Health Board only achieves 15 per cent of practices opening for all their core hours and there has been no change in this since 2010. Note the Health Board was the sixth lowest of the seven health boards on this measure.

93. We asked practice managers what prevented practices from meeting demand for urgent or same day access. Perceived barriers include:

- increasing patient expectations;

- patients not turning up for appointments; and

- variability of demand because of high influx of holiday makers in the summer.

94. The aim of primary care out-of-hours services is to ensure individuals with urgent primary care needs, which cannot wait until the next available in-hours surgery, are met and that other patients accessing the service are given appropriate advice and information. The primary care out-of-hours period is defined as from 6:30pm until 8:00am on weekdays, and all weekends, bank holidays and public holidays.

95. The Health Board's expenditure on primary care out-of-hours services is generally higher than the Wales average (see Appendix 12). Expenditure on primary care out-of-hours services totalled £7.5 million in 2010-11, the equivalent of £10.80 per registered patient. This has reduced from 2007-08 where expenditure was £7.9 million or £11.49 per registered patient. The reduction is the result of bringing services in-house in both North East Wales (Wrexham) and Conwy and Denbighshire from the original external contractors.

96. Around two-thirds of the practices responding to our survey perceived the out-of-hours service to be good or very good at meeting the needs of patients. In addition, the out of hours service internal performance management information suggests that it performs well in terms of calls received and handled, appointments and triage.

97. The Welsh Government's *Ten High Impact Steps to Transform Unscheduled Care* states that primary care out-of-hours units should ideally be functionally integrated within EDs. This means the unit and the ED should have a common reception and common triage and operational processes.

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[12] The contract requires practices to be open/accessible between 8am and 6:30pm. But GPs do not necessarily have to be available this whole time.

98. The Health Board operates out-of-hours services at its three EDs but there is no integrated triage. Appointments to the service are made by telephone. In some instances patients are redirected to out-of-hours services from the ED but this is not a formal process and usually occurs during times of high pressure within the ED.

Limited progress has been made to influence the way the public uses services and to improve self-care

Considerable scope remains to improve the utilisation of public marketing to help citizens make informed choices

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

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

The Health Board was the first in Wales to implement 'Choose well'

101. The Health Board adopted the 'Choose Well' message first in Wales, and at the time of the launch much was done. However, the emphasis on the message since that time, has been traditional using posters and leaflets. More innovative ways of disseminating the 'choose well' message are starting to be adopted. For example the new 'iphone app' which helps users choose which service is appropriate, and also shows opening times. Opportunities to engage with GPs and other stakeholders to actively promote alternatives to attending EDs in the community should also be explored post consultation.

Progress on single points of access and communication hubs has been slow

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

103. The Health Board's plans for a single point of access via the communications hub are still in their infancy. Currently there is no single contact number for:

- information and advice;
- sharing appropriate information; and
- signposting.

104. This is due mainly to the lack of a key lead to drive forward the project. A dedicated project manager has been recently appointed. Work has begun to map service provision and identify bottlenecks in the system. The Health Board needs to continue developing its approach and formalising plans and timescales for the implementation of the single point of access. Another complicating factor is the number of local government partners in North Wales, who will all need to agree the approach adopted.

The Health Board has yet to see the benefits from the self-care agenda

105. It is essential that individuals are encouraged and supported in looking after their own health and well-being. Self-care[13] is associated with positive outcomes for individuals, as well as helping to reduce reliance on healthcare services. The Welsh Government's framework for self-care[14] set out the key elements of support for self-care, such as information and signposting, skills training for patients and assistive technologies, such as telehealth and telecare.

106. The Health Board supports the national generic self-management program Expert Patients Programme (EPP) Cymru, for people with long term conditions and those caring for someone with a long term condition. The programme's aim is to give participants the confidence to look after their own health needs. In a ministerial letter to Chief Executives in 2009, the Minister for Health indicated that Health Boards should aim to get one per cent of the chronic condition population through EPP courses over the following three to four years.

107. The Health Board has provided 70 EPP courses (Exhibit 14) between April 2010 and December 2011. Overall, 1,071 people (less than one per cent[15]) registered for a course and just over half of these patients (55 per cent) took up a place and completed the course. The completion rate (that is the number of individuals registering for a course and completing it) was one of the lowest amongst the health boards; the Wales average was 63 per cent (Appendix 13). In order to achieve the expectations set out in the ministerial letter, the Health Board will need to ensure that twice as many individuals complete a course.

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[13] The self-care continuum starts with actions that individuals take to stay fit and healthy, 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.

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

[15] One per cent of the CCM population is roughly 1,668 and 1,835 people. This is based on one-third of the BCU population having at least one chronic condition.

Exhibit 14: Quarterly trends in the provision of Education Programmes for Patients* at Betsi Cadwaladr University Health Board

Quarter and year	Number of courses	Numbers of people registering for EPP courses	Number of people who do not attend	Number who drop out once course started	Number of registrants completing a course
Q1 - 2010-11	8	134	32	33	69
Q2 - 2010-11	7	90	12	23	55
Q3 - 2010-11	11	174	30	52	92
Q4 - 2010-11	12	159	16	43	100
Q1- 2011-12	7	115	12	31	72
Q2 - 2011-12	11	178	14	77	87
Q3 - 2011-12	14	221	18	86	117
Overall total	*70*	*1,071*	*134*	*345*	*592*

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

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

108. In addition to more structured education programmes the Health Board also has telehealth facilities available. Some GP practices use telehealth to manage patients with COPD, heart failure and hypertension more effectively at home. However it is not being utilised consistently well. The Health Board needs to capitalise on the opportunities that telehealth provides to move care closer to home.

109. Finally, the use of rehabilitation (such as cardiac rehabilitation) and smoking cessation programmes shows the Health Board's commitment to improving public health, and effective models to enable patients' self-care. Such models should be extended to cover all patients who might benefit, wherever they live in North Wales.

The Health Board has a vision for both unscheduled care and chronic conditions management services, but plans to implement the vision are vague, high level and undermined by a number of challenges made harder by complexity

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 has a strategic vision articulated in a number of documents but a lack of overall cohesion between the documents hinders clarity

110. The Health Board's vision for services for Unscheduled Care and Chronic Conditions Management was developed in the run up to the NHS reforms in 2009 following engagement with key partners and stakeholders across North Wales. The Health Board's vision is to provide a responsive, safe and high quality service that continually improves, and is easy to access and understand. This vision is set out in a number of strategic documents, which reflect the direction of travel articulated in the national primary and community services strategy, *Setting the Direction*, in particular:

    - *Designed for North Wales,* which was finalised in 2008. This document describes the three acute site model for EDs and medical admissions, its aim being that patients receive the highest standards of treatment, services are as convenient as possible for patients, and patients only have to go into hospital when they need specialist medical care.

    - *A Strategic Direction 2009-2012*, which was approved by the Board, at its first meeting in October 2009. This document sets out a high level vision for the future delivery of services in the context of five clinically focused strategic themes: making it safe; making it better; making it sound; making it work; and, making it happen. It emphasises the importance of chronic conditions and a move to community based treatment and care, ie, care closer to home.

    - The *Five Year Plan 2010-2015*, which was approved by the Board in 2010. This strategic framework sets out the Health Board's commitment to providing safe Unscheduled Care across three EDs and acute hospitals, and enhancing community care and Chronic Conditions Management services by developing services in its localities. This framework makes it clear that all CPGs are responsible for continuing to develop Chronic Conditions Management models to tackle the areas of greatest need.

- The draft *Unscheduled Care Blueprint,* which was developed in early 2011, by the Unscheduled Care Modernisation Group. This document sets out a whole-systems approach to Unscheduled Care and Chronic Conditions Management with patient outcomes at its centre. The intention is to move the focus from EDs to the Unscheduled Care pathway where individuals are clear about what services are most appropriate for their needs and what they should expect at each stage of the pathway. Many clinical and managerial staff within the Health Board are strongly supportive of the proposed whole system approach, and it clearly aligns with the Health Board's high level aims and strategies. At the time of our fieldwork, the *Unscheduled Care Blueprint* had not been approved by the Board and is still in draft. To some extent this is understandable, as the primary and community service elements required additional depth and breadth, and adding these elements to the framework work forms part of the Primary and Community Implementation Board's workstream. The Health Board needs to make rapid progress on implementing this strategy, and ensure it has both community and multiagency support through the work of Primary and Community Implementation Board and the Locality Stakeholder groups established during 2012.

111. From 2009, the Health Board undertook a wide-ranging series of service reviews, including a review of services provided in each of the 14 localities. Each review was led by a Clinical Chief of Staff from each CPG with support from an executive director and senior staff from the planning or primary care department. The service reviews were intended to inform the Health Board's long-term approach for transforming and sustaining services. At the time of our fieldwork, the Health Board had yet to agree how it would take forward the review findings, particularly those which might impact on neighbouring health boards.

112. Subsequently, the community[16] elements of the service reviews' key findings have been incorporated into the Health Board's consultation document *Healthcare in North Wales is Changing,* published in July 2012. This document outlines the Health Board's proposals for acute, community and locality services, including services for Chronic Conditions Management and alternatives to attendance or admission to the three acute hospitals. Overall, the consultation document summarises the services which should be available consistently across North Wales:

- programmes targeted at prevention, promoting good health and preventing illness;
- enhanced care at home with intermediate care teams supporting people in their own homes when it is safe and appropriate;
- moving care from hospitals into the community, including diagnostic services, such as routine blood tests, in a network of community hospitals; and

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[16] *Healthcare in North Wales is Changing*, is also consulting on proposals to change vascular services, and services for the small number of premature babies who need extra intensive care.

- a 'hub' community hospital for each of the local authority areas, with inpatient beds, MIUs, out patients, physiotherapy and X-ray departments.

113. Overall, the current service configuration is neither clinically nor financially sustainable over the medium term, and has to change. Our follow up work in 2010 and 2011 on the consultant contract, and European Working Time Directive, and in 2012 on Locum Doctors highlighted issues with the sustainability of the current service configuration due to limitations in medical staffing. Both in terms of maximising the benefit of consultant staff in post through effective job-planning, and the difficulties in maintaining compliant rotas in middle and training grades at an affordable cost. Our recent (July 2012) report on NHS Finances outlines the challenges facing all health boards, namely unprecedented future financial challenges, with short-term funding gaps remaining a concern.

114. The gap between the first service reviews and the consultation has been in part because the Health Board asked the CPGs to undertake further evidence gathering and engagement. Secondly, whilst the Health Board took time to ensure that linkages between service reviews were made, and for the National Clinical Forum to consider the proposals (twice). After all of these stages the Board then re-considered and approved the proposals.

115. The need for a clear, coherent articulation of all of these various documents, developments and proposals is only partially fulfilled by the public facing summary document, provided as part of the current consultation.

The Health Board's vision for unscheduled care and chronic conditions management services is not supported by appropriate and detailed transformation plans

116. The Health Board's high level vision for Unscheduled Care and chronic conditions is not underpinned by clear operational implementation or transformation plans describing how the service will move to the desired model. There is an annual overall organisational plan, the *Operational Plan*, and CPG level annual operational plans, which include aspects of Unscheduled Care and chronic conditions in the Primary, Community and Specialist Medicine CPG operational plan. These operational plans focus on the need to provide safe clinical services, and on dealing with the acute aspects of service delivery, including coping with major challenges in activity and demand. In practice the CPG plan provides focus and clarity around operational (within year) priorities, but is not robust enough to provide a clear implementation plan for the changes proposed. In theory detailed plans to deliver the Health Board's vision could be provided by CPG-level plans to implement the *Unscheduled Care Blueprint*, and *Locality Reviews* (Chronic Conditions Management). However, the incremental steps are not clear for future years, so there is no clear route from the current pattern of services to the proposed new pattern.

117. There is a clear expectation from senior Health Board managers that the 14 localities will deliver the required changes needed to develop services to support people with Unscheduled Care needs in the community when it is safe and appropriate to do so and to develop services for Chronic Conditions Management. Localities are expected to develop a plan tailored to local needs. At the time of our audit, the 14 locality plans were not fully developed for 2012-13, and it was clear that they were still work in progress. We made observations that included:

- the need to ensure the 14 plans align, are coherent, and build up to wider CPG (all of the CPGs) and organisation-wide operational plans; and

- the Health Board, CPGs and Locality teams will have to incorporate coherent, staged implementation plans following the consultation.

118. For successful implementation of new, sustainable models of care, it is crucial that the workforce is modernised. *Together for Health* recognises that creating a sustainable workforce is a particular challenge in some specialities and workforce issues are becoming a real limitation on certain services. In particular, services in North Wales still have difficulty recruiting medical staff (see paragraph 28), and we have concerns around the ability of MIU ENP staff to maintain competency levels (paragraph 20), whilst community services remain underdeveloped in many parts of North Wales (paragraph 75 to 78), all of which are reflected in *Healthcare in North Wales is Changing*.

119. The rebalancing of the care system set out in *Setting the Direction* will require an increased capacity within the community. Workforce plans that consider the number and type of staff in the community will therefore be vital to success. Whilst general practitioners are independent contractors and are generally not directly employed by the Health Board, there is a role for the Health Board in working with primary care to ensure its communities have an appropriate primary care workforce. Workforce plans to date do not reflect the scale of change required, and are limited to statutory returns. Our work on Structured Assessment 2012 examined the rationale behind this apparent decision not to model the proposed changes in its workforce plans. In the context of Unscheduled Care and Chronic Conditions Management this decision does mean that only acute workforce plans have sufficient clarity, and necessary training time may delay implementation of home-based community services.

120. The Health Board's strategic vision sets out the need to shift services and resources from acute to community settings. At the time of our audit, there was no demonstrable shift in resources. Instead, the Health Board had to move resources from community services to its acute sites to deal with 2011-12 winter pressures (paragraph 25).

Complex organisational structures which are not yet fully staffed are impacting on the pace of change

121. The Health Board has a complex organisational structure, which relies on CPGs underneath the formal Board structures, through line management to executives, and hence the Board (Appendix 14). The Board is supported operationally and strategically by the Board of Directors, consisting of the 11 CPG Chiefs of Staff and the Executive Team. The CPGs are the key strands of the matrix structure and run horizontally across North Wales. There are no organisation-wide vertical structures, for example at area level, although a number of corporate departments provide support to the CPGs, for example IBS, Primary Care Support Unit, and Planning.

122. The Health Board has established a management structure, which is highly dependent on clinical leaders. Each CPG is led by a Chief of Staff, who is a clinician. Depending on the CPG roughly half of the clinician's time is devoted to the role as Chief of Staff, maintaining their clinical commitments for the remaining 50 per cent. The Chief of Staff is usually supported by two full-time Associate Chiefs of Staff: one for operations (a senior manager) and one for nursing. This triumvirate provides the CPG management structure. The Chief of Staff for the Primary Care Specialist Medicine (PCSM) CPG was also supported (at the time of our fieldwork) by an Associate Chief of Staff for primary care, and a number of clinical directors. The nursing structure is complete now that matrons are in post, but operational general management structures are not yet fully staffed.

123. Each acute site also has a 'Hospital Management Team' to co-ordinate between CPGs at a site level, this sits under the Board of Directors within the Health Board's structures, but it is not clear that this provides sufficient vertical integration to support operational management at an organisation-wide level. At the time of our fieldwork in early 2012, the incomplete structure did not support co-ordinated bed management between CPGs within sites. Subsequently, the site management teams at individual acute sites were re-launched. We have not re-examined their effectiveness, but recent Health Board performance reports show improved admissions performance from EDs and improvements to acute lengths of stay, on the Ysbyty Gwynedd and Wrexham Maelor sites.

124. Most Unscheduled Care and Chronic Conditions Management services (except surgery) sit within the Primary, Community and Specialist Medicine CPG (the PCSM CPG). The PCSM CPG has introduced three areas or geographic patches focused on the three acute hospital sites west, central and east. These three areas are the vertical strands of the matrix (but only within the PCSM CPG), with an acute and a locality clinical director for each area. The PCSM CPG is also divided into cross North wales directorates, each with its own clinical director, acute focused medical sub-specialities, including Emergency Medicine (Accident and Emergency departments), and other medical sub-specialities such as Diabetetology, Chest medicine, etc.

125. The Health Board faces a number of challenges in modernising and transforming services for Unscheduled Care and Chronic Conditions Management, which are complicated by these internal structures:

- **Challenge 1**: Many of the newly appointed clinical leaders in the CPGs have not previously held senior management roles and faced a steep learning curve in their challenging new posts in the context of tightest financial settlement for a generation. These leaders bring a powerful new perspective to the wider management team, and a strong ability to interact with their clinical peers in the same language, and this should have substantial benefits especially around enabling future change. The Health Board has put in place development plans for these leaders, and although it is taking time for these changes to embed, is already seeing the benefits in some CPGs.

- **Challenge 2**: The organisational structural change process is far from complete. Unlike the appointments of Chiefs of Staff, appointments to middle managers (tiers four to six) are being managed by individual CPGs. The Board and Executive Team took the decision not to oversee this final process and the Board has not routinely monitored progress, although Workforce and Organisational Development have monitored progress. At the time of our audit, a survey was undertaken to ascertain the number of tier four to six posts still to be filled. There was significant variation. Within the PCSM CPG, the medical and nursing structure was complete but posts for operational (general) management posts were still vacant, without a clear timescale for completion.

- **Challenge 3**: Many locality clinical leadership teams are recent appointments (completed in March 2012). The teams comprise GPs who work for the Health Board one to two days a week, and Locality Matrons (full-time senior nurses managing all community nursing and community hospitals in their locality). General management posts were vacant at the time of our fieldwork. In addition the structure has vacancies for one band 8A community manager for each area (west, central, east) supporting the locality management teams. Capacity in relation to locality matrons and general management has been an issue, and without key people in place the pace of change has been slow, and as structures are still new there has been a period of learning for the individuals involved.

- **Challenge 4**: The 14 Locality structures took some time to establish.

- **Challenge 5**: Only the PCSM CPG has put structures in place geographically for 14 localities (community services) (Appendix 14). This structure is not mirrored in other CPGs, which complicates co-ordination and bed management at site level, where site management structures are not always clearly understood, resulting in issues escalating to Associate Directors. At the time of our audit each acute site did not always operate as a cohesive whole, with site-management arrangements not always working effectively between CPGs so systems were not resilient. For example, if an ED is full, and there are no medical or care of the elderly beds available, then the hospital management team steps-in to ensure the safe discharge or movement of patients, or approve the placing of patients in surgical beds. The subsequent reclarification of site management arrangements has had some impact on this, however, there is still some variability between sites and Hospital Management Teams in terms of the effectiveness of escalation in practice.

- **Challenge 6**: In addition, the 14 locality teams, which sit under the PCSM CPG must work in partnership with the other CPGs in order to transform local services. Some CPGs are more engaged than others with Locality teams. For example, in order to establish an older persons clinic in a community hospital, other CPGs, such as Pharmacy, Pathology, Radiology, Mental Health, and Therapies and Clinical Support need to be engaged in the process. Other CPGs do not have the same locality structure, and locality management teams do not always have an obvious candidate to attend meetings and contribute to decision-making. Each CPG has its own strategic direction and focus, with variable emphasis on a combined effort to address difficult issues, such as locality working. Whilst the Health Board has established the Board of Directors and Inter-CPG groups to help CPGs manage such issues, and Executive Directors can step-in, the fact that locality teams sit within one CPG and do not have their own voice at these discussions complicates internal partnership working, and may impact on the ability of localities to rapidly change service provision in their areas. The mechanisms the Health Board has put in place to resolve these issues (the Board of Directors and Inter-CPG group) both add complexity, and are time-consuming for both clinical and managerial staff.

- **Challenge 7**: When the Health Board was established, there was a reduction in primary care support teams, with many staff leaving under the voluntary early release scheme. Whilst the development of localities could potentially fill this gap, their slow establishment and location within the Primary, Community and Medicine CPG makes a joined up approach more challenging.

126. The complexity and delay in finalising new structures is having a detrimental impact on the Health Board's ability to make changes in Unscheduled Care and Chronic Conditions Management because a significant amount of management time has been focused on internal re-organisation processes, and fire-fighting the operational issues highlighted in section 1. However, the new structures do embed primary care contractors at the heart of the Health Board's decision-making on localities and community services, and in theory should increase the clinical decision-making capacity of community services.

Accountability and performance management arrangements for unscheduled care and chronic conditions management are complex, and are not supported by comprehensive performance information

127. 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, adequately informed and empowered to drive transformation.

128. The Health Board relies on the matrix structure outlined above, supported by corporate departments, to manage its complex services. Each CPG is responsible for the delivery of safe and effective services that are within budget and achieve Welsh Government targets. Corporate departments, such as IBS, or Planning, or Finance, support the CPGs. Responsibility for delivering, and developing services is delegated to Chiefs of Staff and their teams. For Unscheduled Care, the PCSM CPG Board, which meets every two months, has oversight of day-to-day delivery of services and developing services, including managing the budget and staff. In addition, it has taken a considerable length of time to agree the limits of delegated authority below Chiefs of Staff. For example the PCSM Board reported in September 2012 that its scheme of delegation has just been approved.

129. For Unscheduled Care this complex organisational accountability has direct consequences on patient flow within the acute sites. Executive Directors report that CPG Chiefs of Staff and hospital management teams on each acute site have the delegated authority to take decisions to ensure patient flow. At the time of our fieldwork, operational staff reported uncertainty around the scope of their delegated power, resulting in escalation of problems to Directors and Assistant Directors. This takes the acute site-based Assistant Directors away from their strategic roles into operational management. The need for this level of operational involvement of Directors and Assistant Directors, indicate that inter-CPG arrangements are not sufficiently robust to resolve operational issues on a day to day basis.

130. The Board's committee structures hold the Executive Team to account. By allocating line-management of Chiefs of Staff to Executive Directors, and conducting regular 'performance reviews' the Executive Team can influence CPGs and hold them to account. In essence, the Board has delegated responsibility for delivery to CPGs, but Independent Members do not have a clear line of sight. Direct scrutiny of how CPGs function or their operational delivery by Independent Members at Quality and Safety is on a rolling programme, and Finance and Performance have on occasion brought CPGs in to account for delivery issues. However, at the time of our fieldwork the Health Board the managers responsible for performance (CPG level and below) were not regularly scrutinised by Independent Members on the Finance and Performance or Quality and Safety committees for the consequences of their actions, or inaction.

131. Complexity can be overcome by good co-ordination, but we found that this was happening for specific areas of concern, rather than a co-ordinated effort to knit the complex organisation together. The Board of Directors and Inter-CPG groups are the formal mechanism put in place to improve co-ordination, but in practice these groups are too large (up to 30 attendees) and are not able to adequately co-ordinate site specific actions required for day to day operational management. They are better placed to influence service redesign and strategic direction.

132. The IBS Directorate supports the Unscheduled Care Modernisation Board (paragraph 57) as a response to the need for improved co-ordination, demonstrated by the failure to meet Unscheduled Care targets, and to help implement modernisation plans, including the DSU action plan. This group meets monthly, and established a range of weekly site-based sub-groups attended by Associate Chiefs of Staff from PCSM, Surgery and other CPGs. It is in effect a pragmatic operational support function for acute focused Unscheduled Care services in addition to the CPG structure. The IBS directorate team also use this group to feed information upwards to the Executive Management Team, the Board of Directors and support the monthly performance report to the Health Board's Finance and Performance Committee.

133. Complexity can also be overcome by good information. Information is crucial for informing the planning and delivery of effective services for Unscheduled Care and chronic conditions as well as monitoring service provision and patient outcomes. Our previous report on Chronic Conditions Management highlighted the paucity of financial information and activity data available which undermined the ability of NHS bodies to evaluate existing services, plan new services or to support the shift of resources from hospital to community settings. This position has not substantially improved in the Health Board, as although more information is available, at the time of our fieldwork, it was not regularly reported outside of the primary care support unit.

134. Performance reporting within the Health Board has improved in recent years, and continues to develop. At the time of our fieldwork, reports remained mainly acute target focused with information focused on organisational level processes, ambulance data or bed availability at acute hospital level. Performance reports on Unscheduled Care described four or eight hour waiting times performance and the factors preventing the Health Board achieving targets, such as the unavailability of beds due to Norovirus. Whilst CPG level reports, again focused on the high level issues, and analyse information at speciality level (eg, Chest Medicine). At the time of our fieldwork we identified several gaps in the information provided to both the Board, and PCSM CPG-level reports for Unscheduled Care and chronic conditions services. Specifically, as part of a hierarchical suite of information, we would expect to see:

- Chronic conditions indicators routinely reported to the Health Board, although individual conditions are reported through *Focus On…* reports to Quality and Safety on a rolling programme.

- A Setting the Direction Implementation Board or sub-committee as in other health boards, or a regular report to Board on *Setting the Direction* implementation. The Health Board report that its Primary Care Implementation Board fulfils this requirement, but this workstream is developing over 2012.

- Primary care measures, such as quality and outcomes framework or LES activity routinely reported to Board, and we note that recent Board Performance reports have included some of these measures.

- Community care measures reported at CPG-level, for example on District Nursing (eg, contacts, caseloads and acuity), and community hospital use (beds, outpatient attendances, diagnostics); and Home Enhanced Care (packages in place, or even the number of localities with the service operational).

- Analysis of Unscheduled Care demand ie, numbers of ED attendances and the proportion of these attendances that could have been treated more appropriately if alternatives were in place or patients had been effectively signposted to alternatives, including the reasons patients accessed the ED or other service.

- Patient outcome data, such as numbers of patients returning to their normal place of residence, the numbers re-admitted for the same condition within 28 days, and mortality indicators (RAMI).

135. The DSU report into Ysbyty Glan Clwyd also highlighted the need for the Health Board to focus on information to understand the reasons for breaches in relation to A&E waiting times targets so that actions could be taken to address these. Since the time of our fieldwork the Quality and Safety Committee have introduced a monthly Unscheduled Care report, which brings together activity and safety - we recognise this as a positive step forward.

136. Effecting change on the scale required is extremely challenging and is more difficult without accurate information to understand the demand on services, the causes of demand, and the patient outcomes of current services. All the current information system does is describe that performance is not reaching targets, it does not help CPGs and localities to identify what needs to change to relieve pressure on the acute hospital system. The Health Board faces challenges in compiling consistent performance information across its three acute sites. In particular:

- Each ED has a different ICT system and there is no consistency in what each system can do. The Health Board is at an early stage of developing plans to implement a standard ICT system, already in place in the Wrexham ED, to all EDs and MIUs. The Wrexham system is able to provide on request the type of information on attendances, and patient destinations, which will allow locality teams and the Health Board more widely to understand the reasons patients choose to access Unscheduled Care in the way they do, and to support the development of appropriate alternatives. However, the time-frame is unclear.

- GP admission data is collated by the Primary Care Support Unit for the Primary and Community Implementation Board, but at the time of our fieldwork this was not routinely shared with practices, or the Unscheduled Care groups.

- Information on bed availability is collected daily but in different formats because of the legacy arrangements of the predecessor bodies; none of the information is collated electronically, which would improve understanding of patient flows across the three acute sites.

- Ambulance handover information is collected by the Ambulance Service but feedback to frontline ambulance staff is limited or non-existent.

The clinical leadership model is not yet delivering sufficient clinical engagement to drive successful change

137. 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. Without strong clinical leadership and 'buy in' from the wider base of clinical staff, service transformation plans will be difficult to implement.

138. There is a clear vision for clinicians to be at the heart of service redesign and to be engaged fully in the Health Board's agenda and the organisational structure does place clinicians in the driving seat - Chiefs of Staff for each PCG, clinicians as directors for the speciality areas, like EDs and GPs as clinical directors for each locality. However, there is a two tier system where those who have a post within the CPG structures, and attend meetings understand the issues and feel consulted, while colleagues who are not on key working groups do not appear to be well engaged with the process. This is leading to a disconnect and a perception of communication gaps.

139. Corporate initiatives to engage staff more widely include the *Big Conversation* and *World Café* events. These initiatives focus on values and organisational culture, rather than being specifically focused on driving service transformation. There are clear examples of good engagement with both the Healthcare Professions forum, and the Partnership forum being given early opportunities to consider and influence the service reviews. Outside of the service reviews, engagement relies upon individual clinical leaders within the CPGs to disseminate information and communicate effectively. The sheer size and geographic spread of the key CPGs will always make such interpersonal contact a challenge, especially when historically there was frequent and direct contact with senior decision-makers. Overcoming legacy expectations remains a challenge for clinical leaders.

140. With much of the proposed transformation relying on rebalancing care towards primary and community services, it is vital that primary care practitioners are fully engaged. Two-thirds of the 30 practices responding to our survey (winter 2011-12) disagreed or strongly disagreed that they were involved in the redesign of Chronic Conditions Management and Unscheduled Care services, or were adequately informed of plans for Unscheduled Care services. A typical comment from one of the primary care survey respondents was; *"the health board imposes changes on us, a lot of which are unworkable"*. Practices did not feel that the Health Board provided enough support to become involved in the planning and design of services.

141. In the acute sector, our focus groups and clinical staff survey revealed that many clinical staff do not feel empowered or sufficiently aware of developments to be able to influence change. In contrast, those staff with posts within the CPG structures responded positively both on empowerment, and their ability to influence change. Most clinical staff indicated a willingness to engage, and help the Health Board move forward to improve patient care. These findings suggest that current communication mechanisms are not completely effective. Perhaps given the complexity of

organisation, and the amount of time the Chiefs of Staff spend in meetings to manage this complexity, these findings are not surprising. One key aspect of clinical leadership is the ability to communicate with peers regularly face to face to influence their behaviour, and meetings take Chiefs of Staff away from this direct leadership role.

142. Our additional work on clinical engagement explored these issues further, and reported formally as part of the 2012 Structured Assessment. The Health Board and the localities need to take steps to improve the way in which information is disseminated to clinical staff, to improve engagement at all levels of the organisation.

The complexity of Health Board structures and partnerships makes engagement with key partners harder

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

144. The Health Board has a large number of partners and key stakeholders that it needs to work with. It has six local authority partners, as well as those from the North Wales Police, the community health council and a range of voluntary sector organisations. The Health Board is committed to partnership working, and inherited a strong baseline from predecessor organisations. These partnerships were based on trust, and strong local relations built up over many years. The number and diverse range of partners is a challenge but in 2011 we found progress on partnership working, especially around strategic partnerships.

145. The Health Board is depending on CPGs and locality arrangements, including the Locality Stakeholder Groups from February 2012, to deliver joint working with key partners at an operational level. But many partners struggle to understand the new organisational structure, and although localities are generally co-terminus with local authority and police sub-structures, they too are 'new' concepts for partners and add complexity. In addition, locality arrangements are not yet fully developed. Combined, these issues may hinder the Health Board's ability to engage with partners to implement substantial local change in services over the short-term.

146. The new organisational structure has put operational partnerships under strain, mainly because of:

- changes to relationships: as a substantial number of management staff have left the organisation over the last few years, and partners were not always clear who had replaced their contacts, or even which CPG to speak to;

- an increased number of teams at locality level that external partners have to work with, even within on local authority area, whereas in the past social services has to deal with one Trust, and one Local Health Board, they now have to deal with the Health Board, multiple CPGs, and up to four locality teams within their boundaries; and

- the lack of clarity (both whilst locality teams were appointed, and around the service reviews), on how the Health Board is planning to deliver integrated health and social care services.

147. Through the service reviews, the Health Board has engaged with the six local authorities, the Welsh Ambulance Service, the voluntary sector, Health Board staff, politicians and community groups. Some key stakeholders, such as community pharmacists, and the Ambulance Service reported they found it difficult to fully engage with the process because of difficulties being released from clinical duties to attend meetings. The Health Board have addressed this in the formal consultation by scheduling sessions at various times from 2pm to 6pm.

148. Public engagement is still developing, and although it is based on established good practice, this does not guarantee successful local implementation. There is evidence that communication with the wider community and key stakeholders could be better. For example, temporary closures of community hospitals in some areas led to complaints from both stakeholders and Health Board staff because of a lack of communication about the need to make temporary closures. There has also been public censure from some local politicians and the public around those temporary service changes, particularly in Bryn Beryl. The Health Board needs to learn from this, and ensure its formal strategy is understood and used by all staff to ensure effective communication.

Appendix 1

Attendances at Major Emergency Departments

Change in the number of attendances at major EDs across Wales between 2010 and 2011.

Health Board	Number of ED attendances		Percentage change
	Jan 10 - Dec 10	Jan 11 - Dec 11	
Abertawe Bro Morgannwg University LHB	141,396	142,325	0.7
Aneurin Bevan LHB	130,152	131,521	1.1
Betsi Cadwaladr University LHB	163,931	168,638	2.9
Cardiff & Vale University LHB	125,928	125,402	-0.4
Cwm Taf LHB	105,253	111,356	5.8
Hywel Dda LHB	97,611	97,344	-0.3
Wales	764,271	776,586	1.6

Source: Wales Audit Office analysis of data derived from StatsWales

Appendix 2

Number of attendances at Betsi Cadwaladr minor injury units during 2010-11
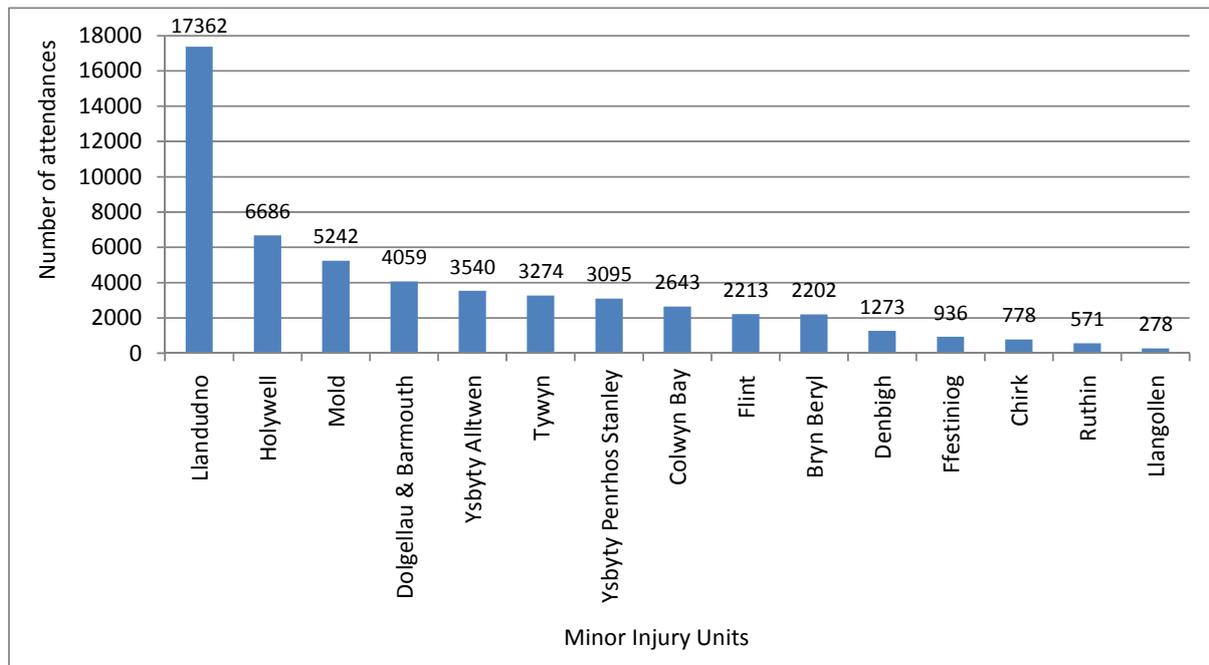
Source: Wales Audit Office analysis of information provided by the Health Board

Appendix 3

Number of attendances in 2010-11 at Betsi Cadwaladr minor injury units per WTE staff
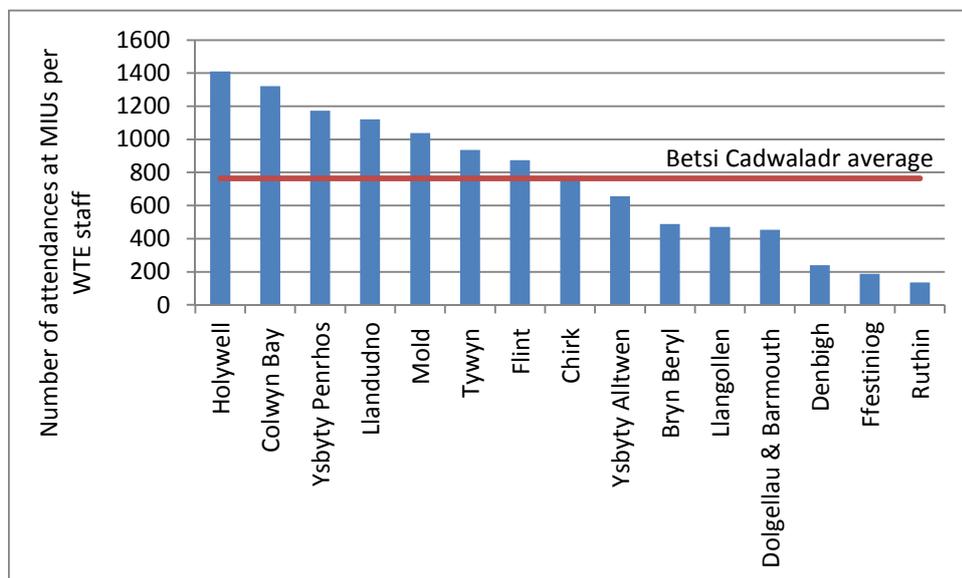
Source: Wales Audit Office analysis of information provided by the Health Board

Appendix 4

Working Hours of Emergency Department 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	9am-5pm	9am-4pm
	Princess of Wales Hospital	9am-9pm	9am-9pm
Aneurin Bevan LHB	Nevill Hall Hospital	9am-11pm	Up to 6 hours
	Royal Gwent Hospital	8am-8pm	9am-4pm
Betsi Cadwaladr University LHB	Wrexham Maelor	8am-10pm	9am-midnight
	Ysbyty Glan Clwyd	9am-9pm	9am-5pm
	Ysbyty Gwynedd	9am-8pm	12pm-3pm*
Cwm Taf LHB	Prince Charles Hospital	9am-5pm	NA
	Royal Glamorgan Hospital	9am-5pm	NA
Hywel Dda LHB	Bronglais General Hospital	9am-5pm	On-call plus Hospital at Night team
	Glangwili General Hospital	9am-5pm 9am-7:30pm (Mon and Wed)	9am-3pm
	Withybush Hospital	9am-10pm	1pm-9pm

*Actual hours reported to be longer in practice
NA – Data not available
Data for University Hospital of Wales are not available

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

Appendix 5

Emergency Department Medical Staffing

Numbers of filled and vacant posts for emergency department 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	0	11	1
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	3.2	7	0
University Hospital of Wales	NA	NA	NA	NA	NA	NA

(+ 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.

NA – Data not available

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

Appendix 6

Number of attendances at major Emergency Departments in Wales per WTE medical staff (including locum medical staff) in November 2011
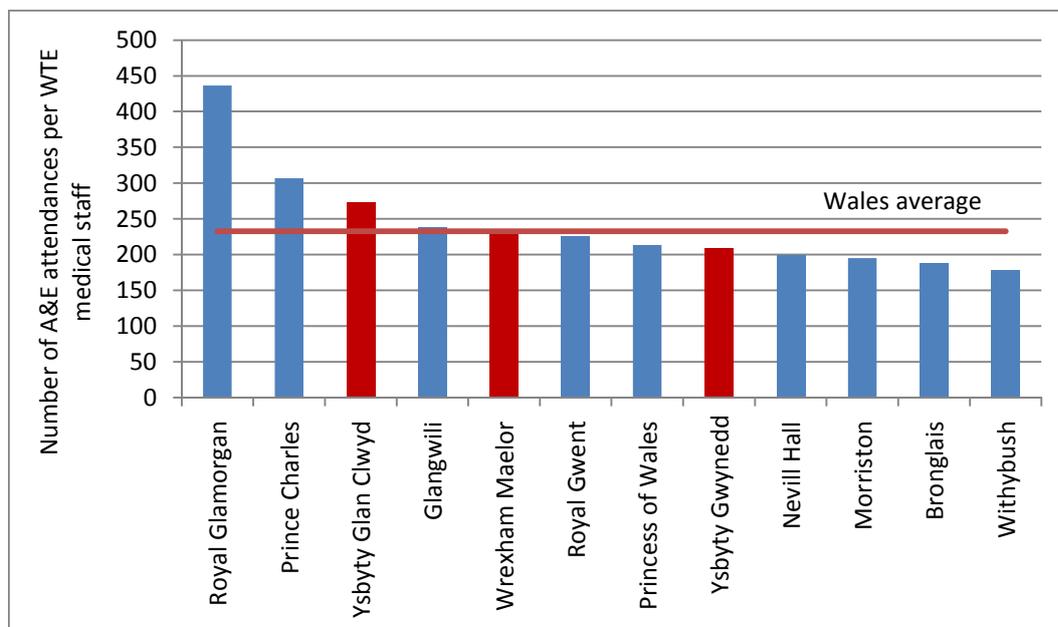
Data for University Hospital of Wales not available.

Source: Wales Audit Office analysis of data provided by health boards

Appendix 7

Number of attendances at major Emergency Departments in Wales per WTE nursing staff in November 2011
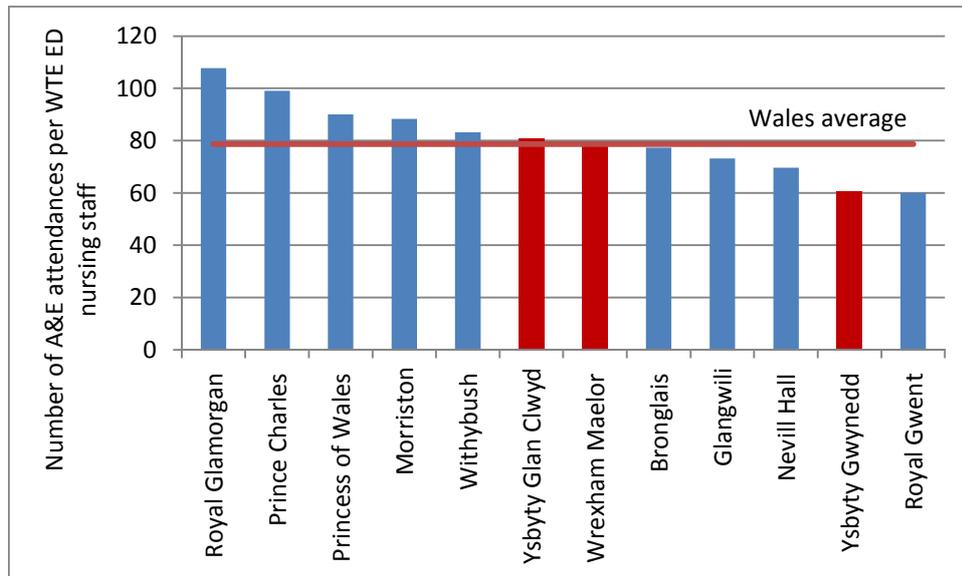
Data for University Hospital of Wales not available.

Source: Wales Audit Office analysis of data provided by health boards

Appendix 8

Time Spent in Major Emergency Departments

Average time individuals spent in major EDs in 2007-08 and 2010-11.

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

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

Appendix 9

Emergency Department Attendances Arriving by Ambulance

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

Hospital	Proportion of ED attendances that arrive by ambulance (%)	
	2007-08	2010-11
Morriston Hospital	27	29
Princess of Wales Hospital	19	22
Nevill Hall Hospital	24	26
Royal Gwent Hospital	28	28
Wrexham Maelor Hospital	20	20
Ysbyty Glan Clwyd	32	33
Ysbyty Gwynedd	24	26
Prince Charles Hospital	22	25
Royal Glamorgan Hospital	NA	NA
Bronglais General Hospital	7	9
Glangwili General Hospital	5	27
Withybush General Hospital	22	24
University Hospital of Wales	NA	NA
Wales	23	25
NA – Data not available		

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

Appendix 10

Rolling multiple admission rates for Chronic Obstructive Pulmonary Disease, Coronary Heart Disease and Diabetes at Betsi Cadwaladr University Health Board

Rolling 12-month multiple admission rate for COPD emergency admissions

Rolling 12-month multiple admission rate for CHD emergency admissions
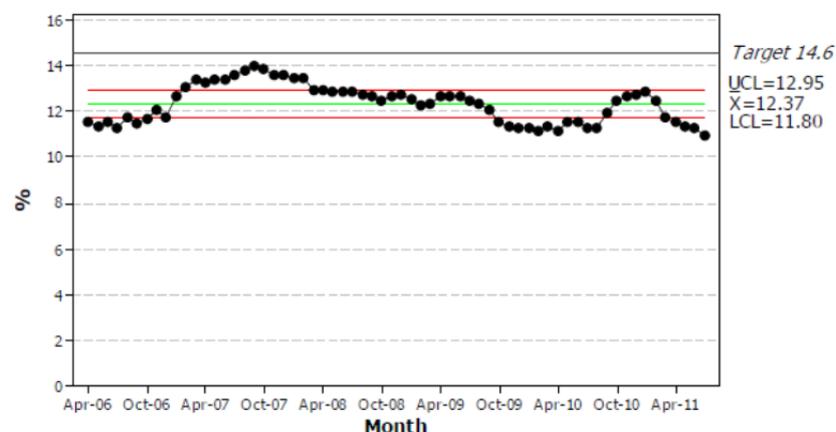
Rolling 12-month multiple admission rate for diabetes emergency admissions
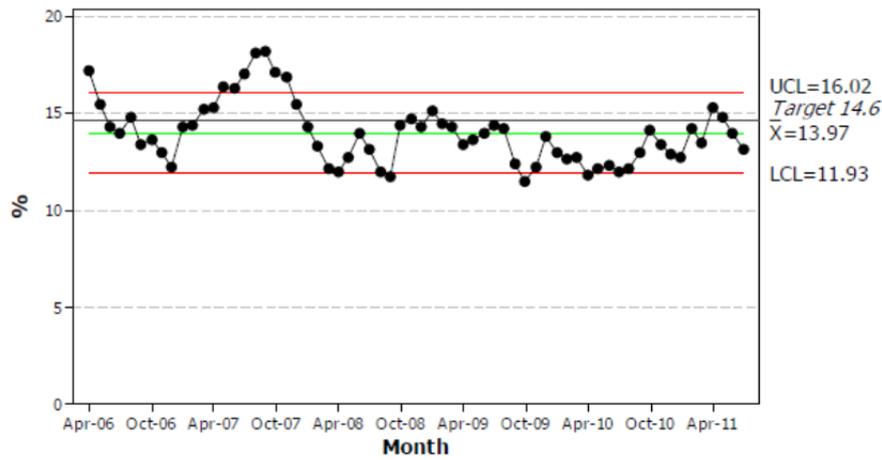
Source: National Leadership and Innovation Agency for Healthcare, Progress Report on the Chronic Condition Management (Chronic Conditions Management) Service Improvement Plan as measured through the Chronic Conditions Management Maturity Matrix, Appendix 4, October 2011

Appendix 11

Rolling 12 month average lengths of stay for Chronic Obstructive Pulmonary Disease, Coronary Heart Disease and Diabetes Admissions at Betsi Cadwaladr University Health Board

Rolling 12-month average length of stay for COPD emergency admissions
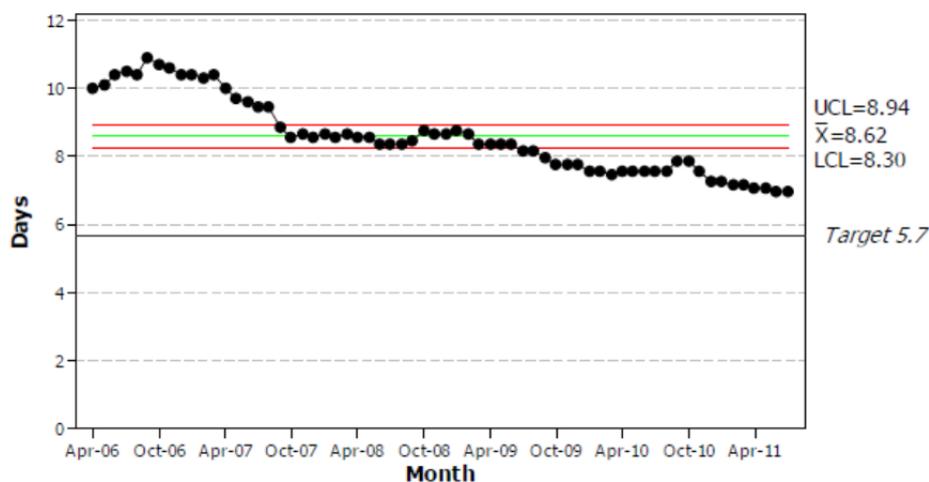
Rolling 12-month average length of stay for CHD emergency admissions
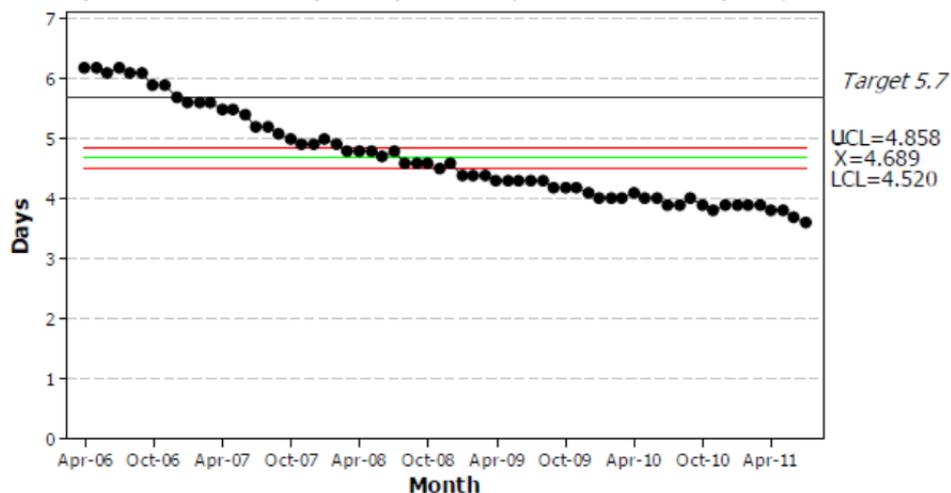
Rolling 12-month average length of stay for diabetes emergency admissions
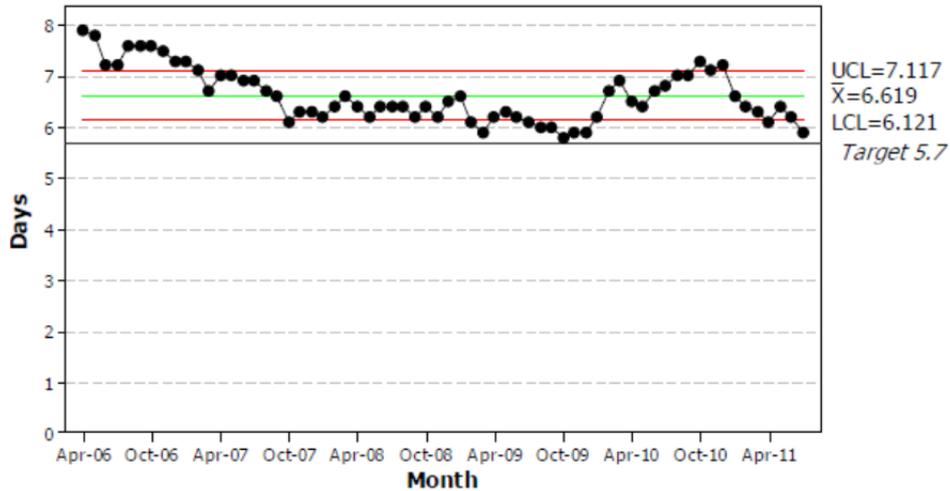
Source: National Leadership and Innovation Agency for Healthcare, Progress Report on the Chronic Condition Management (Chronic Conditions Management) Service Improvement Plan as measured through the Chronic Conditions Management Maturity Matrix, Appendix 4, October 2011

Appendix 12

Expenditure on primary care out-of-hours services

Expenditure on primary care out-of-hours services per registered patient in Betsi Cadwaladr University Health Board and the average for all health boards between 2005-06 and 2010-11.
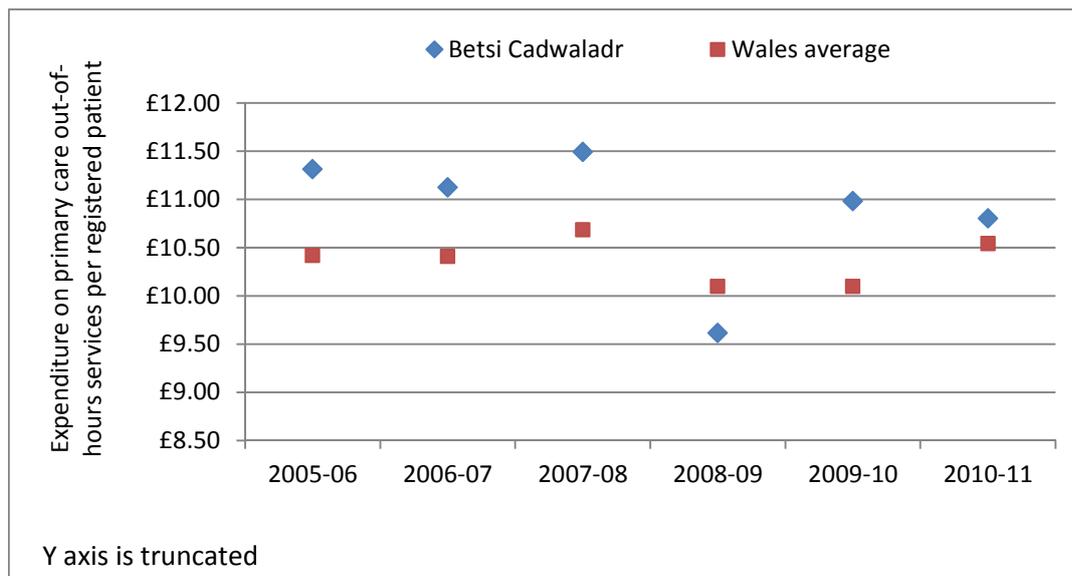
Source: Wales Audit Office analysis of audited accounts

Appendix 13

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

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

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

Appendix 14

Betsi Cadwaladr University Health Board Organisational Structures

Locality structure underpins the Primary, Community and Specialist Medicine CPG

West	Centre	East

Merionydd	Arfon	Dwyfor	Ynys Môn	North Denbighshire	Central and South Denbighshire	East Conwy	West Conwy	South Wrexham	Wrexham Town	West and North Wrexham	Deeside, Hawarden and Saltney	Holywell and Flint	Mold, Buckley and Caergwle
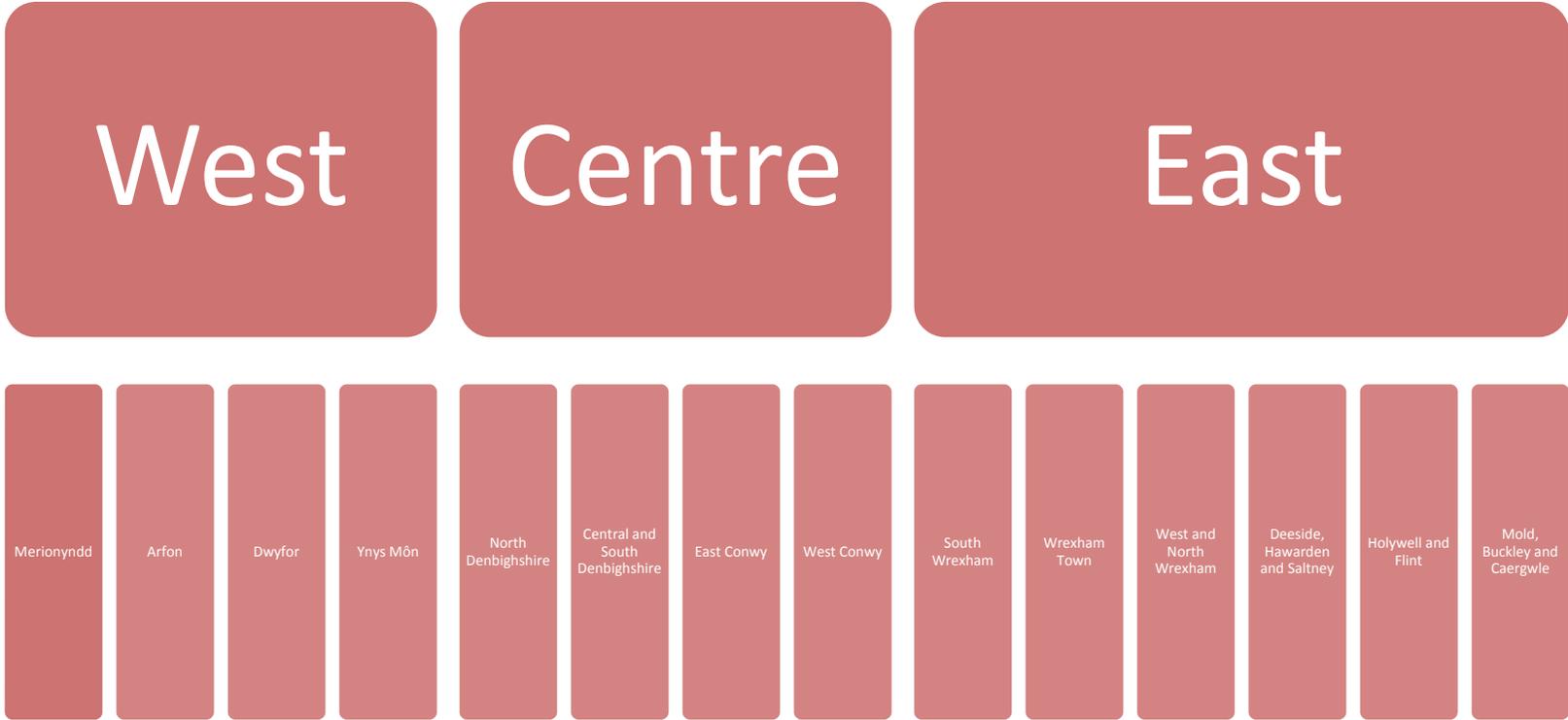
Source: Wales Audit Office

Clinical Programme Groups underpin the Board Structure

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                                    ┌──────────┐
                                    │  Board   │
                                    └──────────┘
        ┌──────────────────────────────┼──────────────────────────────┐
  ┌───────────────┐            ┌───────────────┐            ┌───────────────┐
  │   Board of    │            │  Board sub    │            │  Corporate    │
  │  Directors    │            │  committees   │            │support services│
  └───────────────┘            └───────────────┘            └───────────────┘
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Board of Directors	Board sub committees	Corporate support services
Primary Community and Medicine	Audit	Improvement
Dental and Surgery	Finance and Performance	Planning
Womens	Quality and Safety	Finance
Childrens		Governance and Communications
Anaesthetics and Critical Care		Nursing Midwifery and Patient Services
Therapies and clinical support		Medical Direcor
Pharmacy		Public Health
Radiology		Therapies and Health Science
Pathology		Workforce
Mental Health		Primary Care Support Unit
Cancer		

Source: Wales Audit Office