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Transforming Unscheduled Care and Chronic Conditions Management

Cardiff and Vale University Health Board

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The team who delivered the work comprised Anne Beegan and Phil Jones.

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Summary report

Context

1. It is widely recognised that many parts of the Welsh health and social care system are under considerable pressure. The current situation is unsustainable because these services continue to face excessive levels of demand against a background of constrained financial resources and there is now an urgent need for service transformation and whole system change.
2. The need for change has been apparent for some time. In 2003, the *Review of Health and Social Care Services in Wales* (the Wanless Review) identified the need for radical redesign for health and social care services and for greater capacity of services outside the hospital setting. A number of subsequent Welsh Government policies, alongside the 2009 reconfiguration of the NHS, provide the building blocks to achieve this change. *Setting the Direction* sets out a strategic delivery programme for primary and community services in NHS Wales. It describes the pressures that Welsh hospitals experience, which include the large number of emergency admissions and delays in discharging patients who are ready to leave hospital. The programme states that one of the causes of elevated pressures in hospital is that historically, the health service has gravitated services and patients towards hospital, thus restricting the sustainability and effectiveness of community services.
3. The programme argues for a need to rebalance the whole system of care away from an over-reliance on acute hospitals and towards greater use of primary and community services and an increased focus on preventive approaches. Such a change would have the benefit of reducing the demand on acute hospitals but importantly, it would benefit patients. Currently, too many patients are treated in hospital when they would be better cared for in the community.
4. If health boards are to succeed in implementing these more sustainable models of care, two of the vital and interrelated service areas that must be transformed are chronic conditions management and unscheduled care¹. It is vital to transform these two areas because:
 - a. **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, emphysema or heart disease. This proportion is higher in Wales than the other constituent countries of the United Kingdom. The prevalence of chronic conditions increases with age and given that Wales's population of over 65s is projected to increase by 33 per cent by 2020, the burden of chronic conditions on the system is likely to grow.

¹The 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.

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- b. **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 contacts² with unscheduled care services in Wales every year, with associated use of resources implications.
- c. **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 as 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 three years since the publication of this body of work, the Wales Audit Office has undertaken follow-up audit work on chronic conditions and unscheduled care that considers progress against our previous recommendations but also aims to provide new insight into the barriers and enablers affecting progress. As there are a number of key interrelationships between chronic conditions and unscheduled care, the work has been delivered as a single integrated review. One of the key enablers that we have focused on is clinical engagement, given its crucial importance in delivering the service transformation that is required.

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

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8. Cardiff and Vale University Health Board (the UHB) covers two local authority areas: Cardiff and the Vale of Glamorgan. Just over one fifth (21 per cent) of lower supra output areas (LSOAs) in these areas are among the most deprived fifth in Wales although conversely two fifths are among the least deprived fifth in Wales. Overall the health of the Cardiff and Vale of Glamorgan population is not significantly different from the Welsh average. A quarter of adults smoke, only a third meet physical activity guidelines and whilst the percentage of adults who are overweight or obese is a little lower than the Wales average, over half of them are classed as overweight or obese³.
 9. In addition to these factors which affect the general health of the population, the prevalence of chronic conditions increases with age. Over the next 20 years the number of people over 75 years of age across the Cardiff and Vale of Glamorgan area is expected to increase by a half. In the current economic climate, the projected increase in the economically and care-dependent population poses particular challenges for the UHB, which itself faces continued cost pressures and the need to make year-on-year savings in the order of 6 per cent over the next five years.
 10. The UHB's five-year strategy *Programme for Health Service Improvement plus* (PHSI+) recognises the importance of rebalancing care so more can be delivered nearer to people's homes, closer working between primary care and hospitals and less reliance on hospitals, unless patients really need to be there. These principles are reflected in the UHB's aims for developing unscheduled care and chronic (or long-term) conditions services:
 - Enabling easy, timely access to appropriate care for unplanned needs;
 - Providing as much support and care in the community as possible, to enable people to remain in their own home, minimise hospital admission and facilitate discharge;
 - Simplifying access routes to services to reduce levels of morbidity and avoidable emergency admissions to hospital;
 - Providing excellent response services which will be available through primary care, NHS direct, GP out of hours and Welsh ambulance 24 hours a day, 365 days a year; and
 - Improving the pathways of care to ensure that individuals with an unscheduled care need, can access services in the most appropriate manner.

³ Cardiff and Vale University Health Board: Local Public Health Strategic Framework

Our main findings

11. Our review considered the following question: *'Is the UHB 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?'*
12. We have concluded that the University Health Board (UHB) has made some progress in developing community services, but may struggle to deliver the intended transformation to further reduce reliance on hospitals unless it strengthens planning and performance management arrangements, and secures buy-in from clinicians and partners.
13. The table below summarises our main sub-conclusions.

Part 1 - The UHB has taken positive steps in increasing provision within the community but not enough demand has been taken away from pressurised acute services

1a. Pressures within the emergency department continue to have an impact on performance

- The UHW emergency department is continuing to experience elevated demand whilst attendance rates at the UHB's Minor Injuries Unit are declining;
- Increased attendances and vacancies are causing workload pressures;
- Patients brought to hospital by ambulance constitute a major part of emergency department demand;
- Performance against the four-hour target within the main emergency department has been consistently poor although the average waiting time compares well against other departments;
- Many patients arriving at UHW emergency department by ambulance wait too long before being handed over to the hospital staff;
- Poor outflow from the emergency department continues to cause considerable pressure in UHW despite numerous improvement initiatives;

1b. The rate of emergency admissions and overall lengths of stay for chronic conditions have markedly improved although multiple admissions remains problematic

- The UHB has performed comparatively well in reducing emergency admissions although multiple admission rates for some conditions remain high;
- Lengths of stay for patients with chronic conditions are now in line with the target level although delayed transfers of care are increasing, despite a significant reduction in levels since our previous review in 2009; and
- The UHB could do more to support GP's to reduce emergency admissions even further.

1c. The UHB has made positive progress in expanding the range of community services although more needs to be done to reduce reliance on the acute sector

- The range of chronic condition services available within the community has increased, although more needs to be done to further embed risk stratification and make greater use of enhanced services and community hospital beds;
- The formation of CRTs represents an important step forward but the teams are at variable degrees of maturity and there is still more to do to shift the focus to admission avoidance; and
- Access to both in-hours and out-of-hours primary care is generally good although there is some variation across practices and the out-of-hours service could benefit from the full roll-out of the integrated health record.

1d. Positive steps have been made in changing the way that the public uses services and improving the concept of self-care

- The UHB has made a good attempt at improving public understanding on the use of unscheduled care services but the work has been hampered by a lack of resources;
- The UHB has made good progress in establishing a communications hub which provides a single point of access to a broad range of services;
- Increasing participation in self-management courses could further strengthen the positive developments that have been made around the self-care agenda.

Part 2 - Arrangements being put in place to deliver the strategic vision and transformational change would benefit from greater integration across agendas, strengthened clinical engagement and improved partnership working

2a. The direction of travel for unscheduled care and chronic conditions is becoming clearer although implementation is likely to be affected by regional decisions and success will be reliant on workforce transformation

- The UHB's transformational change programme is the key driver for change for unscheduled care and chronic conditions management although this could be strengthened by the development of a single comprehensive delivery plan;
- National and regional decisions about the future network of hospital services will impact on the ability of the UHB to plan the future of its unscheduled care and chronic conditions services; and
- While the workforce plan recognises the changes that need to take place, the plans need to be updated and further developed to enable the UHB to meet its financial and workforce challenges and to support service transformation.

2b. Governance arrangements to support the transformation of unscheduled care and chronic conditions management have been, and continue to be, strengthened but a lack of comprehensive performance information may hinder progress

- Organisational and structural changes have strengthened governance arrangements and recent proposals for change should bolster these further;
- The absence of comprehensive organisational wide information means that the UHB is unable to effectively performance manage its services and their effectiveness.

2c. The UHB needs to strengthen its engagement with clinicians and its partners if it is to take forward the necessary service transformation

- Clinical leaders are in place and there are encouraging developments in primary care but greater clinical engagement is needed to secure support for service transformation; and
- Further strengthening of relationships with the public, local government and the ambulance service are essential to secure sustainable improvements and service transformation.

Recommendations

14. We make the following recommendations to the UHB:

- R1 Strengthen the understanding and management of the demand placed on unscheduled care services to ensure that services are being targeted appropriately. The UHB should:
- assess and analyse information on unplanned re-attendances at the minor injuries unit in Barry Hospital, using the results to inform the actions required to reduce the numbers of patients who may attend on an unplanned basis; and
 - in partnership with GPs, identify how demand and pressure on the acute sector can be reduced. This should include:
 - reviewing repeat attenders to the emergency department or other unscheduled care services, and developing a trigger system to support greater proactive management of patients within primary care and the community;
 - building on the work already undertaken by the UHB's Innovation and Improvement team to understand the reasons for multiple emergency admissions;
 - understanding what information would usefully support GPs to manage the level of emergency admissions from primary care; and
 - gaining a greater understanding of the perception amongst practice staff for the need for additional support to prevent hospital admissions, such as rapid access clinics and direct access to diagnostics.
- R2 Secure further improvements in primary care services to enhance the vital role that the GPs play. The UHB should:
- in partnership with GPs, use the Local Enhanced Service provision of the GMS contract more constructively to develop services that focus on prevention and early intervention for chronic disease management;
 - use existing forums for engagement with primary care to share good practice and to examine solutions to common problems such as 'did not attend' rates. The Primary Care Foundation practical guide for transforming same-day care in general practice provides a very helpful framework on which to inform this; and
 - work with GPs to address the variation in performance outlined in the Welsh GP Access Survey and examine the reasons when performance is below average and/or deteriorating.

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- R3 Further develop primary and community based services so that patients' needs are more consistently met and unnecessary attendances and admissions to hospital are avoided. The UHB should:
- explore the ways in which existing community services can support the minor injuries unit to prevent patients being admitted unnecessarily;
 - reignite the focus on stratification of patients at greatest risk of emergency admission across the two localities;
 - through the Wyn Campaign, explore the potential to extend the range and focus of the existing community based services to support greater admission avoidance; and
 - extend the distribution of the service directory to include other services such as GP practices and the minor injuries unit at Barry Hospital.
- R4 Secure improvements in the flow of patients from the emergency department through to other clinical areas so that patients are treated in the most appropriate place. The UHB should:
- work with clinical specialities within the UHB to ensure the smooth and timely transfer of patients from the emergency department through such initiatives as liaison arrangements. This is particularly important for patients with mental health needs; and
 - closely monitor the impact of the redevelopments within the emergency department at UHW to ensure that there are no negative impacts on waiting times and patients' throughput.
- R5 Influence the way in which the public uses services to ensure that resources are used effectively. The UHB should :
- examine the reasons for the low levels of completion on the Expert Patient Programme (EPP) and the high rate of patients who do not attend, with a view to optimising attendance; and
 - reinforce the 'Choose Well' campaign by increasing the level of signposting to alternative services at the points at which patients access services, such as the emergency department at UHW.
- R6 Strengthen planning arrangements to better support the development of comprehensive and equitable services across the UHB. The UHB should:
- develop a comprehensive plan which brings together the focus of chronic conditions management and unscheduled care into a single delivery plan, ensuring there are links with the UHB's overarching strategic vision and the transformational themes;
 - review the group structures in place which feed into the chronic conditions and unscheduled care agendas to ensure that resources are fully maximised and that action plans are integrated; and
 - establish an on-going process of evaluation to shape the services of the future.

R7 Further strengthen the approach to workforce planning, to ensure that workforce issues do not impact on the provision and quality of services. The UHB should:

- maintain a focus on ensuring sustainable solutions to improving the level of senior medical staffing, particularly at consultant level, within the major emergency department at UHW;
- review nurse staffing levels across both the major and minor emergency departments to ensure that levels are sufficient to meet the workload safely and to the required quality standards;
- ensure that there are appropriate succession planning arrangements in place to secure chronic conditions and unscheduled care services for the future; and
- put an action plan in place to meet the Welsh Government target for sickness absence within the emergency department.

R8 Secure improvements in the performance management of chronic conditions and unscheduled care services across Cardiff and Vale of Glamorgan. The UHB should develop a comprehensive range of performance indicators. These should include specialty response times and should cover primary care and community based services.

R9 Work with partner organisations to improve the experience of Cardiff and Vale of Glamorgan patients who require unscheduled care or chronic conditions services. The UHB should:

- work with the Welsh Ambulance Services NHS Trust to identify local solutions to improve performance within the emergency department at UHW. This should include:
 - the high percentage of patients who arrive by ambulance that are subsequently discharged from the department; and
 - the patient handover process and the need to strike the right balance between speed and the need for quality of care and patient safety, and the accurate recording of handover times.
- work with Cardiff and Vale of Glamorgan local authorities to identify solutions to reducing the level of delayed transfers of care and to support timely access to social workers, particularly across Cardiff.

Detailed report

The UHB has taken positive steps in increasing provision within the community but not enough demand has been taken away from pressurised acute services

15. Across Wales, demand for hospital services is high and rising with increasing numbers of emergency department attendances and emergency admissions. Managing demand is about ensuring patients receive the most appropriate care in the right setting. Reducing inappropriate demand and preventing unplanned admissions should enable hospitals to operate more efficiently and ensure patients who truly need their services are seen as quickly as possible. This section of the report discusses the progress that the UHB 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.

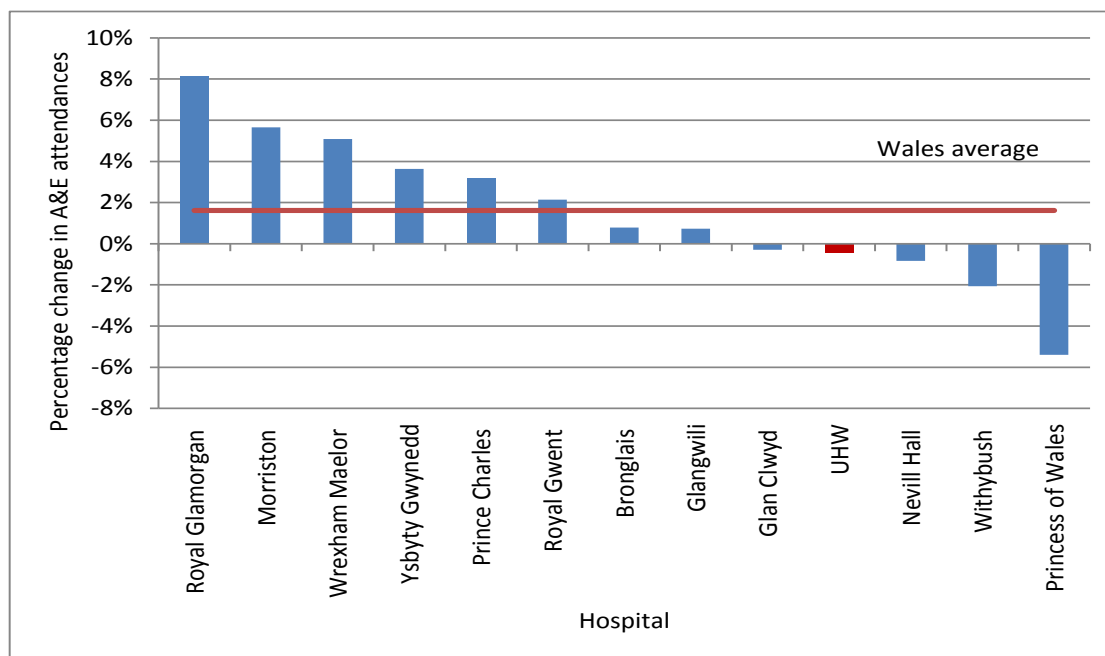
Pressures within the emergency department continue to have an impact on performance

The UHW emergency department is continuing to experience elevated demand whilst attendance rates at the UHB's Minor Injuries Unit are declining

16. There are roughly 2,000 attendances at major accident and emergency (A&E) departments⁴ each day across Wales. The Welsh Government's *Delivering Emergency Care Services* strategy highlighted a year-on-year increase in the number of patients attending hospital emergency departments. As well as the general upward trend in demand, emergency departments can also face sharp peaks in activity that, if not managed effectively, can result in congestion within the department and a slowing down in the provision of care to patients.
17. Between 2010 and 2011, there was a small rise (1.6 per cent) in the total number of attendances at major emergency departments across Wales ([Appendix 1](#)). During that period, attendances at the University Hospital of Wales (UHW) actually decreased by 0.4 per cent ([Exhibit 1](#)), from 125,928 in 2010 to 125,402 in 2011 (equivalent to 1.5 attendances per day).

⁴ Major A&E departments are available continuously 24 hours a day to provide the resuscitation, assessment and treatment of acute illness and injury in patients of all ages.

Exhibit 1: Annual percentage change in A&E attendances between 2010 and 2011



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

18. **Exhibit 2** shows the longer term trend and shows that despite the decline in 2011, attendances at UHW have increased by 12 per cent between 2008 and 2012.

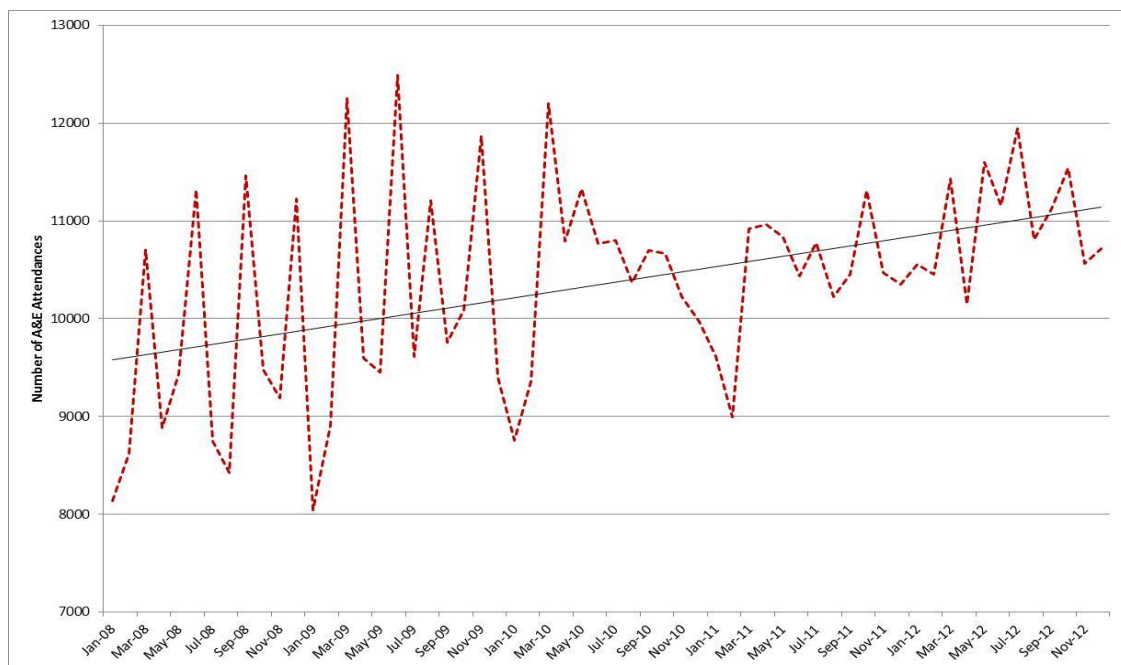
Exhibit 2: Long-term trend in demand at hospital emergency departments

	2008	2009	2010	2011	2012
UHW A&E department	115,640	122,691	125,928	125,402	132,059

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

19. The level of attendances can fluctuate during the year (**Exhibit 3**) however an analysis of attendance data would suggest that the rate of attendances are becoming more consistent on a month by month basis. The data also suggests that the bad winter weather which was experienced across the UK may have resulted in a drop in attendances in late 2010 and early 2011, and the reported slight decline in attendance levels between 2010 and 2011.

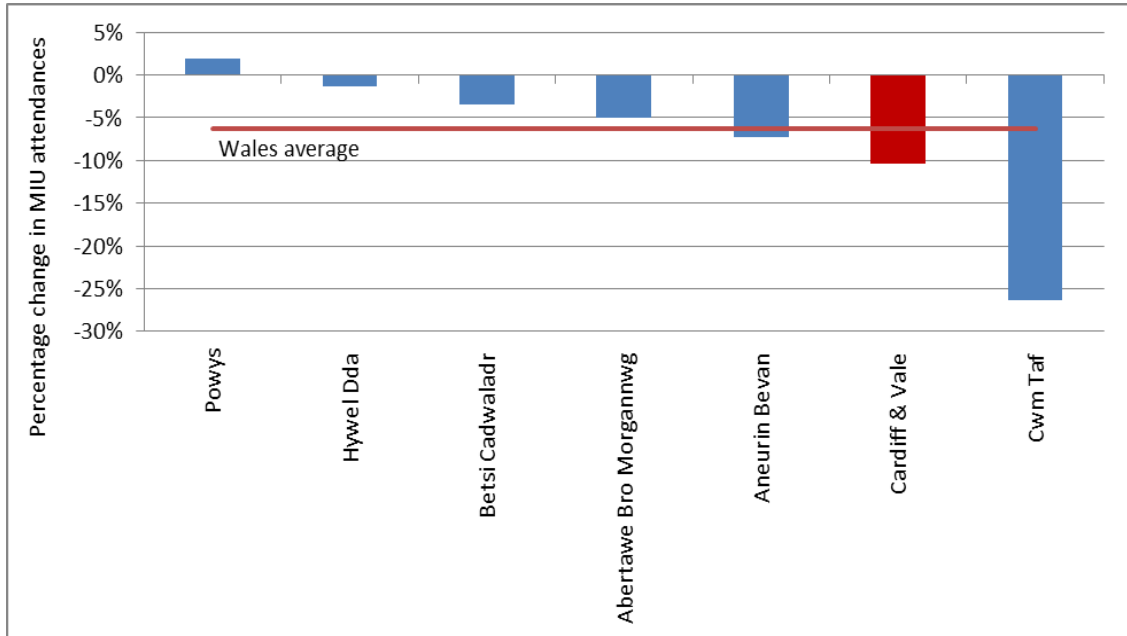
Exhibit 3: Trend in monthly attendances at the major A&E department at the UHB, January 2008 to December 2012



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

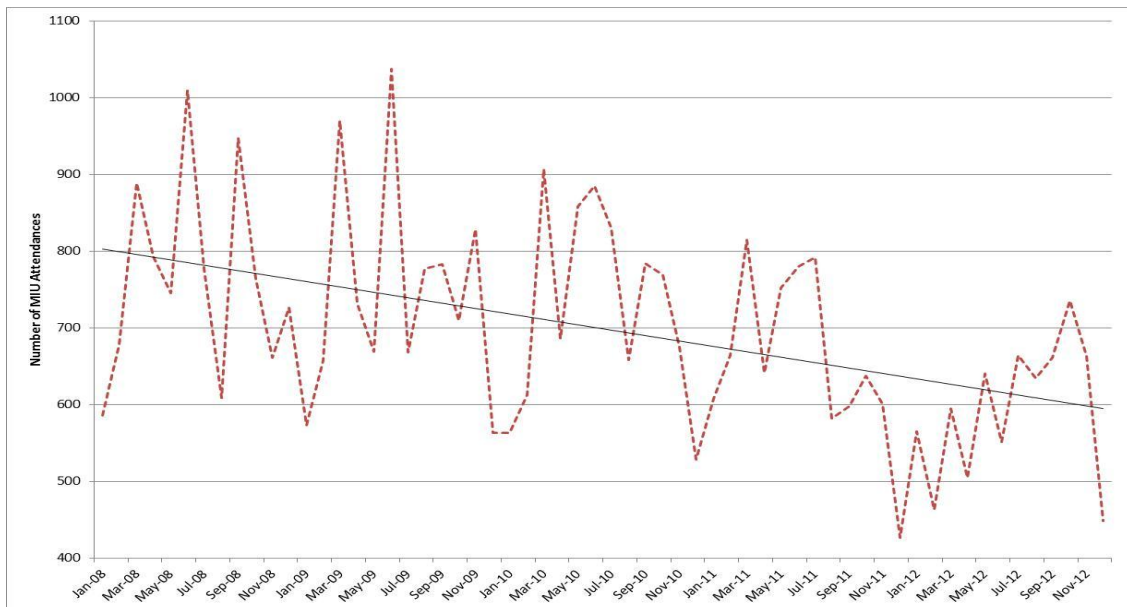
20. Between 2010 and 2011, the number of attendances at minor injury units (MIUs) across Wales reduced by six per cent (Exhibit 4). The UHB experienced one of the biggest reductions with attendances at its Minor Injuries Unit at Barry hospital falling by just over 10 per cent from 8,705 to 7,805. This is a continued reduction from previous years, with an overall reduction in attendance rates of 15 per cent from 2008, when attendance rates stood at 9,188. The fall in number of attendances particularly from July 2011 is as a result of the reduction of operating hours that came into force at that time and a subsequent change in the service model provided in the unit (Exhibit 5).

Exhibit 4: Percentage change in the number of attendances at minor injury units between 2010 and 2011



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

Exhibit 5: Trend in monthly attendances at the minor injury unit at the UHB, January 2008 to December 2012



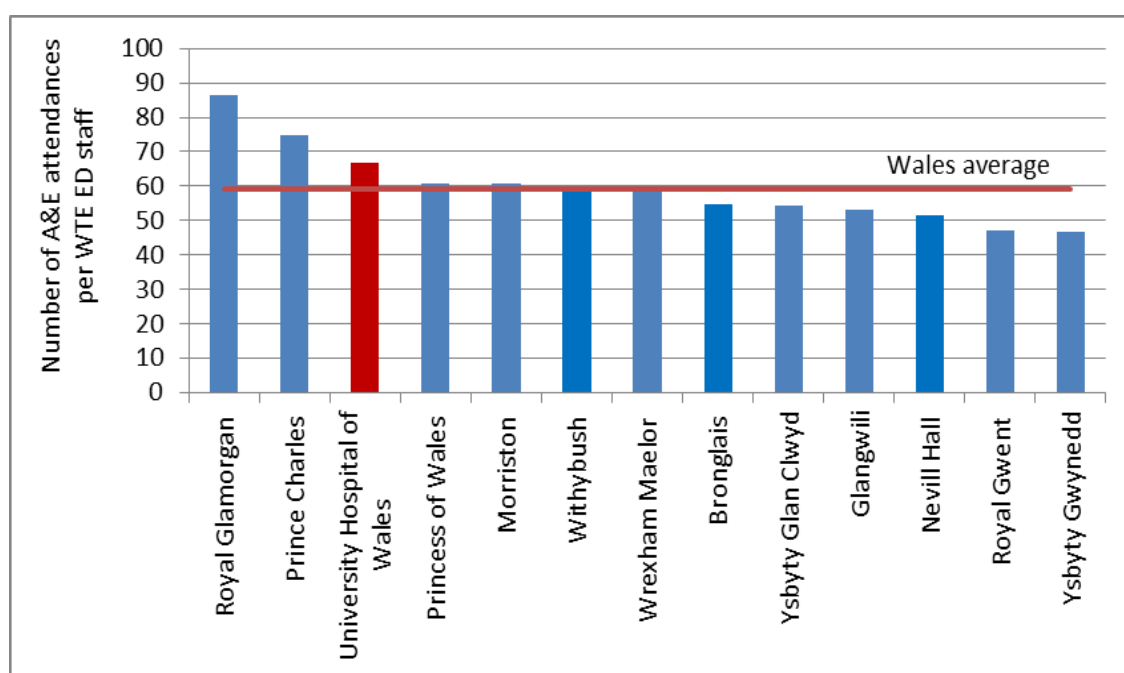
Source: Wales Audit Office analysis of A&E attendances derived from Stats Wales [statswales.wales.gov.uk]

21. Staff within the MIU did not have any strong views as to whether patients attending the department were appropriate. However the staff identified that services in the community are not yet effective in preventing attendance and some patients are attending as the only option. Staff also felt that they had no option but to admit patients because alternative services in the community are unavailable.
22. Just under seven per cent of attendances to the unit were re-attendances, equating to 609 patients in 2010-11. Two-fifths of these attendances were unplanned.

Increased attendances and vacancies are causing workload pressures

23. Data we collected as part of our survey of emergency departments provide evidence of the pressures experienced within the UHB’s emergency departments. **Exhibit 6** shows that the total number of attendances in 2010-11 per whole time equivalent staff (medical and nursing bands 1 to 9) at UHW⁵ would appear high in comparison to many other units, suggesting that the staff in the department are under workload pressure.

Exhibit 6: Number of attendances at major emergency departments per whole time equivalent staff



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

Note: Data on UHW were derived from Stats Wales [statswales.wales.gov.uk].

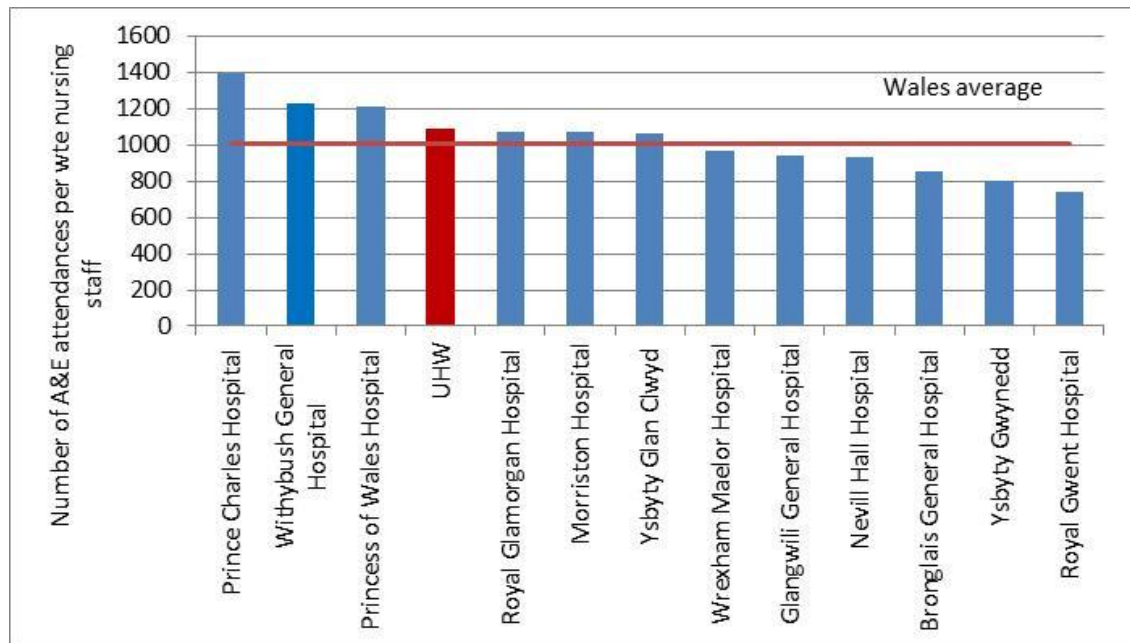
⁵ The survey of emergency data was not fully submitted for University Hospital of Wales. Some data has been derived based on information obtained from www.statswales.wales.gov.uk.

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24. The College of Emergency Medicine now recommends that every major emergency department should have a minimum of 10 emergency medicine consultants (increasing to 16 for departments with more than 100,000 attendances per year) to provide up to 16 hours 'on-site shop floor' cover seven days a week⁶. At the time of our fieldwork, the UHB did not meet this requirement, although the UHB was moving towards having 14 hours of emergency medical consultants cover every day of the week (Appendix 2). The ability to provide the 14 hours cover was based on a commitment from the consultants to work extra sessions although this solution is not sustainable.
 25. Like other health boards across Wales, the UHB has a shortfall in the number of consultants and at November 2011 the division were identifying four consultant vacancies (Appendix 3). This is despite a number of recruitment campaigns which have failed to attract suitable candidates for appointment. The division is now looking at ways of increasing its consultant capacity by considering joint consultant posts with other specialties. In addition, two of the existing consultant posts are currently being fulfilled by locum consultants.
 26. The level of middle grade medical staff is also problematic. Workforce planning indicates that the emergency department requires eight middle grades although there are currently only four in post. Middle grade posts are also shared appointments with the Medical Assessment Unit which is located next to the emergency department. This can mean that staff are not always accessible within the emergency department as they may be dealing with patients elsewhere.
 27. The National Unscheduled Care Board's June 2011 document *Ten High Impact Steps to Transform Unscheduled Care* states that health boards should be measuring the percentage of time that intended senior clinical decision maker shop floor presence is achieved. The absence of senior decision maker presence is recognised as problematic in the UHB's emergency department, although it is unclear whether this measurement has taken place. Staff identified that the lack of senior decision makers can have implications for waiting times in the department with patients overflowing into the corridor once the wait for a senior decision maker exceeds two hours.
 28. Exhibit 7 shows that the total number of major emergency department attendances per WTE nurse is just higher than the Welsh average. This suggests that the nurse staffing level, when taking account the activity of the emergency department, is slightly lower than the Welsh average. Just over 15 WTE nurses, within the establishment, are emergency nurse practitioners (ENPs). At the time of the fieldwork, the emergency department was reporting a vacancy rate of 2.9 per cent (Appendix 4). In addition, the cumulative sickness absence rate reported by the department in April 2012, at 5.79 per cent is above the Welsh Government target. This suggests that vacancies and sickness absence are also placing pressure on staff. This is reflected in the views

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

expressed to us by staff who considered that staffing levels were a constraining factor in delivering timely care.

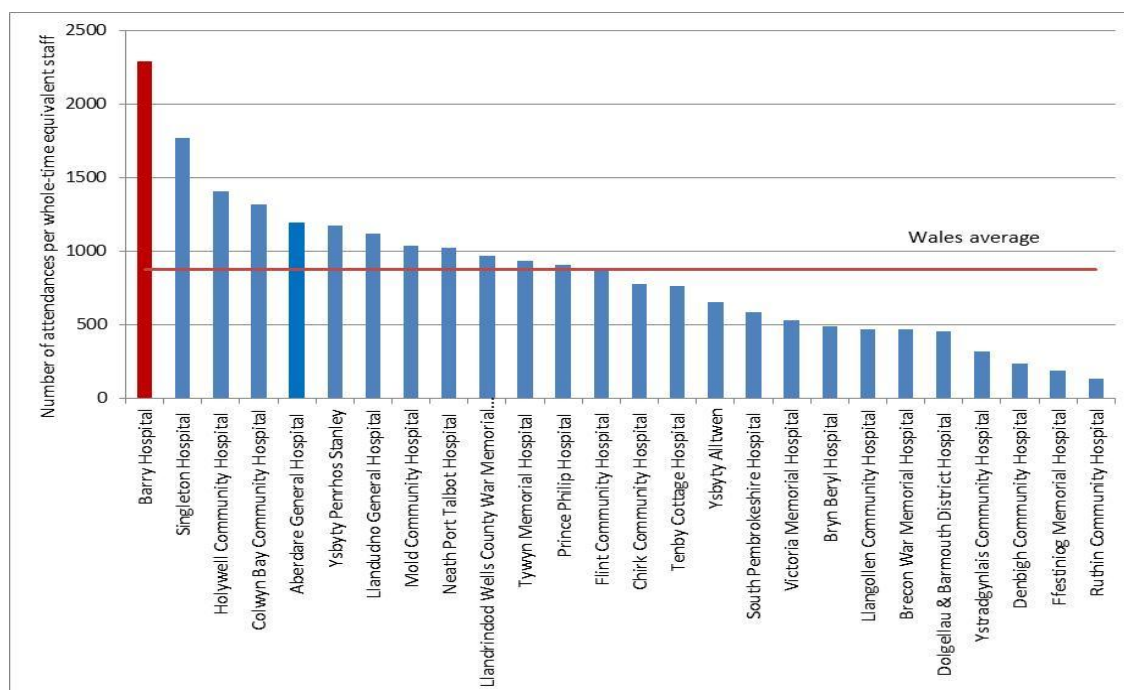
Exhibit 7: Number of attendances at major emergency departments per whole time equivalent nursing staff



Source: Wales Audit Office, emergency department survey.

29. Staff reflected that staffing levels within the department had remained static for the last two years despite increases in activity. The pressure of short term sickness absence was resulting in the need to use bank and agency, and the increase in part time workers placed challenges on developing robust staff rotas. The impact of transporting paediatric patients to the children's hospital, which can require 30 minutes of nursing resources, was also identified as placing pressure on staffing levels in the paediatric emergency department.
30. **Exhibit 8** shows that minor emergency departments and minor injuries units have a higher level of attendances per member of staff than major emergency departments. Significantly, the level of attendances per member of staff in the Barry Minor Injury Unit is the highest across Wales.

Exhibit 8: Number of attendances at minor emergency departments and minor injuries units per whole time equivalent staff



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

31. The indicated workload pressures on staff correlates with the findings of our survey of the minor injury unit at Barry which identified the views that there were too few staff in the unit. Similarly access to appropriate senior clinical decision making was also identified as problematic. At the time of fieldwork, the minor injury unit was a nurse led unit with clinical advice provided by the medical staff at the major emergency department at UHW. Changes have subsequently been put forward to develop a GP led unit supported by a unit based paramedic. The original opening hours have also been reinstated.

Patients brought to hospital by ambulance constitute a major part of emergency department demand

32. A large proportion of the demand experienced in the major emergency department is through patients brought to hospital via ambulance (see [Appendix 5](#)). In 2011 at UHW, 29 per cent of all attendees arrived by ambulance, which was the third highest in Wales⁷. The average for Wales in 2011 was 26 per cent which had increased from 23 per cent in 2009. No data was available for UHW in 2009.

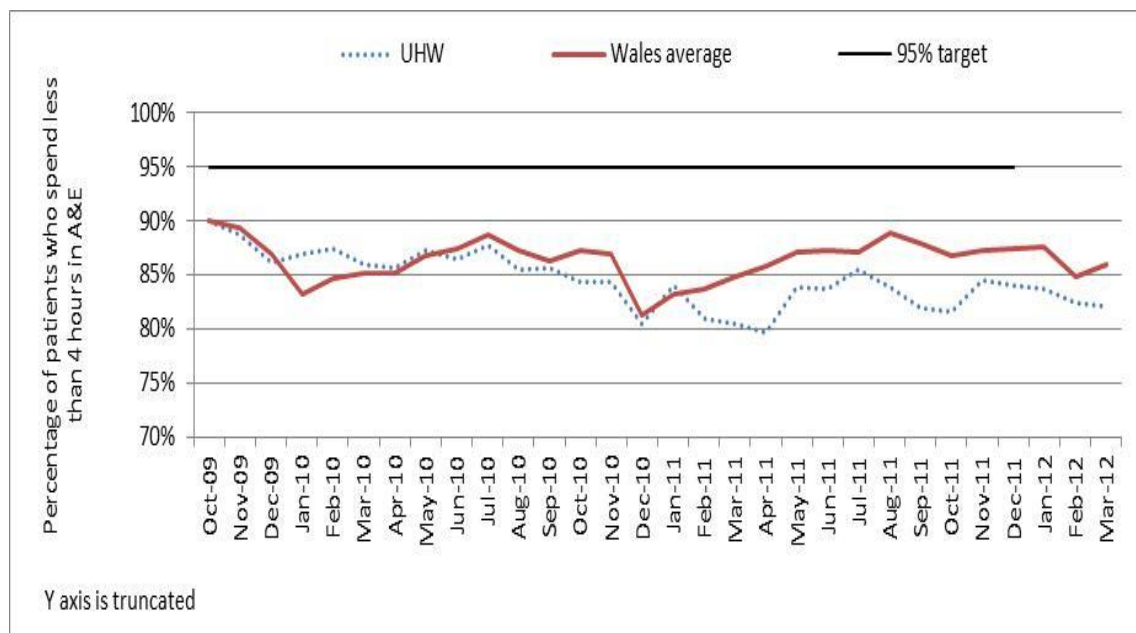
⁷ These data do not include the Royal Glamorgan Hospital. Data were not available at this time.

33. Of the patients that arrived by ambulance at UHW, 54 per cent did not require primary or secondary care follow up. This represented the highest figure in Wales⁸ and equated to just over 20,000 patients per year, or 55 patients per day. These data suggest that there is scope to reduce the proportion of patients brought to hospital via ambulance.

Performance against the four-hour target within the main emergency department has been consistently poor although the average waiting time compares well against other departments

34. People accessing hospital emergency departments are, in the majority of cases, in need of rapid assessment and treatment. For this reason, hospital emergency departments have been set a national target of ensuring at least 95 per cent of their patients spend no longer than four hours in the department from arrival until admission, transfer or discharge and that 99 per cent spend no longer than eight hours.
35. As shown in Exhibit 9, performance against the four-hour waiting time target at UHW was poor throughout 2011 and a continuing deterioration since 2009.

Exhibit 9: Trend in proportion of patients who spend less than four hours in the emergency department



Source: Welsh Government, Stats Wales

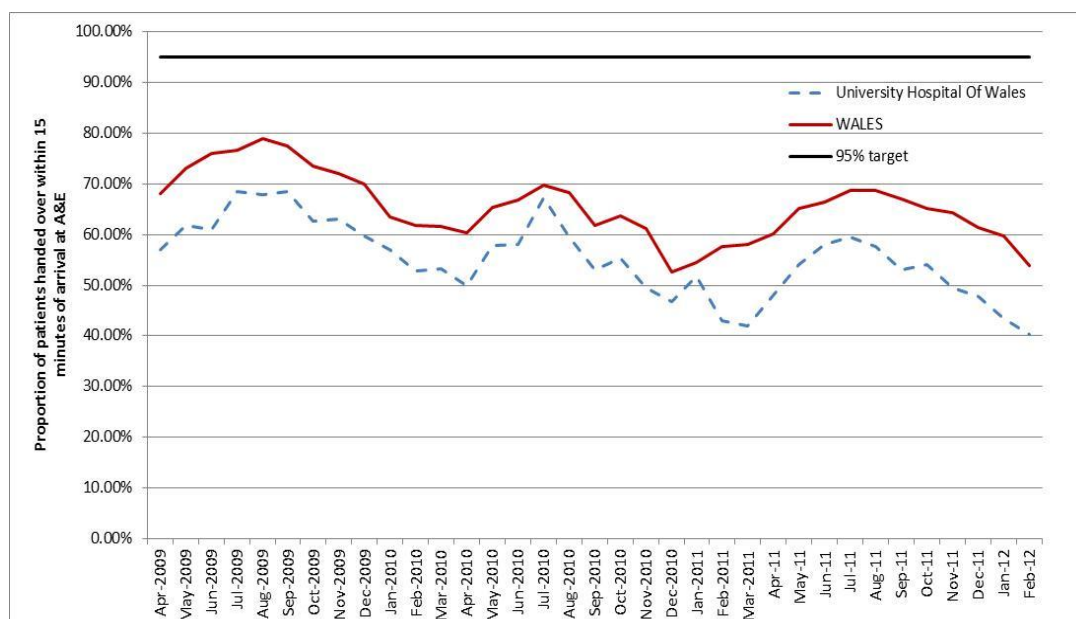
⁸ These data do not include the Royal Glamorgan Hospital. Data were not available at this time.

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36. From December 2011, the Welsh Government changed the way in which breaches to the waiting time targets are counted. If it is clinically appropriate for patients to remain within the emergency department for longer than four hours, this is no longer counted as a breach. This means that data for December 2011 are not strictly comparable with data for previous months. It is thought these exclusions may have given rise to a small increase in the number of patients waiting less than four hours. Most recent data for December 2012 shows that performance has not changed significantly with 85 per cent of patients waiting less than four hours at UHW. We recognise however that there had been an improvement in performance during September and November 2012, when performance reached 92.9 per cent and 90 per cent respectively.
37. With any target there is a risk that in seeking to meet the required performance level, health organisations will focus less on other important aspects of care. With the four-hour target, there is a risk that health boards focus too much on the four-hour threshold at the expense of looking more broadly at the timeliness of their care. For this reason we requested information from health boards on their average waiting times in hospital emergency departments.
38. Across Wales, individuals attending major emergency departments are spending longer waiting to be seen in the department ([Appendix 6](#)). Data from our review in 2009 showed that individuals spent on average 2 hours and 2 minutes in major emergency departments compared to 2 hours and 38 minutes in 2011. Average waiting times for the major emergency department in the UHB was reported to be 2 hours and 31 minutes in 2011. The average wait at UHW was fifth lowest of all major emergency departments after Bronglais hospital (1 hour and 45 minutes). Royal Glamorgan hospital had one of the highest average waits in Wales at 3 hours and 30 minutes. No comparative data was provided UHW in 2009.
39. The UHB plans to improve waiting times as part of a £2.8 million redevelopment of the UHW emergency department. The investment will provide additional resuscitation capacity, a new and improved combined medical and surgical assessment unit with observation beds for the emergency department, and the removal of the internal corridor area. The development aims to provide better patient flow, although it is recognised that the level of investment may not be sufficient to make substantial improvements in waiting times.

Many patients arriving at UHW emergency department by ambulance wait too long before being handed over to the hospital staff

40. When emergency departments and the rest of the acute hospital experience elevated pressures, this can have the impact of delaying the handover of patients from ambulance crews to hospital staff. Such delays have detrimental impacts on patients who often await medical attention in the back of an ambulance or on trolleys in hospital corridors. These delays also have a detrimental impact on the ambulance service's ability to react quickly to emergencies because when crews are delayed at hospital they are unable to respond to other emergency calls.
41. A 15-minute handover target was introduced in 2008 to improve the timeliness of handovers between ambulance crews and emergency departments and in June 2011, a five per cent tolerance was built in to allow time for more complicated handovers. 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.
42. The handover period starts from when the ambulance crew notifies the emergency department staff they have arrived with a patient. The period ends when the ambulance crew transfer the patient's clinical care to the emergency department staff. Exhibit 10 shows that handover performance fluctuates considerably within the hospital's emergency department with compliance with the target much lower than the Welsh average.

Exhibit 10: Trend in proportion of patients handed over within 15 minutes of arrival in the emergency department



Source: Welsh Ambulance Services NHS Trust

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43. The UHB recognises the importance of ambulance handovers and, in February 2011, a number of initiatives were put in place to ensure that delays in the handover of patients from ambulance crews were kept to a minimum. This included the development of an internal operational policy for emergency department staff and escalation arrangements to minimise the number of patients managed on trolleys in the departmental corridors. A UHB-wide focus on improving timely discharges on wards to free up capacity and improve patient flow within the emergency department was also established. However, more recent data would indicate that handover performance has deteriorated since 2011 to around 40 per cent reported in October 2012.
 44. During our fieldwork, we observed the handover process and interviewed a range of staff. Ambulance staff that we met described the working relationship between themselves and the staff in the emergency department as good or very good. They felt that the recording of patient handover times was important although they had mixed views as to whether initiatives had been put in place to improve the patient handover process. Ambulance staff perceived patient flow within the department as the major factor in delays in patient handover and identified that nursing staff can occasionally be over enthusiastic to record handovers, even when the handover process had not been completed.
 45. On the day of observation, the data terminal used to record handover times was not working. This was identified as a common problem which was often slow to fix. Emergency department staff also reported that there were no operational protocols in place for the ambulance crews which could help to improve the handover process.
 46. During the twelve month period December 2010 – November 2011, a total of 5,897 hours were lost over and above the twenty minutes allowed for ambulance handover and turnaround ([Appendix 7](#)). This equates to just over 16 hours per day and is one of the highest in Wales, after Royal Gwent and Morriston hospitals.
 47. Delays in releasing crews from emergency departments can have an impact on the ability of the service to respond to emergency calls in the community. Response times for ambulance crews to Category A calls across the two localities however is regularly some of the best in Wales ([Appendix 8](#)) with performance continuing to be above the target. Responses to Category B and urgent doctor calls were less positive, with performance around or below the average for Wales, and below the target level.

Poor outflow from the emergency department continues to cause considerable pressure in UHW despite numerous improvement initiatives

48. Our fieldwork found that the major emergency department was struggling to ensure good outflow of patients, with the department susceptible to congestion. We were told that there was no correlation between attendance numbers and four-hour performance, suggesting that the outflow of patients from the department is a greater issue than the front door demand.
49. The UHB has taken several actions to improve outflow within the emergency department including:
- The continued separation of the minor and major streams, with patients with minor illnesses or injuries being treated through the minor stream which is led by Emergency Nurse Practitioners, supported by other healthcare professionals such as physiotherapists and pharmacists;
 - The development of fast track pathways which route patients directly through to the relevant specialty, such as the direct access pathway to gynaecology, fast track to coronary care for patients requiring primary percutaneous coronary intervention (PCI) following a myocardial infarction and the fast track pathway to the epilepsy nurse led assessment service;
 - The introduction of a GP screening pilot initiative to assess and screen ambulant patients who present at the department and re-direct them to the most appropriate setting, although we understand that this pilot ceased following an evaluation;
 - Plans in place to introduce an acute physician in the emergency department; and
 - An increasingly good working relationship with South Wales Police to manage violent patients.
50. Despite these improvement actions, there is widespread recognition that outflow remains problematic. Of particular concern is the relationship between the emergency department and other key departments within the hospital. For example, emergency department staff told us that a key problem is slow responses from in-house specialty doctors to requests for assessments within the emergency department. This is particularly the case for out-of-hours psychiatry, with examples of patients waiting up to nine hours to be assessed. The department is starting to address this relationship through the implementation of the Bristol assessment matrix for mental health patients.
51. Another concerning relationship exists between the emergency department staff and that of the medical assessment unit. We were told that these relations can be strained, partly due to the workload and pressure for outflow experienced in both areas. The current redevelopment of a single surgical and medical assessment unit will see an increase in assessment beds, including six emergency department observation beds which should give rise to improved patient flow. A review of staffing levels within the assessment unit will also take place.

The rate of emergency admissions and overall lengths of stay for chronic conditions have markedly improved, although multiple admissions remains problematic

The UHB has performed comparatively well in reducing emergency admissions although multiple admission rates for some conditions remain high

52. One of the key aims of the Chronic Conditions Management (CCM) model and framework was to reduce the number of avoidable emergency admissions and readmissions, and ensure that lengths of stay were not excessive. Achieving this will help ensure that acute sector resources are used more appropriately, and support a more efficient 'flow' of patients through the hospital. Problems at a ward level caused by high emergency demand, long lengths of stay and delayed discharges can also have a knock-on effect on the transit of patients through the emergency department.
53. The rate of emergency admissions is an indicator of demand experienced within the acute sector. The *Delivering Emergency Care Services* strategy noted an increase in the rate of emergency admissions across Wales. **Exhibit 11** shows that between 2005-06 and 2010-11 the number of emergency admissions in Wales increased by 4.1 per cent. During this period, the UHB experienced a 5.9 per cent increase in emergency admissions, although since 2009-10, emergency admissions have started to decline.

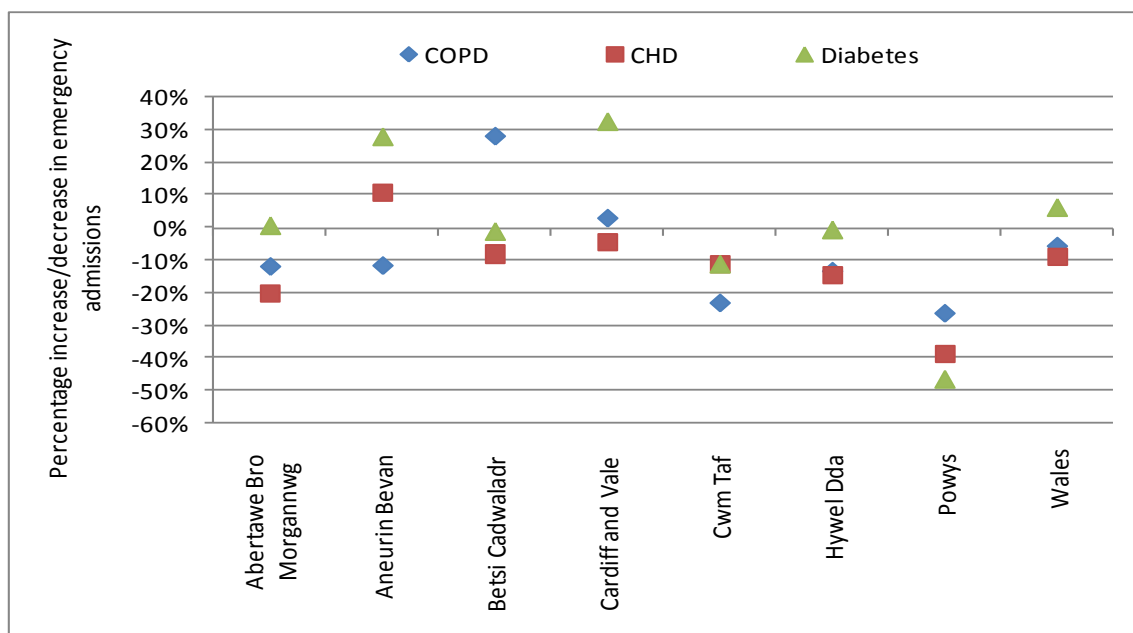
Exhibit 11: Emergency admissions at the UHB, 2006-05 to 2010-11

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
Emergency admissions (C&V)	43,395	43,779	44,627	46,887	46,273	45,945
Per cent change on previous year (C&V)	-	3.0	2.5	7.4	-1.4	-3.7
Per cent change on previous year (All Wales)	-	1.8	-1.9	2.0	1.0	1.2

Source: PEDW

54. Since 2007-08, NHS bodies have been expected to achieve reductions in emergency admission rates for chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD) and diabetes. Across Wales, over the last five years, the number of emergency admissions for COPD and CHD fell by six per cent and nine per cent respectively. However, the number of emergency admissions for diabetes increased by six per cent (Exhibit 12). Emergency admission rates for COPD and CHD in the UHB have remained static since 2006-07; however the emergency admission rate for diabetes has increased by 32 per cent, although it is important to note that the number of emergency admissions for diabetes is comparatively low. More recent data in September 2012 would indicate that emergency admission rates are now improving for COPD but are starting to increase for CHD.

Exhibit 12: Percentage change in the number of emergency admissions for Welsh residents due to chronic conditions between 2006-07 and 2010-11

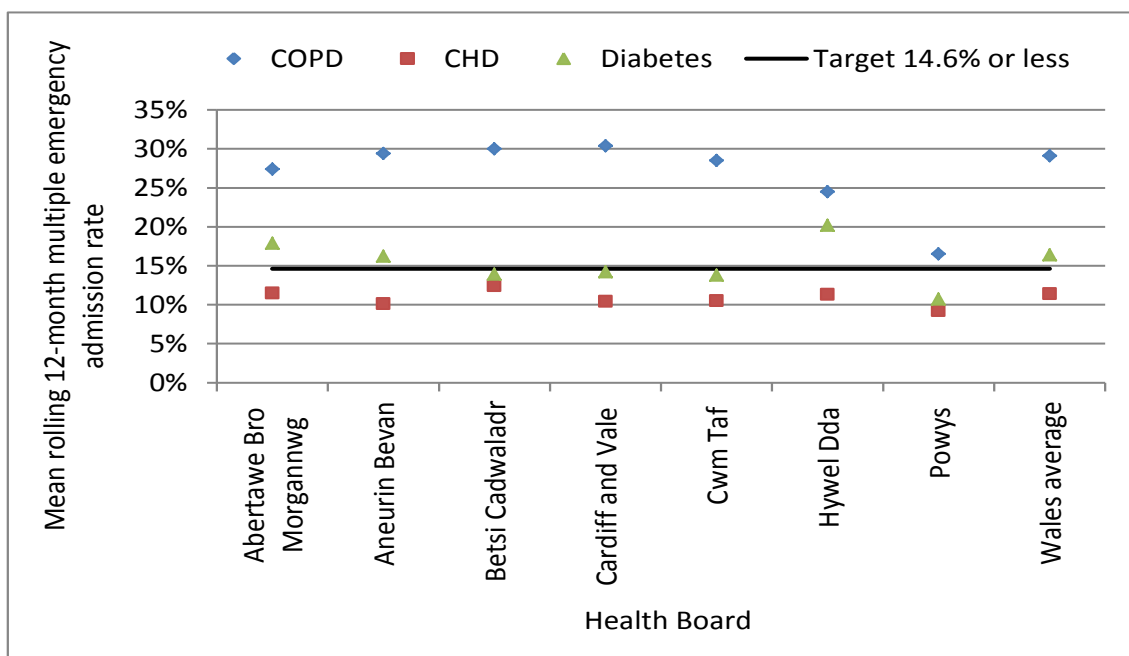


Source: Wales Audit Office analysis of the Patient Episode Database for Wales

55. Trends in the emergency admission rates for a range of other chronic conditions (asthma, heart failure, stroke, acute myocardial infarction and angina) show that in all cases they are reducing across Wales. This pattern of reduction is repeated in the UHB with admission rates generally lower than average.

56. NHS bodies are also expected to reduce the multiple admission rates ie, the proportion of repeat admissions, to 14.6 per cent or less. Performance against this target 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). Exhibit 13 shows that during the period April 2006 to July 2011, the UHB's mean rolling average performance was generally better than the average for Wales in terms of repeat admissions, with the exception of COPD which was higher than the average for Wales and above the target level.

Exhibit 13: Mean rolling multiple emergency admission rate between April 2006 and July 2011



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

57. Appendix 9 shows the UHB's performance over the last five years. In summary:

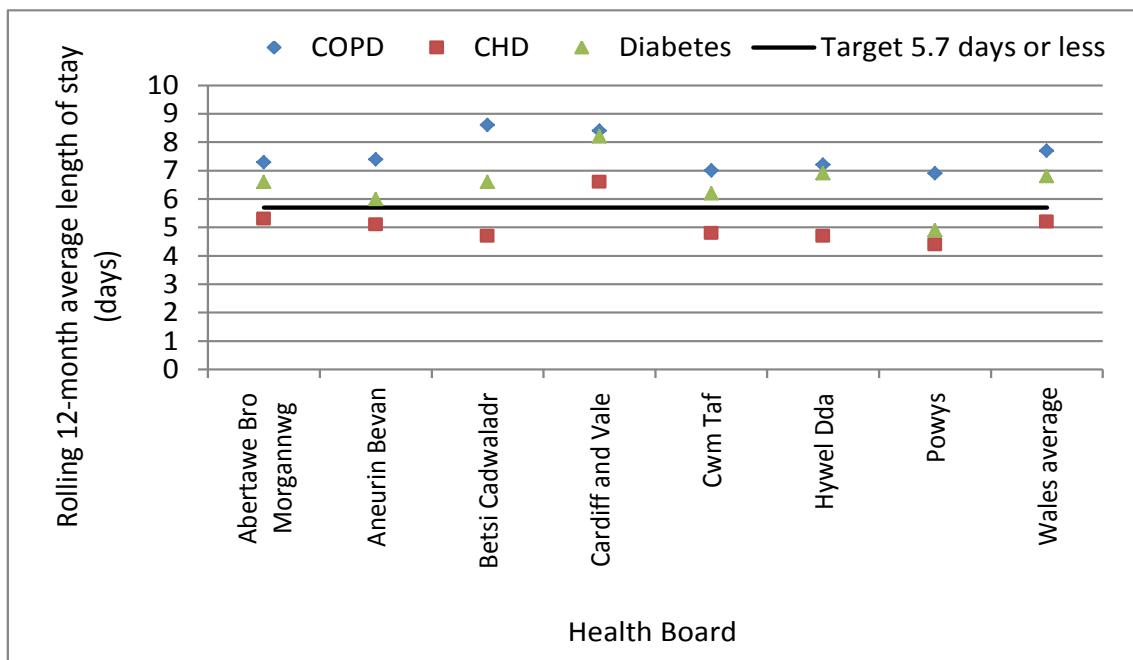
- for COPD, the UHB has a high multiple admission rate which has fluctuated since 2006, but has never reached the target level;
- for CHD, the UHB has consistently met the target for multiple admissions at all times since 2006;
- for diabetes, despite meeting the target in 2006, multiple admission rates have increased and have been consistently above the target since 2010.

58. The UHB's Innovation and Improvement team had recently started to focus on patients with chronic conditions who experienced multiple admissions, referred to as 'frequent flyers', by reporting the top 20 patients to each practice. The work required each practice to identify appropriate actions to reduce the impact of multiple admissions.

Lengths of stay for patients with chronic conditions are now in line with the target level although delayed transfers of care are increasing, despite a significant reduction in levels since our previous review in 2009

59. Efficient discharge processes are another key determinant of good hospital flow. If discharge processes do not work well, patients spend too long in hospital which can pose risks to their independence as well as prevent flow from the emergency department to the wards. In line with reducing emergency admission, NHS bodies are also required to reduce the average length of stay to 5.7 days or less for patients admitted with COPD, CHD and diabetes, measured on a rolling 12 month basis. Exhibit 14 shows that during the period April 2006 to July 2011, the UHB's mean rolling average performance was longer than the average for Wales and above the target level.

Exhibit 14: Mean rolling average length of stay for chronic conditions between April 2006 and July 2011



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

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- 60.** **Appendix 10** shows the UHB's performance over the last five years. In summary:
- Lengths of stay for emergency admissions for COPD have reduced steadily since 2006 and are now in line with the target, and have been since 2011;
 - Lengths of stay following emergency admissions for CHD were high in 2006, but have reduced steadily to reach the target in 2009, although lengths of stay increased above the target for a nine month period during 2010-11, reducing back to the target in April 2011. A second peak was also experienced during the latter part of 2011-12 with performance returning to within the target level in May 2012; and
 - Lengths of stay for diabetes have reduced steadily since 2006 and are now in line with the target, and have been since March 2011. More recent data on lengths of stay however shows a decline in performance since May 2012.
- 61.** The picture for mean length of stay for a range of other chronic conditions is similar in terms of reductions, although the UHB's lengths of stay are consistently longer than the average for Wales, with the exception of asthma. The mean length of stay for asthma is however one of the shortest in Wales with a reported length of stay of 2.4 days in 2010-11.
- 62.** When a patient is ready to be transferred to the next stage of care but for one or more reasons transfer is prevented, patients will experience a 'delayed transfer of care'. Delayed Transfers of Care (DTC) have negative impacts on the people who become delayed, with significant implications for their independence. Delayed transfers of care also have an impact on wider service delivery and performance across the whole health and social care system but the immediate effects manifest themselves within hospitals. The Welsh Government's Delivery Framework for NHS Wales for 2011/2012 included a Tier 2 target of continuing to improve performance in relation to delayed transfers of care.
- 63.** **Exhibit 15** shows that the extent of delayed transfers of care within the UHB reduced significantly from 2005-06. This was true of the number of bed days lost as a result of these delays and the number of patients experiencing delays, although the latter has started to increase since 2008-09. The major causes of the increase was due to an increase in the number of patients who experienced a delay because of 'healthcare reasons' in 2008-09, but more latterly because of an increase in delays because of 'social care reasons' and 'patient/carer/family related reasons'.

Exhibit 15: Trend in the number of patients experiencing a delayed transfer of care from acute and community facilities (excluding mental health facilities) at the UHB

	Number of patients experiencing a delayed transfer of care	Number of delayed bed days	Average lost bed days per patient
2005-06	1034	72,787	70.4
2006-07	949	77,513	81.7
2007-08	755	59,257	78.5
2008-09	732	50,802	69.4
2009-10	755	45,365	60.1
2010-11	798	43,201	54.1

Source: Data provided by NHS Wales Informatics Service (NWIS)

64. The trend in delayed transfers of care varies by unitary authority area. [Appendix 11](#) shows that between 2005-06 and 2010-11, the number of lost bed days and patients experiencing delays has substantially reduced in Cardiff, whilst in the Vale of Glamorgan, with the exception of a peak in 2006-07, the extent of delayed transfers of care in 2010-11 remains similar to that in 2005-06.
65. Following the Wales Audit Office follow through review of delayed transfers of care in Cardiff and Vale of Glamorgan, reported in 2009, the UHB has implemented a range of initiatives to improve discharge planning and processes:
- The introduction of a Choice policy to support the management of situations where patients awaiting discharge have to choose a care or residential home;
 - A targeted focus, through the patient flow improvement programme, on discharge on planned date and discharges before noon. This is supported by the 'Super Tuesday' initiative which brings together the discussion around medically fit patients scheduled for discharge during the week and the need to get the necessary arrangements in place; and
 - Early discussion around arrangements to increase capacity for ward rounds and discharges at the weekend.

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- 66.** Many of the patients experiencing delayed transfers of care in the UHB however are those requiring complex care packages in the community which are not available through the current capacity levels. Initial plans to develop additional capacity within the community in partnership with the local authorities and the independent sector have not yet come to fruition. These plans have now been overtaken by the UHB's 'Wyn Campaign'⁹ which is discussed further in this report at [paragraph 90](#).
- 67.** A second cohort of patients experiencing delayed transfers of care are those requiring social care packages. Although there are hospital social workers based on the older people wards, many of the hospital wards in the UHB do not have access to this facility and are reliant on timely assessment being undertaken through the general social worker teams. Timely access to social workers is identified as problematic as, on admission, patients' social care packages are ceased resulting in a new assessment to be initiated on discharge. This is often leading to patients experiencing delayed discharges due to lengthy social worker assessments and delays in care packages being put in place to support the patients at home. Delays for Cardiff have also become an increasing problem since 2010-11 when a number of social workers across the local authority area took voluntary redundancy and those posts were not replaced.

The UHB could do more to support GP's to reduce emergency admissions

- 68.** Part of the solution to reducing unnecessary admissions or referrals to major emergency departments involves sharing information with GP practices about their admission and referral 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.
- 69.** The Quality and Outcomes Framework (QOF) includes a range of indicators within the organisational domain of the framework focused on reviewing and comparing data for the practice on emergency department attendances and emergency admissions.

⁹ The Wyn Campaign is a work stream of the Integrated Health and Social Care Programme, aimed at integrating community health and social services in Cardiff and the Vale of Glamorgan, to improve the experience of older people

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- 70.** This data has been provided to all practices across the UHB, and with the support of the Community Directors, has been used to inform discussions across neighbourhoods. The results of our GP practice survey¹⁰ however suggested there is scope to improve the impact of data on emergency admissions provided to each practice as part of the Quality and Outcomes Framework (QOF):
- Just under a half of the practices in the UHB area that responded to our survey (7 out of 18) believed that data on emergency admissions was helpful. Across Wales, 38 per cent of practices felt the data was helpful;
 - Seven of the 18 respondents felt the data was actually used by the practice whilst only three practices agreed or strongly agreed that the data would lead to changes in the way practices provide services; and
 - Five practices believed that the data would lead to improvements in patient care.
- 71.** One of the concerns raised to us during our fieldwork was the ability for the information systems to disentangle attendances and admissions at a practice and doctor level. The information also did not reflect decisions for emergency admissions made by consultants on behalf of the GPs or whether admissions were made out of hours. Clarity around these aspects of the data were required with NHS Wales Information Service (NWIS) to fulfil the commitments of the QOF for 2012-13, although it is unclear as yet whether this has been addressed.
- 72.** All practice managers reported that practices were notified when their patients access the emergency department, with GPs able to access information through the clinical portal. Across Wales, a high proportion (84 per cent) of practices reported being notified. Seven of the 18 practices responding to our survey reported undertaking any work to identify patients who repeatedly attended the emergency department or other unscheduled care service.

¹⁰ In November 2011, we e-mailed a questionnaire survey to general practice managers at 498 GP practices in Wales. Practice managers were asked to complete the survey on behalf of the practice. The overall response rate across Wales was poor with only 26 per cent of practices responding. At the UHB, 18 of the 67 practices surveyed (27 per cent) responded, despite encouragement from the UHB to do so. While unlikely to be representative of all Cardiff and Vale of Glamorgan practices, we have used these responses to illustrate particular issues.

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- 73.** Minimising unnecessary admissions will not be possible if GPs are not aware of, or do not have access to an adequate range of support services such as rapid diagnostics, access to consultant advice and hot clinics. Our practice survey showed that:
- only five practices out of the 18 responding perceived that they had good access to either telephone or e-mail advice from consultants (or other specialists) to help manage a patient's acute condition and avoid an emergency admission/hospital attendance or emergency department attendance when appropriate;
 - eight practices out of the 18 responding perceived they had good access to 'rapid access clinics' or 'hot clinics';
 - seven practices said they had good access to diagnostic services;
 - seven practices perceived that they could refer patients to a good range of community services to avoid emergency admissions/hospital attendances and emergency department attendances when appropriate; and
 - only five out of 18 practices (28 per cent) agreed or strongly agreed that they had enough information about the range of community services available to prevent avoidable admissions. This compares with 42 per cent across Wales.
- 74.** Discussions around the need to extend the range of rapid access clinics and widening the availability of some diagnostic tests had taken place, but funding and a lack of prioritisation had been identified as being problematic by clinicians.

The UHB has made positive progress in expanding the range of community services although more needs to be done to reduce reliance on the acute sector

The range of chronic condition services available within the community has increased, although more needs to be done to further embed risk stratification and make greater use of enhanced services and community hospital beds

- 75.** Our previous audit work highlighted the fact that community services were often fragmented and poorly co-ordinated with many services unavailable 24 hours a day. We found that patients who were at risk of readmission to hospital were not consistently identified or offered adequate support to reduce that risk. In addition, health and social care professionals reported a lack of information about what services were available to care for and support individuals in the community as alternatives to hospital referral or admission.
- 76.** The Welsh Government's CCM model and framework signalled the need to rebalance services on a whole-system basis meaning relocating care and treatment closer to home. It identifies four levels of care, ranging from primary prevention through to complex case management, to ensure support is targeted and effectively co-ordinated, according to individuals' risk and care needs.

Risk stratification has not been fully embedded

77. Delivery of the proposed model relies on health boards identifying the needs of their communities and to 'stratify' practice populations according to levels of risk. Those individuals identified at greatest risk of unplanned admissions should be actively managed to ensure they receive the right care in the most appropriate place.
78. In 2009, the NHS Wales Informatics Service (NWIS) developed a software tool that provided GP practices with a list of patients ranked according to their percentage likelihood of emergency admission to hospital within the next 12 months, referred to as the PRISM (Predictive Risk Stratification Model) tool.
79. Initially piloted in a number of GP practices, the PRISM tool was intended to be rolled out to all GP practices across Wales. The PRISM tool has been rolled out across 43 of the 70 practices in the Cardiff and Vale of Glamorgan localities. Delays in the national rollout has meant that there are no firm dates to rollout PRISM to the remaining practices as yet, preventing the UHB from undertaking a full chronic condition patient risk stratification. Delays in the national programme has also meant that some of the practices that have PRISM have lost interest in using the system with the exception of those who have access to a clinical case manager.
80. Following the allocation of transitional funding in 2008, the UHB appointed six clinical case managers covering ten practices across the Cardiff localities. Three frailty nurses were also appointed to the Integrated Care Teams in the Vale of Glamorgan who acted as clinical case managers. Using PRISM, the clinical case managers identify patients who are at medium to high risk and examine what services could be put in place to support these patients and where possible prevent any unplanned admissions. A review of district nurses being undertaken at the time of our fieldwork was identified as an opportunity to expand the level of case managers across the UHB. This has since been taken forward through the first phase of the UHB's 'Wyn Campaign' with a proposal to increase the number of clinical case managers by ten.
81. GPs are generally aware of those patients at risk of admission but raised concerns around the potential of the risk stratification process identifying patients who require services which are not currently available or have limited capacity. This was identified particularly for those patients at low risk who could benefit from self-management support which is not always available. Without that support those patients could place unnecessary demand on primary and secondary care services or be left unmanaged. GPs have some awareness of patients who are frequent attenders to hospital although our work identified that this could be improved. Staff identified that they would welcome a system which flagged up patients who were repeat attenders to hospital.
82. Risk stratification should be used to develop services to meet the needs of the population. Until risk stratification is fully embedded across the UHB, it will be difficult to gain a full understanding of the extent to which services are required.

Through the use of additional funding, improvements have been made in the range of chronic condition services to maintain patients in the community and facilitate early discharge although limitations still exist particularly around the extent to which services are available

- 83.** When we last reported on chronic conditions in 2008, we identified that whilst some services had been developed to support patients with chronic conditions there was scope for significant further development of community focused services. In 2008, the Welsh Government made £15 million of transitional funding available to NHS bodies in 2008-09, 2009-10 and 2010-11. The funding was intended to support NHS bodies in achieving more sustainable, effective and efficient health and social care services, through better planning and integration of services and resources, strengthened community-based services and a shift in the balance of care between hospital and community settings.
- 84.** The UHB and its predecessor bodies received a total of £1.52 million in transitional funding over the three years. This funding was used, alongside the wider reconfiguration of services as a result of NHS reorganisation, to help further implement the chronic conditions integrated model and framework in a number of ways. Many of the services established have been mainstreamed since the transitional funding ceased, which included:
- The establishment of the locality and neighbourhood structures supported by the appointment of nine community directors, and a number of cross system community directors focusing on such aspects as heart disease and diabetes;
 - The appointment of six (4.6 whole time equivalent) clinical case managers covering ten practices in the Cardiff localities and the development of the Integrated Care Teams across the three neighbourhoods within the Vale of Glamorgan locality to provide case management of the complex frail elderly;
 - The establishment of the Cardiff East Locality Team (CELT) to provide multidisciplinary intervention to patients who are suitable for discharge from hospital with additional support, and to provide an alternative to hospital admission for some GP practices;
 - The extension of the district nursing service to provide full support seven days a week, 24 hours a day;
 - The expansion of the Elderly Care Assessment Service (ECAS) to cover both the Cardiff and Vale of Glamorgan localities. Previously only available across Cardiff, this service was expanded to cover the Vale of Glamorgan localities in January 2011. The service aims to provide a rapid-access assessment for people who are at risk of deteriorating, or who are deteriorating, who could benefit from multidisciplinary intervention and prevent a hospital admission. The service in the Vale of Glamorgan however is currently only available three days a week and draws on resources from within the day hospital at Barry hospital;

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- The development of a fracture liaison service supported by a falls pathway. The service focuses on patients experiencing a low risk trauma fracture who are at risk of further, more significant, fractures. Patients are screened for osteoporosis and, where indicated, offered a bone scan. Patients are then referred back to the GP for management within primary care. The new falls pathway supports patients who suffer with a fall, or are at high risk of falls to access services to provide rehabilitation and prevent falls in the future. Professionals, including paramedics are able to refer patients onto the pathway;
 - The introduction of an end of life pathway, although we were told that the pathway is initiated too late;
 - The pilot of a community based Chronic Obstructive Pulmonary Disease (COPD) service which saw a Consultant Respiratory Physician hold joint clinics within primary care with the GP and practice nurse to manage complex COPD patients. This pilot has since ended;
 - The expansion of the stroke outreach service to cover the Vale of Glamorgan localities in order to support timely discharge from hospital across the whole of the UHB.
- 85.** The UHB also continues to provide the Acute Response team which aims to prevent hospital admission, or expedite transfer home for medically stable patients who are deemed safe to be at home without 24 hour supervision. The service continues to be available 24 hours a day and supports referrals direct from the emergency department. In partnership with the local authorities through Section 33 arrangements, the UHB also continues to provide community based Reablement and Rehabilitation services across the UHB localities.
- 86.** Services to support the management of chronic conditions across Cardiff and Vale of Glamorgan are now available to a wider population than those that were previously in place in 2008. Access to the services can be made from a wider range of professionals, as well as patients and carers, and most services can be accessed relatively quickly. Protocols are in place for referrals and all services facilitate early discharge from hospital and to some extent support admission avoidance. Funding for these services has also been continued following the end of the period of transition funding with all services now mainstreamed into the wider delivery of services for chronic conditions management.
- 87.** However, many services are only provided during normal weekday hours and are time limited generally for a period of up to six weeks. Staffing levels within each of the services can also mean that there are limitations to the service either in terms of the catchment area that the service covers or the extent to which the service can provide a full range of intervention. Although some services are UHB wide, others have been established on a locality or neighbourhood basis and this can mean that the way in which services are provided can vary slightly.

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- 88.** In addition to the transitional funding, the UHB also received an additional £159,000 as a demonstrator¹¹ site. As well as supporting the implementation of PRISM, this funding was used to support two key service developments:
- Shifting the focus of the management of patients with diabetes from secondary care, to a community based model. This included the development of a diabetic pathway, the establishment of outreach clinics run by the consultants within the primary care setting, the realignment of diabetic specialist nurses to localities and the strengthening of the support mechanism for GPs. This included providing clinical support to practice nurses and direct access to consultants for advice. This work focused solely on one neighbourhood area within the Cardiff localities.
 - The development of an Epilepsy Nurse Led Assessment service initially focusing on patients experiencing a first seizure. This is supported by the development of an epilepsy pathway which triggers direct access to the team on presentation within the emergency department, as well as direct access by other professionals including GPs and paramedics. This work has subsequently focused on epilepsy in pregnant women, and the management of patients with epilepsy who are admitted.
- 89.** It is positive to see that the work around the management of epilepsy has been mainstreamed into wider service delivery. The establishment of diabetic outreach clinics within the primary care setting however has not been sustained following the ceasing of the additional funding, although the wider work around diabetic management including the clinical support provided to the primary care practitioners within the pilot area continues.
- 90.** In 2012, the UHB secured Invest to Save funding from the Welsh Government of £3.2 million (£0.8 million of which is to be received during 2013-14) to support the first phase of the Wyn Campaign. The campaign is aimed at integrating community health and social services in Cardiff and the Vale of Glamorgan to improve the experience of older people across the catchment area. The principle objective of the campaign is to design services around people and throughout the development test out *'what would Wyn want to regain and retain independence?'* based on three different scenarios:
- With no additional needs (universal services);
 - With additional needs (targeted intervention); and
 - With complex needs (longer-term care).

¹¹ To help deliver and drive improvements across Wales in relation to Chronic Condition Management, three National Service Improvement Demonstrator Projects were established with an aim to: 'Provide and test a sustainable, affordable generic CCM service model, that supports people's needs locally and promotes independent living within the community in order to communicate and inform service change across Wales'

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91. Phase 1 aimed to strengthen the services in place to support scenarios 1 and 2, and it is through this that additional capacity to support the services identified in [paragraph 84](#) is being taken forward.

The level of hospital beds to support step up from the community is minimal

92. Our previous work on chronic conditions found that the role of community hospitals in helping to manage chronic conditions was unclear. Community hospitals were typically not used to prevent or divert acute hospital admissions or to facilitate early discharge home for patients with chronic conditions. This will become increasingly harder at the UHB as the number of community hospital beds shrinks.
93. Data published by the Welsh Government show that across Wales the average number of daily-staffed beds reduced 5.5 per cent between 2009-10 and 2010-11. Across Cardiff and Vale of Glamorgan hospitals, the reduction was four per cent with a large proportion of the reductions seen across the acute hospitals.
94. [Exhibit 16](#) shows the way in which community hospital beds across the UHB area were used at the time of our audit, excluding those dedicated to mental health services and specialist services such as neurosciences. Just over half were used for elderly care while the other half were for rehabilitation. Twenty per cent of the beds were available for GP admissions; however only GPs based in the Vale of Glamorgan localities could access these ([Exhibit 17](#)).

Exhibit 16: Profile of community hospital beds across the UHB in November 2011

Type of community hospital bed	2011
Elderly care	137
Generic rehabilitation	43
Orthopaedic rehabilitation	30
Stroke rehabilitation	24
Palliative care	0
Respite care	0
Other types of beds	0
Total	234

Source: Wales Audit Office analysis of information provided by the UHB for Barry Hospital, Rookwood Hospital, Cardiff Royal Infirmary and St David's Hospital

Exhibit 17: Proportion of community hospital beds available for GP admissions in November 2011

Health Board	Percentage of beds available for GP admissions (%)
Abertawe Bro Morgannwg	0
Aneurin Bevan	5.2
Betsi Cadwaladr	42.3
Cardiff and Vale	20
Cwm Taf	0
Hywel Dda	77.4
Powys	46.3
Wales	22.2

Source: Wales Audit Office analysis of information provided by Health Boards in November 2011

Despite a range of enhanced services in place, the use of primary care contracts to support patients with chronic conditions and unscheduled care needs remains limited

95. Historically, the use of primary care contracts in creating capacity to care and support patients in the right place has been limited. In our previous work we made no reference to the use of enhanced services to support the management of chronic conditions and demand for unscheduled care services. In 2011-12, the UHB reported having twelve enhanced services in place, although it recognised that the enhanced services in place were largely historic. Of those in place, a number support the broader management of chronic conditions and demand for unscheduled care services, although only one enhanced service is focused on managing a specific chronic condition:
- The UHB has further developed the directed enhanced service for diabetic care and built it into the programme of local enhanced services. Sixty three of the 67 practices provide the simple form of the enhanced service, with 34 practices providing the advanced service;
 - Sixty-one practices provide a local enhanced service for wound care and minor injuries to prevent unnecessary visits to the Minor Injuries Unit and the Emergency Department;
 - Twenty-nine practices have taken up the first UK registration enhanced service to support patients moving in to the UK. Without GP registration these patients could place unnecessary demand on the Emergency Department should they need to access unscheduled care services; and

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- Eighteen practices have taken up the care/nursing home enhanced service which supports the management of patients placed in homes preventing unnecessary admissions to hospital.
- 96.** The total expenditure for enhanced services in 2011-12 was in the region of £5.08 million. This accounts for 8.4 per cent of the total expenditure on general medical services, and less than 2.5 per cent of the total expenditure on primary care services. This is comparable across Wales. We were told that the monies allocated to enhanced services had been fully utilised with very little opportunity to further develop enhanced services without replacing services that already exist.

The formation of CRTs represents an important step forward but the teams are at variable degrees of maturity and there is still more to do to shift the focus to admission avoidance

- 97.** *Setting the Direction* and the CCM model and framework both advocate the need for an integrated multidisciplinary team that focuses on co-ordinating community services across geographical localities for individuals with complex health and social care needs. These Community Resource Teams (CRTs) will target care and support to help individuals identified at greatest risk of hospital admission to maintain independence in their own communities.
- 98.** The UHB has developed the CRT's using the existing community based teams (outlined in [paragraph 84](#)) as a basis. Phase one of the CRT's were introduced across the localities between November 2011 and January 2012 with an initial focus on pulling patients out from hospital. Additional resources, in the region of £450,000, were made available through capacity planning monies to ensure that the teams in each of the locality areas provided sufficient geographical coverage initially:
- In Cardiff South and East, additional staff were made available to CELT to provide service coverage to the south of the locality, forming the basis of a CRT for this locality. The team is medically led, with input from both hospital consultants and GPs. The team also includes input from social services although there were concerns raised at the time of fieldwork that the 1.00 whole time equivalent social worker assigned to the team would be lost in the immediate future. The initial focus of the CRT in this locality was on supporting early discharge, although there continues to be an element of step up provided to a small cohort of GP practices as was the case with the original CELT service.
 - In Cardiff North and West, the existing Reablement services were co-located and expanded to provide the basis of a CRT for the locality, given that there had previously been no services in the North area. This team was predominantly a therapeutic and domiciliary service consisting solely of therapy professions, home care staff and voluntary sector input.

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- In Vale of Glamorgan, the three Integrated Care Teams and the rehabilitation service came together to form the basis of a Community Resource Service (CRS) for this locality. The service included the frailty nurses identified earlier in [paragraph 80](#) alongside input from GPs, a range of therapy professions and home care staff.
- 99.** The next phase of the CRTs is still to be worked through. Plans are in place to further expand the capacity of the CRTs through recruitment to effectively deliver on pulling patients out of hospital within three days and to extend the remit of all of the teams to include a step up service and avoid admissions from the community. Funding to support these plans is through the £3.2 million received by the UHB in relation to the *Wyn Campaign*, and recruitment steps have been put in place although delays in recruitment processes has meant that the additional capacity is only just starting to filter through to support the delivery of this next phase.
- 100.** Given that each of the CRTs were starting from a different basis, an operational policy was introduced for the teams in July 2012 which developed a level of consistency in the way in which the teams operated. Consistent referral forms and governance structures for each of the teams were also adopted.
- 101.** The CRTs have started to provide the interface between primary and secondary care services and the visibility of the services across the localities is well recognised by GP practitioners. The opportunities that the CRTs present are also being recognised with a recent pilot in place which brought pharmacy input into the CRT as a way of improving medicines management processes for patients in the community. However, like many of the other community services that the UHB provides, the CRTs remain an in-hours service provided only five days a week. If the CRTs are to have a full impact on admission avoidance, the UHB needs to consider extending the availability of the CRTs as part of its forward planning.

Access to both in-hours and out-of-hours primary care is generally good although there is some variation across practices and the out-of-hours service could benefit from the full roll-out of the integrated health record

Access to primary care is generally good with some positive action being taken to make improvements although variation in performance across practices suggests more focused attention is needed

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

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- 103.** In a 2009 report supported by the Royal College of General Practitioners and the British Medical Association's General Practitioners' Committee, the Primary Care Foundation highlighted a wide range of issues for practices to consider that have the potential to free up capacity within their core hours¹² and have resulting benefits for patient access. Only one practice of the 18 practices in Cardiff and Vale of Glamorgan who responded to our survey was aware of the report. However, the Primary Care Foundation report¹³ had not been used in any way to review arrangements for providing urgent access in this practice. Across Wales, 13 per cent of practices had used the report.
- 104.** The UHB has 67 primary care practices, providing services across 93 surgery locations. The Welsh GP Access Survey undertaken by the UHB in May 2011 identified that 13 of the 67 practices had half day closing. The UHB has adopted the Aneurin Bevan Health Board Access Accreditation Scheme which brings together a targeted approach to improving access to primary care service by focusing on the achievement of two standards over time:
- Standard 1 – No practices closing half day.
 - Standard 2 – No practices closing two or more hours before 6:30 one day per week.
- 105.** As well as the 13 practices identified in relation to closing half day, the work undertaken by the UHB also identified five practices closing two or more hours before 6:30 one day per week. The UHB, through its primary care team, has worked with practices to reduce the number with half day closing, with 11 of the 13 practices opening fully from April 2012, and the remaining two practices also now opening fully. Two of the five practices closing two or more hours before 6:30 one day per week also committed to opening fully from April 2012. Work continued with the other practices to find solutions to increasing opening hours and the remaining three practices are also now opening fully. Two practices across the Vale of Glamorgan have taken up the enhanced service for extended hours, offering early morning appointments in one practice and late evening appointments in the other.
- 106.** The Welsh GP Access Survey 2011 also provided a patient perspective in relation to urgent access to primary care. The survey asked patients whether they were able to access urgent primary care appointments within 24 hours. [Appendix 12](#) shows that there is a marginal difference between Cardiff and the Vale of Glamorgan, with overall 81 per cent of patients reporting that they were able to do so. This was just above the Welsh average of 80 per cent and an improvement on the performance reported in the 2010 survey which reported 79 per cent.

¹² Core hours are defined as being from 8am through to 6.30pm.

¹³ Primary Care Foundation, Breaking the mould without breaking the system: new ideas and resources for clinical commissioners on the journey towards 24/7 integrated urgent care, November 2011.

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- 107.** Urgent access performance varies across the practices, with some practices achieving over 90 per cent. However whilst many practices achieved between 70 and 90 per cent, the performance of a number of practices was lower with two practices only achieving 45 and 54 per cent respectively. The practice performing at 45 per cent had marginally improved since 2010; however the practice performing at 54 per cent had significantly deteriorated since 2010 when performance was reported to be 77 per cent.
- 108.** The findings of the Welsh GP Access Survey are a fundamental part of the programme of work undertaken by the primary care team to support GP practices in the development of their services. The findings of our practice survey suggest that in the main this has worked well, with 10 of the 18 practices who responded to our survey reporting that they had used the Welsh GP Access Survey to review access issues, as well as review issues around same day and urgent access. As a result, some changes had been made to improve access including introducing triage systems, increasing the number and type of appointments available and increasing the telephone capacity.
- 109.** Analysis of other primary care access indicators indicates that generally patients across Cardiff and Vale of Glamorgan are able to access services when they need to, with:
- 68 per cent of patients able to access an appointment with a GP or healthcare professional more than two full days in advance, compared to the Welsh average of 69 per cent;
 - 79 per cent of patients reported that it was 'very easy' or 'fairly easy' to get through to the practice on the phone, compared to the Welsh average of 80 per cent; and
 - 83 per cent of patients reported that it was 'very easy' or 'fairly easy' to book an appointment, compared to the Welsh average of 84 per cent.
- 110.** When reviewing the indicators at a practice level, there are a number of outlier practices. The UHB needs to be assured that performance within these practices, particularly around ease of access, is not resulting in patients diverting to other services inappropriately.
- 111.** Practices will struggle to meet access needs if they haven't sought patients' views. Our survey of GP practices found that 14 out of the 18 practices (78 per cent) had sought patients' views about how to improve access to same day care. This compares well with the picture across Wales, with 59 per cent of practices reported to have sought patients' views.

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- 112.** The receptionist is the first point of call for a patient in a GP practice. Nine out of the 18 practices (50 per cent) responding to our survey identified that they have formal protocols in place to deal with requests for appointments (compared with 55 per cent across Wales). Receptionists in 14 of the practices receive training on induction, and 12 subsequently received refresher training on identifying urgent and emergency calls. Over the last two years, seven practices had reviewed receptionists' effectiveness in identifying emergency/urgent calls and as a consequence some practices have trained their receptionists to ask patients specific questions to aid the prioritisation process.
- 113.** Reviewing the practice's pattern of telephone calls can provide an insight about the level of demand and whether the practice is geared up to this demand. Only 6 practices (38 per cent) have reviewed the pattern of telephone calls received from patients. The performance across Wales was 41 per cent. The survey suggested there was also scope to utilise appointments more effectively. Respondents estimated that on average seven per cent of GP consultations are used for patients with non-clinical needs (ie, they see a doctor to ask for an insurance form to be signed). Respondents also estimated that an average of 11.5 per cent of patients did not attend their appointment.
- 114.** Previously one of the issues faced by the UHB in relation to access to primary care was the extent to which practices had full lists and patients were unable to register. This has since been resolved through such initiatives as the enhanced services for student registration. A further issue had been the demand placed on services from asylum seekers and the homeless. In July 2011, the UHB took over the management of the Cardiff Health Access Project which provides initial health provision to new asylum seekers arriving in Cardiff. One of the objectives of the project is to ensure that all asylum seekers have access to primary care services which helps to minimise inappropriate attendance to emergency departments. This is supported by an enhanced service for first UK registrations, as discussed earlier, as well as an enhanced service for the homeless.
- 115.** In October 2011, the UHB introduced a GP screening pilot initiative to assess and screen ambulant patients who present at the emergency department and re-direct patients to the most appropriate setting. This scheme was only available during normal working hours and aimed to provide some indication of whether primary care patients were inappropriately attending the emergency department. Early findings from the pilot suggested that few patients were attending the emergency department inappropriately, with an average of one to two patients being re-referred back to their GP an hour. The annual report for primary care for 2011-12 reported that 400 patients had been redirected between October and December 2011. This pilot ceased after a formal evaluation of the scheme was completed.

The standardisation of out-of-hours primary care services is a positive step and the service appears to be functioning well although delays in the national rollout of the Integrated Health Record are impacting on its full potential

- 116.** 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.
- 117.** In Cardiff and Vale of Glamorgan, the out-of-hours service is now provided in-house. The service provided in Vale of Glamorgan was repatriated to the UHB in April 2011, with the service for Cardiff following at the end of September 2011. Previously the services had been provided by Primecare¹⁴ for Vale of Glamorgan, and Cwm Taf Health Board. Triage is undertaken through the communications hub (referred to later in [paragraph 135](#)). Patients who require a consultation are then referred to the treatment centres in the Cardiff Royal Infirmary, Barry Hospital and UHW where they will either be required to attend the centre or will receive a home visit from the out-of-hours GP. Consultation for patients registered with the western Vale of Glamorgan practices are provided through Abertawe Bro Morgannwg (ABM) University Health Board.
- 118.** The Welsh Government's *Ten High Impact Steps to Transform Unscheduled Care* states that primary care out-of-hours units should ideally be 'functionally integrated within emergency departments'. This means the unit and the emergency department should have a common reception and common operational processes.
- 119.** The treatment centre at UHW is based within the emergency department although the two entities are run separately. Patients who attend the emergency department inappropriately with primary care needs out-of-hours are required to be referred to the service. The out-of-hours service takes on average 300 referrals from the emergency department per month. This is a positive redirection of patients to a service that more suits their needs, whilst intelligently managing down the demand in the emergency department.
- 120.** The out-of-hours service is increasingly becoming resourced by the UHB's own GPs which means that there is continuity for both patients and other professionals working with the service. Staff who previously worked with the service in Cwm Taf Health Board were transferred over when services were repatriated. A number of recruitment campaigns run by the UHB at the time of the services transferring also positively attracted a number of UHB GPs. However we were told that on occasions GPs can pull out of shifts at short notice which can place pressure on the service. We were also told that due to home visits, the resources within the out-of-hours service at certain times can also become depleted and cause long waits for patients.

¹⁴ Primecare is an independent company providing GP out-of-hours services.

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121. **Appendix 13** shows that in 2010-11, the UHB spent just over six per cent of its GMS expenditure on the out-of-hours service. This is below the Welsh average of 7.24 per cent and the second lowest in Wales equating to some £3.78 million. The average spend on the out-of-hours service is the lowest in Wales at £7.71 per registered patient, a level which has remained relatively static since 2005-06.
122. The findings of our survey suggests that GPs are satisfied with the service provided, with 14 out of the 18 practices (78 per cent) rating the out-of-hours service as 'very good' or 'good'. This was marginally higher than the picture across Wales of 76 per cent. Twelve out of the 18 practices (67 per cent) also reported receiving information about patients who frequently access the out-of-hours service, compared to 62 per cent across Wales.
123. Since the transfer of services, the performance data provided as part of this review also suggests that the out-of-hours service performs well. Ninety five per cent of calls were reported to have been answered within 60 seconds and all patients received telephone advice within one hour. However this information related only to the Vale of Glamorgan service following initial transfer in April 2011. The primary care annual report for 2011-12 provided further information and stated that:
- 45 per cent of patients saw a doctor within one of the treatment centres. This is in line with our previous review of *Unscheduled Care* which considered data from 2007-08 and showed the average across Wales at that time was 47 per cent; and
 - 23 per cent of patients in Vale of Glamorgan and 30 per cent of patients in Cardiff received over the phone advice from a doctor or nurse. This compared to 38 per cent across Wales reported in our previous review of *Unscheduled Care*.
124. More generally, performance data relating to the out-of-hours service in the UHB is not routinely reported to the Board. The UHB should consider providing some key performance indicators as part of its overall monitoring of unscheduled care services.
125. Better integrated working between the acute hospital and primary care could be facilitated through faster and wider roll out of the Individual Health Record (IHR). The IHR allows a summary of the patients' GP records to be made available electronically to other unscheduled care services. The IHR is seen as important for improving the safety of out-of-hours consultations, as well as speeding up decision-making. For example, if a patient presents with an exacerbation of their chronic condition, the out-of-hours GP will see what treatment was initiated the last time. Across Wales, just over half of GP practices are using the IHR covering nearly half the registered patients (**Exhibit 18**). As at October 2011, only 55 per cent of the UHB's practices were using IHR. These practices are all Cardiff based practices and are as a result of the early rollout of IHR in Cwm Taf Health Board whilst providing the out-of-hours services for Cardiff.

Exhibit 18: Extent of the roll out of the Integrated Health Record (IHR) at October 2011

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

Source: NWIS Programme Update, October 2011

Positive steps have been made in changing the way that the public uses services and improving the concept of self-care

The UHB has made a good attempt at improving public understanding on the use of unscheduled care services but the work has been hamstrung by a lack of resources

126. Our 2009 report on *Unscheduled Care* noted that as a consequence of the complexity of the system of health and social care, the public can be uncertain about how and where to seek help. Part of this uncertainty stems from the wide range of different access points within the system. For example, a person suffering a minor injury may have a choice of attending an emergency department or minor injury unit, going to see their GP, phoning NHS Direct Wales or caring for themselves. People face further uncertainty because of the variation in services that are available at different times of the day and night, and at weekends, in different areas of Wales.
127. 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 the Welsh Government launched the national 'Choose Well' campaign in March 2011 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*'.

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- 128.** The 'Choose Well' campaign is considered by the UHB to be a key component in managing demand for services and following the launch of the national campaign, links were made available on the UHB's internet and intranet site in line with all other health boards across Wales. The UHB however recognises that more could be done to promote the campaign.
- 129.** The campaign is predominantly led by the UHB's communications team who have very limited resources to dedicate to the programme. Despite this the UHB have made a number of positive steps to improve the public's awareness of unscheduled care services:
- Used the UHB's media attention as an opportunity to promote the 'Choose Well' campaign with a number of TV and radio discussions focused on the need for the public to understand the options available to them;
 - Promoted the campaign through a 'back of bus' advertisement supported by the local transport network;
 - Recognised the opportunity of the neighbourhood structures and linked into ethnic groups to promote the campaign through community newsletters; and
 - Issued posters to all GP practices within the UHB although a lack of resources from the communications team meant that these were issued electronically and reliant on practices to print and display them.
- 130.** While the national campaign focuses predominantly on the winter pressures faced by the NHS, the UHB recognises that the campaign needs to be all year round. The UHB also recognises the need to look at different mechanisms for communicating to different audiences. Although the campaign is promoted on the UHB's website, it is felt that the website itself is not interactive enough to encourage the public to use it. In November 2011, the UHB's website received 16,000 hits. The majority of these hits were related to ward opening times and local health services, such as GP practices and dentists.
- 131.** The communications team are keen to use modern day technology such as Twitter and Facebook to target specific audiences, although IT security prevents these being used to their full effect. Despite this, the UHB does have both a Facebook and Twitter account which are proving popular with the public. Work has also taken place to look at the potential of a local smart phone application which was being shared with other communication teams across Wales. The communications team are also looking at mechanisms to tap into existing initiatives in order to reach specific groups, for example, educational programmes in schools and work being undertaken on frequent attenders to the emergency department.

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- 132.** The Primary Care Foundation's 2011 report on unscheduled care commissioning also highlighted the importance of providing information to the public about how to use the care system, at the point at which they access care. The report states '*For the message about how to use health services to get across, it needs reiterating consistently as a routine part of the consultation in all urgent care services over many years*'. At a patient level, our work has found that this is supported in the UHB through such examples as:
- The development of the communications hub as a central point for accessing a range of services which supports the ability of staff to direct the patient to the most appropriate service;
 - The GP screening service in the emergency department which supports the redirection of patients who do not require the services of the department; and
 - The introduction of pathways, already discussed in [paragraph 49](#), which allow professionals to redirect patients appropriately, including the development of a pathway which allows paramedics to redirect patients to the Barry Minor Injuries unit.
- 133.** During our fieldwork we visited the UHW's emergency department and reviewed the layout of the department and the information available to the patient. Interestingly we found very little reference to signposting information aimed to reduce inappropriate demand on the emergency department, with the exception of a small poster entitled 'Pointing you into the right direction'. The UHB should consider the level of signposting within the emergency department to promote appropriate access at the point in which patients access the services.

The UHB has made good progress in establishing a communications hub which provides a single point of access to a broad range of services

- 134.** 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.
- 135.** In April 2011, the UHB established a communications hub based in the leisure centre in Barry. Developed in partnership with the Vale of Glamorgan local authority, £2.2 million was invested in 2011-12 through efficiency savings to establish a hub which provides a single point of contact for both patients and professionals to a range of services. As well as signposting to services identified through an up-to-date service directory and transferring calls where appropriate, the hub handles calls, takes referrals and schedules appointments for a broad range of services ([Exhibit 19](#)).

Exhibit 19: Scope of the Communications Hub

Service	Handle Calls	Take Referrals	Schedule appointments
Social services (Vale)	✓	✓	
Other local authority services	✓		
GP surgeries	✓	✓	✓
Community resource teams	✓	✓	✓
Community teams	✓	✓	✓
GP out-of-hours service	✓	✓	✓
District nursing services	✓	✓	✓
Dental services	✓	✓	✓
Voluntary sector	✓	✓	
Minor injuries unit	✓		✓

Source: Wales Audit Office 2012

- 136.** The hub is available 24 hours per day, seven days a week and consists of 137 whole time equivalent (WTE) staff. The establishment includes 76 clinical staff, 33 support staff including receptionists and drivers, and 24 call handlers. At the point the hub was established, the call handlers for the local authority services were separate to those for NHS provider services. The UHB, in partnership with the local authority, has worked to bring the call handlers together as a single team to support overnight call handling and make greater use of the resources available. The hub is overseen by two managers, one of whom is focusing on developing integrated ways of working, supported by two team leaders.
- 137.** The development of the communications hub has been a positive one and the UHB is exploring opportunities to further expand on the achievements to date. Consideration was being made around the potential to bring in the clinical referral centre, the route for all elective referrals into the UHB and other services such as the estates department. Since our fieldwork, we understand that the estates helpline has now become an integral part of the communications hub. Other areas include the potential to route emergency 999 calls through the hub although national discussions around the '111' campaign and NHS Direct would influence how this could be achieved locally.

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- 138.** The communications hub is overseen by a steering group to monitor its development and ensure that any proposed expansion to the range of services fits within the wider service developments for the UHB and resources are allocated appropriately. Since the establishment of the hub, the UHB has seen a marked improvement in the out-of-hours service. Calls are all handled consistently regardless of the service that is being requested using the Aadastra software and management has better oversight of the total capacity available to deliver this front-end service. However very little information is available to demonstrate the true impact of the communications hub on the delivery of services. The UHB should look to develop a range of outcome measures for the communication hub which could include:
- the extent to which professional time has been released;
 - patient/user satisfaction of the service;
 - the number of appropriate calls closed by call handler; and
 - the outcome for the patient if the hub had not intervened.
- 139.** The communications hub is also reliant on having an up-to-date directory of services available. At the time of our fieldwork this was reported to have been done through a national project, however this had ceased and concern was raised as to how the service directory would be maintained going forward. The UHB needs to ensure that an appropriate mechanism is put in place to make sure that the service does not become less effective over time by having out-of-date information.

Increasing participation in self-management courses could further strengthen the positive developments that have been made around the self-care agenda

- 140.** It is essential that individuals are encouraged and supported in looking after their own health and well-being. Our 2008 report on *Chronic Conditions* found that the provision of patient education to support self-care was insufficient given the high prevalence of chronic conditions and a growing population of older people. Self-care is associated with positive outcomes for individuals, such as improved knowledge of their condition and better coping behaviours. Other benefits include reduced reliance on healthcare services, which help to sustain services long-term. The Welsh Government's framework for self-care¹⁵ describes a continuum of self-care starting with healthy living, self-care of minor ailments with or without the support of professionals, like GPs or pharmacists, to more formal help in managing complex health problems.

¹⁵ Welsh Government, *Improving Health and Wellbeing in Wales, A Framework for Supported Self-care*, October 2009

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- 141.** There are four key elements of self-care support covering this continuum. These are:
- information and signposting;
 - skills training for patients and professionals;
 - peer support networks; and
 - assistive technologies, like telehealth and telecare.
- 142.** Both the Cardiff and the Vale of Glamorgan strategic plans^{16,17}, which set out the approach to jointly planning and delivering public services across the two authorities, include a key outcome for the local population to be well and healthy. To achieve this outcome, the UHB has committed to implement the key actions identified within *Our Healthy Future* including the production of an annual report that demonstrates the health needs of the population of Cardiff and the Vale of Glamorgan, and progress made against each of the priorities within it. The UHB's public health team, in its strategic framework for 2011-12, set out the actions that need to be taken to deliver the priorities which include increasing physical activity rates and reducing unhealthy eating. This includes such activities as emphasising the importance of self-care and promoting both physical and mental wellbeing.
- 143.** Enabling patients to self-manage chronic conditions is a key component of effective care and improved patient outcomes. It is well recognised that self-management education programmes, bringing together patients with a variety of chronic conditions, can improve clinical outcomes and reduce costs. Expert patients are defined as people living with a long-term health condition who are able to take more control over their health by understanding and managing their conditions, leading to an improved quality of life. In particular they make fewer visits to the doctor, communicate better with health professionals, take less time off work, and are less likely to suffer acute episodes requiring admission to hospital.
- 144.** Education programmes for patients (EPP) is a national generic self-management programme, supporting people with long-term conditions and those caring for someone with a long-term condition. The programmes aim to give participants the confidence to look after their own health needs. In a ministerial letter to Chief Executives in 2009, the Minister for Health indicated that health boards should aim to get one per cent of the chronic condition population through EPP courses over the following three to four years. **Exhibit 20** shows the number of Chronic Disease Self-Management Programmes (CDSMP) and Looking After Me (LAM) programmes provided at each health board in Wales during 2010-11.

¹⁶ Cardiff '*What Matters*', 2010:2020 - The 10 year Strategy

¹⁷ Vale of Glamorgan Community Strategy 2011-2021

Exhibit 20: Number of Education Programmes for Patients (and carers)* provided during 2010-11 along with numbers of participants and completion rates

Health Board	Number of courses	Number of participants registered for a course	Percentage of registered participants completing a course (%)**
Abertawe Bro Morgannwg University	24	259	80
Aneurin Bevan	36	512	63
Betsi Cadwaladr University	38	557	57
Cardiff & Vale University	12	188	57
Cwm Taf	10	127	48
Hywel Dda	13	167	75
Powys	7	98	69
Wales	140	1,908	63

*Data relate to both the Chronic Disease Self-Management Programme and the Looking After Me programmes.

**Although participants register for a course, some fail to attend and others drop out before completing the course.

Source: Education Programme for Patients Cymru, Quarter Four Report All Wales Overview

145. The UHB's main focus on education programmes is around the management of diabetes, asthma and COPD. During the period 2010-11, 12 courses were held across the UHB (Exhibit 21), with the majority of courses held in the Cardiff areas. One course was focused on supporting the carers of patients with chronic conditions. More recent data would indicate that the level of courses now available has increased with the national EPP Cymru website offering in the region of 26 courses during 2013.
146. The proportion of patients who go on to complete the EPP course is comparatively low at 57 per cent, with data for the period April 2010 – December 2011 indicating that on average 12 per cent of patients do not attend the course and a further 31 per cent drop out once the course has started. The UHB needs to understand the reason for the completion and did-not-attend rate, with a view to optimising attendance.

Exhibit 21: Quarterly trends in the provision of Education Programmes for Patients* at the UHB between quarter one of 2010-11 and quarter three of 2011-12.

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	2	28	8	7	13
Q2 - 2010-11	2	32	8	8	16
Q3 - 2010-11	4	70	6	23	41
Q4 - 2010-11	4	58	3	17	38
Q1- 2011-12	3	32	1	9	22
Q2 - 2011-12	2	40	8	7	25
Q3 - 2011-12	6	97	9	38	50
Overall total	23	357	43	109	205

*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

147. At the time of our fieldwork, the UHB were piloting EPP on a one-to-one basis up to the end of March 2012. This was being supported by funding through the National Leadership and Innovation Agency for Healthcare (NLIAH). Funding was identified as a barrier to developing a wider programme of education, resulting in only a small number of trainers being available. We understand that the level of trainers now available has improved.

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- 148.** In addition to education programmes, the UHB also support a range of other initiatives to promote health and wellbeing and support patients with self-care. These include:
- A range of groups such as the 'Breathe Easy' group run by the British Lung Foundation;
 - Through the neighbourhood structures, tailored work with the local communities to tackle different aspects of health promotion and self-management of chronic conditions. Examples include the involvement in the Black and Ethnic Fair focusing on chronic conditions prevalent within black and ethnic minorities, and the development of the 'speakers of other languages' initiatives focusing on public services such as health for speakers of other languages (HSOL); and
 - Referrals into such schemes as the National Exercise Referral Scheme (NERS) and other local activity schemes, supported through joint working with local authorities, although we are aware that there is a waiting list for the this scheme.
- 149.** Telecare is a modern day solution to helping to keep people in a lower care group for longer. The idea of telecare is about enabling people to remain independent in their own homes by providing person-centred technologies to support the individual or their carers. In its simplest form, it can refer to a fixed or mobile telephone with a connection to a monitoring centre through which the user can raise an alarm. It is understood that telecare services are in use in all 22 local authorities across Wales. One extension to telecare within the NHS is telehealth which allows the delivery of health services to be provided via telecommunications. One of the most significant increases in telehealth usage is the home monitoring of conditions by patients whose clinical trials in the UK have shown to reduce mortality by around 47 per cent.
- 150.** Through the demonstrator work, the UHB is undertaking a pilot focused on using telehealth to support the management of patients who have frequent hospital admission. Working with the Vale of Glamorgan based clinical case managers, patients are required to provide daily recordings of their vital signs. A combination of these results at certain levels would trigger an alert to the community based team, leading to a telephone triage being undertaken by the GP and where appropriate a domiciliary visit. Fifty telehealth hubs are available to support the pilot, with the service operating during in-hours. Early indications from the pilot would suggest reduced hospital admission, improved self-management and improved quality of care. A formal evaluation is planned to be undertaken, comparing the patient's condition and treatment prior to the use of telehealth against their condition and treatment during the first six months of using the technology.

Arrangements being put in place to deliver the strategic vision and transformational change would benefit from greater integration across agendas, strengthened clinical engagement and improved partnership working

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

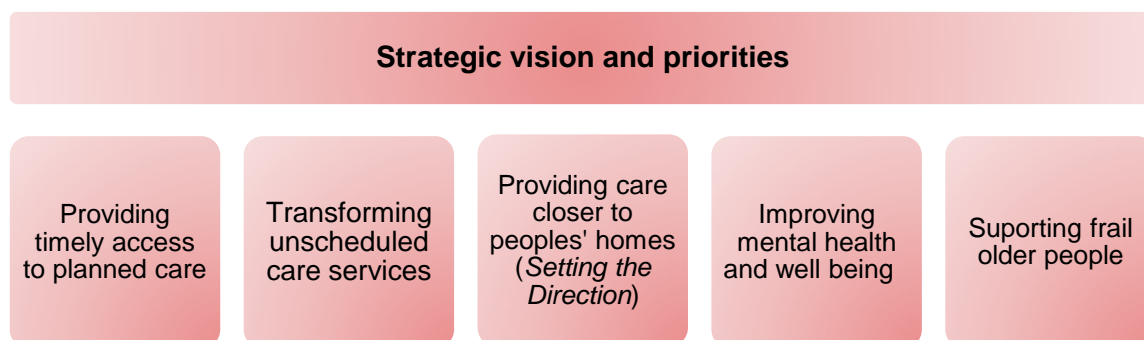
The direction of travel for unscheduled care and chronic conditions is becoming clearer although implementation is likely to be affected by regional decisions and success will be reliant on workforce transformation

The UHB's transformational change programme is the key driver for change for unscheduled care and chronic conditions management although this could be strengthened by the development of a single comprehensive delivery plan

- 152.** The UHB's five year strategic document for 2011-15, *Programme for Health Service Improvement plus* (PHSI+) provided the high level framework for developing chronic conditions management and unscheduled care services for Cardiff and the Vale of Glamorgan. Developed in 2010, the framework built on the previous strategy adopted by the former NHS Trust and LHBs which took account of the principles outlined in *Setting the Direction*. These were included in the revised PHSI+ and included:
- helping and encouraging a greater responsibility for individual health and wellbeing, and providing services that support and maximise independence;
 - developing a network of locally based services to meet the needs of individuals and communities including access to an appropriate member of the primary care team, education, support and care that helps them to maintain independence;
 - improving access to emergency hospital treatment when required; and
 - simplifying access to health care services by developing 'one point' of access for the majority of services.
- 153.** More specifically, the PHSI+ recognised the need to improve the quality of services for people who are at risk of, and those who have chronic conditions. It went on to identify how improved management of chronic conditions would be achieved through the locality structures and through strengthened management of care pathways by the multi-disciplinary team with a focus on promoting independence and avoidance of hospital care. It also identified the need to reduce the number of emergency admissions to avoid patients being admitted to hospital unnecessarily.

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154. To achieve the delivery of the UHB's overall strategic vision and its supporting priorities, a transformational change programme was introduced in 2012-13 to focus attention on the five key areas (referred to as 'themes') which require significant change ([Exhibit 22](#)).

Exhibit 22: Transformational themes 2012-13



Source: Cardiff and Vale University Health Board

155. Prior to 2012-13, improvements in unscheduled care were predominantly focused around improving access to services and reducing waiting times in the emergency department. The previous Annual Operating Framework (AOF) set out the requirement for the production of a local delivery plan (LDP) for unscheduled care, and as a result the UHB developed an Unscheduled Care Delivery Plan for 2011-12. This reflected the national *Ten High Impact Steps to Transform Unscheduled Care* and followed on from a detailed unscheduled care action plan which had been in place since 2010.
156. In developing the transformational change programme, the UHB itself has recognised that whilst it has its overall vision for UHB services, it did not have a clear vision for unscheduled services. Consequently a key action within the transformational tasks has been to develop a vision and strategy for unscheduled care with partner organisations. A draft vision statement has since been developed which focuses on people receiving the right care, in the right place by the right professional. The strategic vision for unscheduled care however is somewhat influenced by factors other than those locally. The final unscheduled care strategic plan will be influenced by the soon to be published National Urgent and Emergency Care Delivery Plan. The national plan will provide clear guidance on different aspects of unscheduled care. The outcome of the South Wales Programme (discussed further in this report) will also have some impact.

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- 157.** A second transformational theme is that of rebalancing the care system and providing care closer to people's homes. Historically the UHB has 'pushed' patients in and out of hospital, rather than proactively 'pull' patients through primary, community and secondary care in a co-ordinated way. The UHB has recognised that the foundations of *Setting the Direction* is a high quality primary care service, with a need to focus at a neighbourhood and locality level. This is reflected through the structure which was adopted on the creation of the UHB which aligns those services with neighbourhood and locality communities. The UHB also recognises the need to empower localities with primary care, community and social care teams, working together to plan and deliver services which keep people out of hospital. This is reflected in a third transformational theme focused on supporting frail older people and developing models of care, with partners, which will enable them to regain and retain independence.
- 158.** Although chronic conditions management predominantly sits within the *Setting the Direction* transformation theme, it also features within the other two themes reflecting the fact that many patients with chronic conditions are frail older people, and when unmanaged, patients are likely to access unscheduled care services. Similar to unscheduled care however, the UHB has not had a clear vision for chronic conditions management. The generic focus of providing services much closer to patients' homes is the overarching vision for the UHB and in particular its primary, community and intermediate care division but it is important that the specific focus on chronic condition management, which can be both community and acute based, is not lost.
- 159.** Delivery of both the transformational themes on *Setting the Direction* and supporting frail older people is through local delivery plans which reflect various actions relating to specific chronic conditions, such as the development of condition specific pathways. However there is limited reference to the impact on unscheduled care and consequently there is a greater need for the UHB's plans to come together. The relationship between chronic conditions, unscheduled care and the services provided not only in the community but across the acute sector as well suggests that for the UHB to move forward on its strategic vision, it needs to have a single comprehensive delivery plan. This plan should draw together these interrelationships and provide a clear and detailed delivery plan for both chronic conditions and unscheduled care which feeds directly into the transformational programme. Although the UHB has made some improvements in the delivery of services, as discussed in the first section of this report, strengthened planning arrangements would provide the UHB with a stronger foundation to move services forward in the future.

National and regional decisions about the future network of hospital services will impact on the ability of the UHB to plan the future of its unscheduled care and chronic conditions services

- 160.** National and regional discussions about the network of hospitals that will exist in future are vital to ensuring patients across Wales have appropriate access to services, such as those at emergency departments. The UHB's *Making the Difference* campaigns has started to provide the clarity of the role and function of its major acute hospitals, with a clear shift towards UHW being the centre for emergency and complex care. Along with the other health boards located in South Wales, the UHB has recently consulted with its local population on the proposals set out in the South Wales Plan, *Matching the Best in the World*. Although it is unlikely that the UHB will see any fundamental changes in services in the short-term, potential increased demand from neighbouring health communities particularly in relation to trauma may result in the UHB having to reconsider its unscheduled care pathways. Proposals may also need to be developed which focus on freeing up capacity currently used to support district general hospital activity within UHW which could result in services, such as specific chronic condition services, being relocated elsewhere.
- 161.** The pattern of hospital services cannot be decided by the UHB in isolation. National and regional discussions about the broader network of hospitals are vital to ensuring patients across Wales have appropriate access to services. Change to the pattern of hospital services is a highly emotive subject and is notoriously difficult to implement. Effective involvement and engagement with the public and other stakeholders will be a critical success factor in implementing these plans.

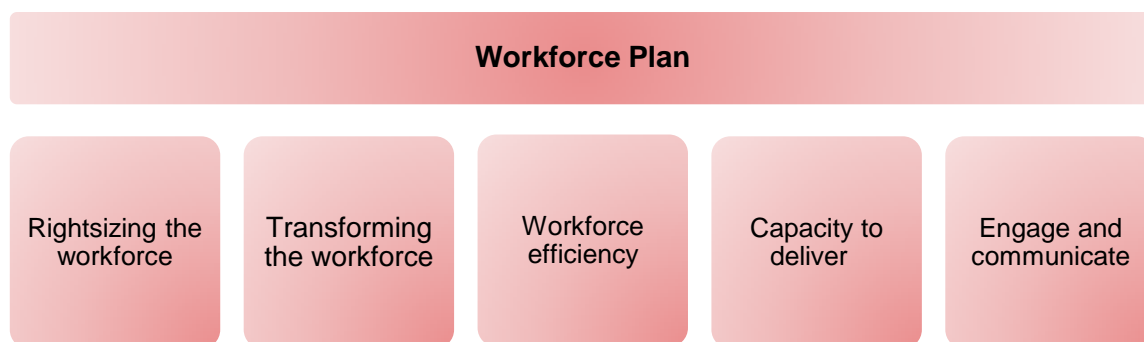
While the workforce plan recognises the changes that need to take place, the plans need to be updated and further developed to enable the UHB to meet its financial and workforce challenges and to support service transformation

- 162.** For successful implementation of new, sustainable models of care, it is crucial that there are sustainable changes in the workforce. *Together for Health* recognises that creating a sustainable workforce is a particular challenge in some specialities and workforce issues are becoming a real limitation on certain services.
- 163.** In its integrated workforce plan for 2012-17, the UHB recognises the need to develop a transformed, redesigned workforce that is flexible, sustainable and skilled, to facilitate service transformation and change which will provide high quality services for the patients of Cardiff and Vale of Glamorgan. However, it also recognises that this is against a backdrop of:
- the challenges associated with recruitment in some key specialties and the implications of changes to training and the Deanery in particular;
 - the predicted increase in the older population and the associated predicted demands on services; and
 - the UHB's financial constraints and the need to improve workforce efficiencies within a decreasing budget.

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- 164.** The South Wales Plan recognises the significant medical staffing and recruitment problems in emergency departments and acknowledges the need for health boards to share plans to provide safe and sustainable services. The South Wales Plan was recently out for consultation prior to moving into a period of public engagement which started in February 2013. The outcome of the plan will have significant consequences on the workforce within the emergency department at UHW.
- 165.** The overarching vision for the UHB will see an increase in demand within the primary and community setting, shifting resources and demands away from institutionalised care such as community hospitals, district general hospitals and care homes. This is in line with the national vision and the subsequent national target of shifting 10 per cent of the workforce to a community setting between 2010 and 2013. The vision will also see patients with greater complex needs being managed within the community. As a result the UHB has recognised that it needs to focus its skill areas around increasing capacity within the community, particularly:
- nurses with extended skills, including clinical assessment, prescribing and managing chronic conditions, who are able to work across all care settings;
 - senior therapists with extended skills able to manage the overall care of individuals;
 - developing the role of the case manager for nurses, therapists and social workers; and
 - new roles working with people at home in support of nurses, therapists and social work teams.
- 166.** Our review of services has identified that in some areas, the UHB is starting to make progress in increasing capacity with increases in the number of advanced nurse practitioners (including emergency nurse practitioners), new therapy roles within the community, and the extension of integrated roles through the development of the CRTs. The UHB has also undertaken a full scale review of district nurses taking into account the role of the clinical case manager. However, as more patients become more appropriately managed within the community, the need for additional staff will become greater. Our fieldwork identified that as well as the challenges set out in the workforce plan, there are a number of barriers the UHB still need to overcome in order to create an increased workforce in the community which will deliver the necessary improvements.
- 167.** The financial climate not only means that health boards are required to get more for less, but with a lack of pump priming monies, there is an expectation that financial resources to invest in services can only be made through increased efficiencies or a reduction in one service to create additional capacity in another. The need to shift financial resources from one service to another creates apprehension, with nervousness that disinvestment in secondary care services in particular may happen before the right services are in place in the community. This is evident within the UHB. There are also concerns around the lack of evaluation of services and the lack of robust planning information to provide reassurance to clinicians that demand will reduce and that acute services will not be left with less resources dealing with the same level of demand going forward.

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- 168.** The lack of a clear direction around the strategic vision for unscheduled care and chronic condition management means that it is very difficult to plan for the workforce for the future. This is reflected in the UHB's workforce plan which, although covers the period 2012-17, does not fully take into account the implications of the South Wales Plan and also the developments focused around frail older people services. More developments are also required around pathways of care to inform the debate around the types and location of skills required, and how those skills then work with others around them.
- 169.** To support the delivery of the UHB's workforce plan, a workforce transformation programme was due to be introduced during 2012 (**Exhibit 23**). This programme is designed to help overcome the challenges that the UHB has identified that it needs to address. However this programme is still in the early stages and will take time to embed.

Exhibit 23: Workforce Transformational Programme 2012-13



Source: Cardiff and Vale University Health Board

- 170.** Whilst general practitioners are independent contractors and are generally not directly employed by the UHB, there is a role for the UHB in working with primary care to ensure its communities have an appropriate primary care workforce. Data provided by the UHB for 2009-10 indicates that the level of primary care resources, in terms of GPs is lower than many other parts of Wales with the average list size per WTE GP between 1,600 and 1,700 patients, compared with the Wales average of 1,584 patients. Although there is no comparative data for practice nurses, the level of practice nurses across Cardiff and the Vale of Glamorgan was not raised as a concern. However, in line with the national picture, the age profile of the GPs and practice nurses poses challenges within the next five years as staff reach retirement age.

Governance arrangements to support the transformation of unscheduled care and chronic conditions management have been and continue to be strengthened but a lack of comprehensive performance information may hinder progress

Organisational and structural changes have strengthened governance arrangements and recent proposals for change should bolster these further

- 171.** If the UHB is to deliver the necessary improvements required for unscheduled care services and chronic condition management, it must have an organisational and management structure that supports clear responsibilities and lines of accountability. Within that structure there must be individual leaders and groups of staff and stakeholders that are well positioned and empowered to drive transformation.
- 172.** The corporate agenda for chronic conditions is led by the Director of Public Health under her wider responsibilities for the *Setting the Direction* agenda, with operational delivery resting with the relevant Divisional Directors and their divisional teams. Up until 2011, chronic conditions management was the responsibility of the Director of Primary, Community and Mental Health. This post no longer exists, although the functions of this role now form part of the Director of Public Health's portfolio on an interim basis.
- 173.** A Chronic Conditions Management Board had been established to oversee the use of the transitional funding and the demonstrator projects but as the focus of the CCM Board became more generic, the level of engagement from clinicians started to reduce and the CCM Board was disbanded. This subsequently resulted in a reduced focus on chronic conditions management from the Board for a period of time. In March 2012 however, a new *Setting the Direction* Programme Board was established to act as a mechanism for providing the momentum and focus on implementing the framework outlined in *Setting the Direction*. Recognising the challenges faced by the CCM Board with clinical engagement, a range of task and finish work streams have been established to ensure that the most appropriate professionals are engaged at the right stage. The *Setting the Direction Programme* Board meets bi-monthly and reports to the Strategic Planning and Partnership Committee (now replaced by the People, Planning and Delivery Committee) and subsequently the Board.
- 174.** The corporate agenda for unscheduled care, at the time of our fieldwork, was led jointly by both the Director of Planning/Deputy Chief Executive and the Director of Innovation and Improvement. Similar to chronic conditions, responsibility for service delivery and improvement lies with the relevant Divisional Directors and their divisional teams. Previous responsibility had rested with the former Director of Acute Services, a post which also no longer exists within the UHB's structure.

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- 175.** The UHB had established an Unscheduled Care Programme Board chaired by the Director of Planning, with the aim to provide strategic direction and advice, and oversee the delivery of the unscheduled care delivery plan. The Programme Board included wide representation from within the UHB and from partner organisations, and met monthly. However in early 2012, it was recognised that the Programme Board was becoming too operational and submerged in boundary issues. It was replaced by an Unscheduled Care Forum which refocused on the strategic direction and addressing cross-cutting issues. The Forum, like the *Setting the Direction* Programme Board, also reported to the Strategic Performance and Planning Committee, and subsequently the Board.
- 176.** To support the Unscheduled Care Programme Board, an Emergency Unit Operational Performance Group (EUOPG) was established. It was chaired by the Director of Acute Services and its primary focus was on monitoring four hour waits. On the establishment of the Unscheduled Care Forum, the EUOPG was reformed into an Unscheduled Care Operational Performance Group in recognition that the problems associated with unscheduled care were wider than the emergency unit and involved issues such as delayed transfers of care, recruitment and patient flow through the hospital. Chaired by the Director of Innovation and Improvement, the group met weekly and included operational leads from within the UHB.
- 177.** The *Setting the Direction* Programme Board recognises the interrelationships it has with Unscheduled Care and also the Frail Older Peoples Services Delivery Programme (FOPSDP) which is led by the Director of Therapies. It also identifies the need to ensure good communication between these programmes however there is no formal mechanism for bringing these together. The Executive Directors who lead the various boards are not present on the other corresponding boards, and whilst the *Setting the Direction* Programme Board and the Unscheduled Care Forum both report into the Strategic Planning and Performance Committee, the FOPSDP reports into the Integrated Health and Social Care Partnership Board.
- 178.** There is clear cross-over between the work plans for these programmes with the communications hub and CRTs being prime examples. Representation at officer level can be the same on a number of these groups and there is potential for some duplication, particularly between the *Setting the Direction* Programme and the FOPSDP. It is important that the UHB is able to bring together the work of all of these programmes to provide a comprehensive position to the Board as previously identified in [paragraph 161](#).

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- 179.** Our previous Structured Assessment work in 2010, reported the potential for the UHB's organisational structure at that time to be silo focused. This was demonstrated through the leadership provided by the Director of Acute Services in relation to unscheduled care and the Director of Primary, Community and Mental Health for chronic conditions management. The direction of travel for unscheduled care at that time was predominantly hospital focused and the chronic conditions management agenda was being led in isolation through the primary, community and intermediate care division. The departure of both of these director posts resulted in the leadership of these agendas moving to other directors within the organisation. This, alongside a change in the organisational structure, saw the creation of a Chief Operating Officer post with the clinical divisions reporting directly to this post.
- 180.** Much of the positive improvements in unscheduled care and chronic condition management, as reported in the first section of this report, have been since these changes have taken place although there are still some challenges remaining. Our Structured Assessment work in 2011 identified that performance accountability was not fully embedded and whilst there may be strong leadership at the top, if accountability was not embedded within the clinical divisions then the necessary changes which need to happen to services may be difficult to make.
- 181.** The new Chief Executive Officer, on his appointment in July 2012, recognised that more needed to be done to expedite the necessary improvements in unscheduled care in particular and in September 2012, he set up and led a short term task force to focus on immediate pressures facing the emergency department and patient flow through the hospital. The USC Operational Performance Group, and more recently the USC Programme Board, have subsequently been disbanded.
- 182.** In the medium to longer term, the Chief Executive Officer has outlined his proposals for changes to the organisational structure in *Organisation for Excellence*. This paper identifies unscheduled care as one of the UHB's top priorities to be developed into a cross cutting work stream or 'clinical system'. This system will be led by a senior clinician who will be held accountable for delivery of the UHB's vision, requiring that clinician to work alongside the Divisional Directors of the respective clinical divisions' right across the UHB. The paper also sets out the proposals to develop clinical boards as opposed to divisions, which came into being in May 2013. The development of these clinical boards will see accountability and decision-making devolved down to those who are close to the service. The proposals set out in this paper would suggest the revised structures will bring about the changes required to make the necessary service transformation, however the implementation of the proposed models set out in '*Organisation for Excellence*' will take some time. The UHB needs to be assured that the momentum and leadership currently in place, particularly as a result of the Chief Executive's involvement in unscheduled care during the latter part of 2012 is maintained during the interim period.

The absence of comprehensive organisational wide information means that the UHB is unable to effectively performance manage its services and their effectiveness

- 183.** Information is crucial for informing the planning and delivery of effective services for unscheduled care and chronic conditions as well as monitoring service provision and patient outcomes. Our previous reports highlighted the paucity of financial information and activity data available which undermines the ability of NHS bodies to evaluate existing services, plan new services or to support the shift of resources from hospital to community settings.
- 184.** If the UHB is to successfully transform its models of care, it must be able to intelligently measure its progress towards reaching its goals. Our national report on *Unscheduled Care* recommended that health boards should work with partners to agree a set of desired outcomes from their services, and they should consider what measures would indicate the successful delivery of these desired outcomes. We said that these measures should drive change to the system, be agreed with professional leads, and be used to enable the system to learn as new models are piloted and rolled out.
- 185.** The patient management system (PMS) is the core information system used by the UHB, however, this only provides information on activity undertaken within the acute setting, and in some circumstances is not as robust as it should be. During our fieldwork, we were told of occasions where it was difficult to enter data onto PMS in the emergency department leading to some information relating to emergency department performance not being collected.
- 186.** Information relating to activity undertaken in the community is recorded on the PARIS system, although this is high level and only really relates to numbers. Detailed information on intervention and outcomes, such as intervention from CRTs or district nurses is not yet captured although plans were in place to develop some key performance metrics for the CRTs during the latter part of 2012. This lack of information presents significant challenges to the UHB in terms of a lack of robust information to make planning decisions, with reliance on specific data collection exercises or audits. Consequently much of the data reported for both unscheduled care and chronic conditions relates to hospital activity.
- 187.** The *Performance Report* presented to the Board focuses on emergency department performance, emergency rates, average length of stay and DTOC. The focus of which is on 'pushing' patients through the system as quickly and efficiently as possible. There is very little emphasis on measuring how effective the UHB is at 'pulling' patients out of the hospital setting and into the community. For example, the effectiveness of the communications hub in redirecting admissions and the CRTs to avoid hospital admission. This would provide some assurance to the Board that the services in place across the UHB are having an impact on reducing pressure on the acute sector. The Board has recognised that the balance of information presented is heavily biased towards secondary care, and there is recognition that greater attention needs to be given to population health, and primary and community care. More detailed information is available to some of the groups, with information on the out-of-hours service available on a weekly basis for example, which could be fed into the Board reporting mechanism.

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- 188.** The lack of information was specifically identified as a problem during our review in terms of supporting service evaluation. Although our work identified a number of examples where formal evaluations had taken place, such as the GP screening service and the ECAS service, much of the information used was based on manual data collection. With the financial constraints that the NHS faces, service developments are more and more reliant on the ability of organisations to shift resources from one part to another. Without robust and readily accessible information to support on-going evaluation of services, the ability to present the case for releasing resources will be difficult.
- 189.** As part of the demonstrator projects, the UHB adopted the use of Results Based Accountability (RBA)¹⁸ to drive improvements in the management of patients with chronic conditions, in particular those suffering from epilepsy and diabetes. An evaluation report of the use of RBA identified that one of the challenges in supporting the approach was having robust information to support the measurement of outcomes, as well as having a real understanding on what outcomes would be expected.
- 190.** Along with the other demonstrator sites, the UHB has led the way in sharing and learning good practice. The UHB played an active part in the national forums and the experience from the UHB's demonstrator projects is available on the national demonstrator website. While the completion of the demonstrator projects and the end of the transition monies may reduce the incentive to share and learn good practice, we were told of a number of examples where good practice was continuing to be shared internally. This is either being done through the work streams or through other mechanisms such as the neighbourhood and locality forums.
- 191.** To inform performance management arrangements, the UHB has developed an action plan for monitoring the progress made on the aspects identified in the Unscheduled Care Delivery Plan. Detailed work plans have also been established for the Setting the Direction Programme Board and its respective work streams, as well as the Frail Older People Services project, progress against which are reported to the Board with a report on *Setting the Direction* reported to the Board in December 2012.

¹⁸ Results Based Accountability is an outcome focused methodology which aims to improve the quality of life within communities as well as the performance of services.

The UHB needs to strengthen its engagement with clinicians and its partners if it is to take forward the necessary service transformation

Clinical leaders are in place and there are encouraging developments in primary care but greater clinical engagement is needed to secure support for service transformation

- 192.** 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.
- 193.** On its establishment in 2009, the UHB implemented a structure designed to promote clinical leadership and engagement, with eight clinical divisions all being led by a senior clinician in a Divisional Director role. The divisions were all supported by directorates which were also led by senior clinicians in a clinical director role, with the exception of the primary, community and intermediate care (PCIC) division. The PCIC division was based on a locality and neighbourhood model, recognising the need to align services closely with others provided across the community, although the localities and neighbourhoods were also led by senior clinicians in the form of GPs. These clinicians have been appointed into a community director role. In May 2013, the UHB revised its organisation structure through the creation of eight Clinical Boards which replace the divisions. These Clinical Boards are supported by the existing directorates, localities and neighbourhoods.
- 194.** The UHB is one of very few health boards across Wales to contract GPs for management sessions through a job plan arrangement. This provides real opportunities for the UHB to hold GPs who act as community directors to account on corporate matters. There are currently nine community director posts covering the locality and neighbourhood levels. The UHB has also appointed a number of these community directors to take a clinical lead on a range of transformational themes, including unscheduled care, within primary care.
- 195.** The UHB sees clinical engagement as a critical enabler in delivering service changes. During the early years of the UHB, despite having clinicians in senior management posts, the extent to which clinicians had been engaged in service delivery had been weak. The initial structure implemented in 2009 required the eight divisions to be divided into two groups of four reporting to the Director of Acute Services and Director of Primary, Community and Mental Health Services respectively. This structure encouraged silo working with very little opportunity for the eight divisions to come together. The additional layer of the two director posts also gave little opportunity for the divisional directors to be engaged with corporate issues. The focus of the UHB at that time was also seen as 'secondary care centric', with the agenda focusing mainly on acute issues.

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- 196.** In 2011, the two director posts were removed and a requirement for the eight divisions to report directly to a newly created Chief Operating Officer post was introduced. This provided real opportunities for the eight divisional directors and their teams to engage with each other, and through the Board of Directors forum, to be engaged with the senior management team, and have some ownership collectively on corporate issues.
- 197.** Having clinicians in senior management roles has been a positive step in engaging the wider clinical workforce. Engagement with primary care practitioners is reported to have improved with the creation of the community director posts, and other initiatives such as the primary care team. Secondary care consultants also reported to have a good level of engagement through their respective directorate and divisional structures, with examples provided around the engagement with clinicians over the staffing difficulties within the emergency department. However the UHB is challenged with engaging clinicians on matters that do not just have direct relevance to them. This was recognised through a lack of understanding amongst clinicians of the changes proposed through the *Making the Difference* work and the UHB's wider strategic plan.
- 198.** To further strengthen clinical engagement with clinicians, the Medical Director presented a paper to the Board in January 2012 which set out a framework for engagement. This was supported by a number of engagement sessions which were held on the UHW and Llandough Hospital sites although attendance levels were not good. Since the appointment of the current Chief Executive Officer, engagement directly with clinicians, and staff more broadly, has significantly improved. The CEO ran a number of listening sessions with staff over the summer as part of his wider *Picture the Future* programme aimed at engaging staff and stakeholders in the programme of work for the UHB and the solutions to achieving improvements.
- 199.** Focusing specifically on primary care, the UHB has used the Quality Outcomes Framework as a vehicle for engaging with GPs, and through forums such as the clinical governance meetings, the Local Medical Committee and the Medical Advisory Group, as well as the Community Director roles. As a result, it was felt GPs were much more engaged in decisions around service developments, for example, enhanced services. The findings of our practice survey indicates that whilst there is still more work required, engagement with primary care is generally better than other areas across Wales with:
- Just under half (8) of the practices agreeing or strongly agreeing that they were actively involved in planning services (this compares with 31 per cent across Wales);
 - Five practices (28 per cent) agreeing or strongly agreeing that they were actively involved in redesigning services (this compares with 21 per cent across Wales);
 - Eleven practices (61 per cent) feeling adequately informed of plans for USC services (this compares with 43 per cent across Wales); and
 - Six practices (33 per cent) perceiving that they were actively involved in planning and redesigning CCM services (compared with 45 per cent of practices across Wales).

200. However, the majority of practices who completed our survey perceived that the UHB does not provide sufficient practical support to help the practice maintain good practice and further improve its unscheduled care services. Such support would include providing locum cover to allow GPs to attend meetings. During our fieldwork, it was also identified that whilst GPs were engaged, there was a need for the UHB to demonstrate that service developments were working and sustainable, for engagement to continue. This also included demonstrating a shift in resources as patient demand for services is increasingly redirected away from the hospital setting.

Further strengthening of relationships with the public, local government and the ambulance service are essential to secure sustainable improvements and service transformation

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

202. Partnership working is seen by the UHB as a major driver of change and an essential element to improve and sustain the quality and extent of its services by providing alternative and viable methods or sources of service delivery, especially in times of financial constraints.

203. *Making the Difference*¹⁹ provided good foundations on which the UHB engages with the public on its strategic direction. The recent consultation exercise as part of the South Wales Plan, whilst receiving a disappointing level of attendance at the sessions, demonstrated some positive mechanisms being put in place by the UHB to engage with the public, supported by a developing relationship with the Cardiff and Vale of Glamorgan Community Health Council (CHC). The CHC has increasingly started to play an active role within the UHB over the last twelve months, with good involvement both at a Board level and at a locality level. However there appears to be limited CHC or more general patient representative presence on specific issues such as unscheduled care and *Setting the Direction*. The CHC has also had limited involvement in operational aspects of service delivery such as primary care access, although this is starting to improve through examples such as the developments within the Barry Minor Injury Unit.

¹⁹ *Making the Difference* is the process through which the UHB set out its plans for a number of service changes during 2010 and 2011

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- 204.** The UHB works closely with both Cardiff and Vale of Glamorgan local authorities, with a focus on supporting the integration of services over time. An Integrated Health and Social Care Partnership Board has been in place for some time, and it is through this mechanism that the work on frail services for older people is being taken forward. The development of the locality and neighbourhood structure has aligned the services provided by the UHB in the community with those provided by its statutory partners, with positive examples of joint working in place including the establishment of integrated management posts. Other examples of positive joint working include:
- the establishment of a range of Section 33 agreement to provide community based reablement and rehabilitation services; and
 - the use of local authority premises for the communication hub in Barry, with integrated working demonstrated through the joint working arrangements to deal with out-of-hours calls.
- 205.** However, the UHB lacks any local authority representation on its Board, and whilst there is involvement in service aspects, such as unscheduled care and *Setting the Direction*, there appears to be limited commitment from the local authorities at a broader operational level. Social workers no longer are linked to wards to support early discharge and the potential impact of the reduction of social workers in Cardiff as a result of voluntary severance was not discussed in advance with the UHB.
- 206.** Our previous work recommended that the Local Service Boards (LSBs) should get more involved in leading unscheduled care services. In Cardiff and Vale of Glamorgan, there has been no specific reporting to the respective LSBs on unscheduled care services, however, a number of the objectives of the LSB's, outlined in the respective community strategies, cover aspects of unscheduled care. The Director of Public Health is a member of the LSBs.
- 207.** The Welsh Ambulance Services NHS Trust (WAST) is a key partner in transformation and in improving the way in which people experience care. **Paragraphs 32 and 40** emphasises the importance of WAST in helping the UHB manage demand at its emergency department. Our fieldwork suggests that joint working with WAST to date has been generally positive although concerns were raised around the planned changes to the WAST management structure and the potential impact that may have on relationships that have developed. Despite inclusion within the unscheduled care forums, attendance by WAST representatives had been an issue. Although there have been some positive working in relation to the development of pathways, and joint working arrangements with the emergency department during periods of high demand.

Appendix 1

Number of attendances at major emergency departments

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

Health Board	Number of A&E attendances		Percentage change
	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 Stats Wales

Appendix 2

Working hours of consultants in major emergency departments

Health board	Hospitals	Time when a consultant in emergency medicine is available on the 'shop' floor	
		Weekdays	Weekends
Abertawe Bro Morgannwg University LHB	Morrison 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
Cardiff & Vale University LHB	University Hospital of Wales	8am-10pm	8am-10pm
Cwm Taf LHB	Prince Charles Hospital	9am-5pm	NA
	Royal Glamorgan Hospital	9am-5pm	NA
Hywel Dda LHB	Bronglais General Hospital	9am-9pm	No cover
	West Wales General Hospital	9am-5pm	9am-3pm
	Withybush Hospital	9am-5pm	1pm-9pm
*Hours longer in practice			
**NA – data not provided by the Health Board			

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

Appendix 3

Number of medical staff at major emergency departments

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

Hospital	Consultants*		Middle grade doctors		Junior doctors/trainees	
	In post	Vacant	In post	Vacant	In post	Vacant
Morrison	6.9	0	9.55	0	18	0
Princess of Wales	6.4	0	3.2	0	13	1
Nevill Hall	3 (+1)	1	5.7	1	8	1
Royal Gwent	9.4	0	4.5 (+0.4)	4.6	14	4
Wrexham Maelor	7	1	7.1	0	9	0
Ysbyty Glan Clwyd	2	2.5	4.5	4	8	1
Ysbyty Gwynedd	3 (+1)	1	6	2	8	0
Prince Charles	3.4	1.6	3	1	7	1
Royal Glamorgan*	2 (+1)	2	2	7	8	0
Bronglais General	1	0	4	0	10	0
Glangwili General	2	0	7	0	3	0
Withybush General	0 (+2)	2.87	3.8	4.2	6	0
University Hospital of Wales	8 (+2)	4	4	4	22	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 4

Number of nursing staff at major emergency departments

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

Hospital	Bands 1 to 4		Bands 5 to 9		Vacancy rate (%)
	Filled posts	Vacant posts	Filled posts	Vacant posts	
Morrison Hospital	9.05	0	67.05	6	7
Princess of Wales Hospital	9.2	0	44.4	0	0
Nevill Hall Hospital	9.87	0.53	42.93	0.56	2
Royal Gwent Hospital	24.26	0.46	89.3	2.51	3
Wrexham Maelor Hospital	1.73	1	66.6	0	1
Ysbyty Glan Clwyd	7.44	0	45.02	0.8	2
Ysbyty Gwynedd	7.57	0.43	50.95	3	6
Prince Charles Hospital	5.6	0.4	35.9	3.2	8
Royal Glamorgan Hospital	7.91	0.24	44.76	5.65	10
Bronglais General Hospital	5.68	0	21.33	0	0
Glangwili General Hospital	3.78	0	36.57	2.8	6
Withybush General Hospital	2.7	0	26.42	2	6
University Hospital for Wales	18.69	0.8	101.87	2.69	3
Wales	113.48	3.86	673.10	29.21	4

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

Appendix 5

Emergency department attendances arriving by ambulance

Proportion of attendances at major emergency departments that arrived by ambulance in 2009 and 2011

Hospital	Proportion of A&E attendances that arrive by ambulance (%)	
	2009	2011
Morrison Hospital	27	29
Princess of Wales Hospital	19	22
Nevill Hall Hospital	24	26
Royal Gwent Hospital	28	28
Wrexham Maelor Hospital	20	20
Ysbyty Glan Clwyd	32	33
Ysbyty Gwynedd	24	26
Prince Charles Hospital	22	25
Royal Glamorgan Hospital	NA	NA
University Hospital Wales	NA	29
Bronglais General Hospital	7	9
Glangwili General Hospital	5	27
Withybush General Hospital	22	24
Wales	23	25

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

Appendix 6

Average time spent in major emergency departments

Average time individuals spent in major A&E departments in 2009 and 2011

Hospital	Average time patients spend in A&E, from arrival to departure (minutes)	
	2009	2011
Morrison Hospital	138	198
Nevill Hall Hospital	109	169
Royal Gwent Hospital	147	210
Wrexham Maelor Hospital	127	124
Ysbyty Glan Clwyd	NA	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
Princess of Wales Hospital	NA	NA
University of Wales Hospital	NA	151
Wales	122	158

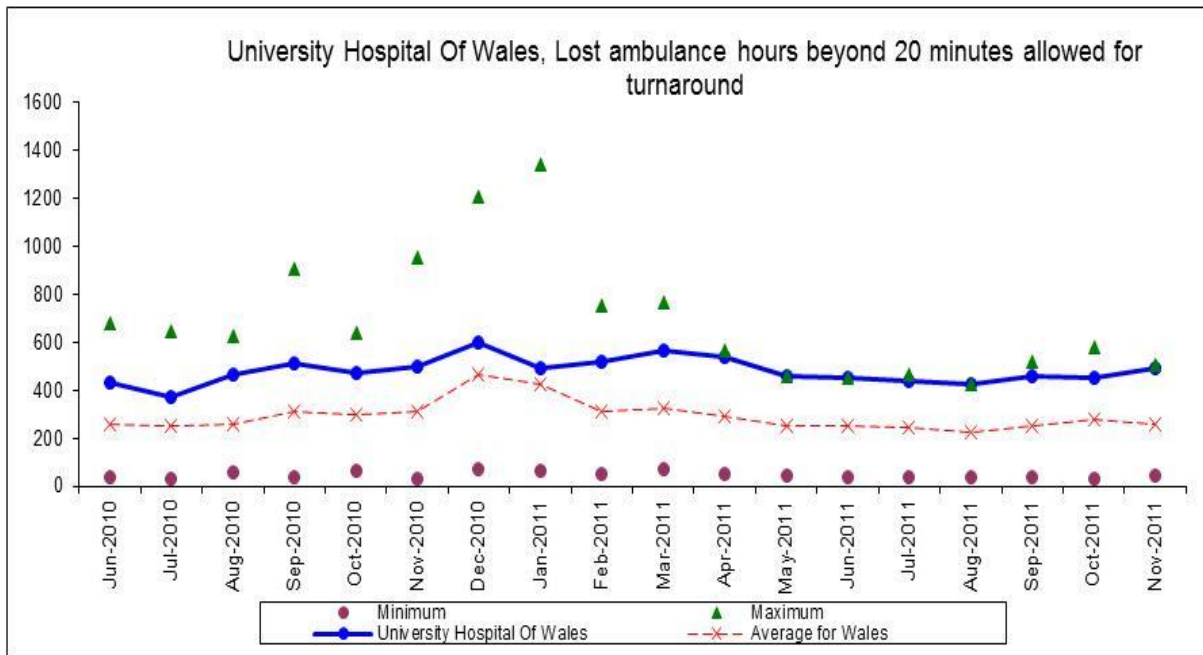
NA – data not available

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

Appendix 7

Lost ambulance hours due to delayed patient handovers

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



Source: Welsh Ambulance Services NHS Trust

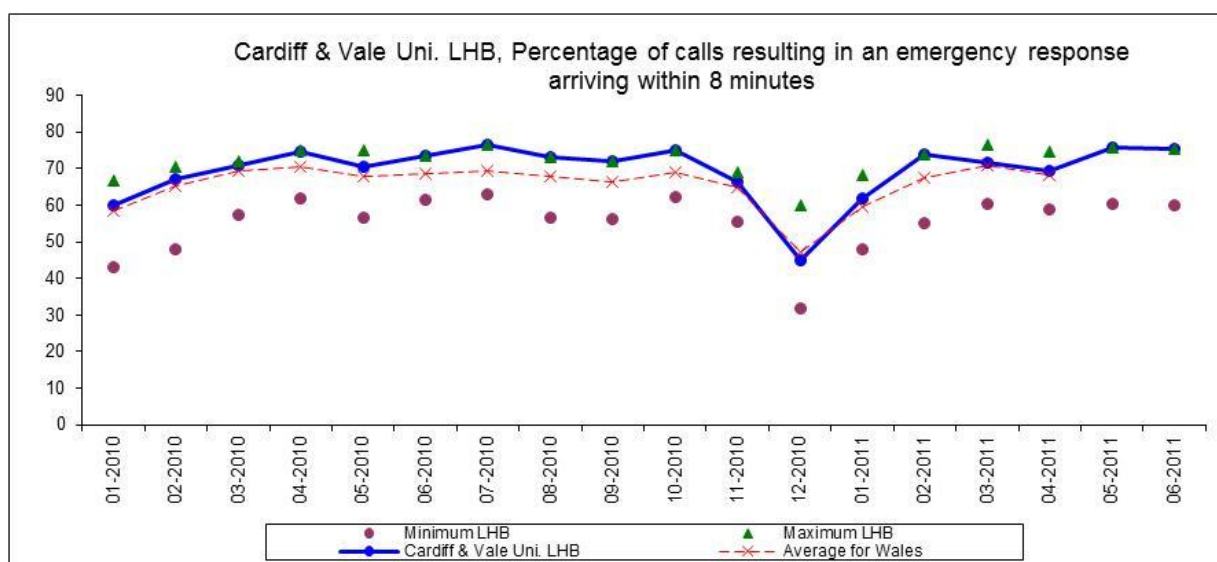
Appendix 8

Ambulance performance data

Exhibit 8a: Emergency incidents responded to within eight minutes

This exhibit shows performance against the main response time target set by the Welsh Government. The targets are:

- a monthly all-Wales average of 65 per cent of first responses to Category A calls to arrive on scene within eight minutes, 70 per cent within nine minutes and 75 per cent within ten minutes;
- a monthly minimum performance of 60 per cent of first responses to Category A calls arriving within eight minutes in each local authority area; and
- performance in all geographical areas needs to reflect continuous improvement in achieving the overall target.

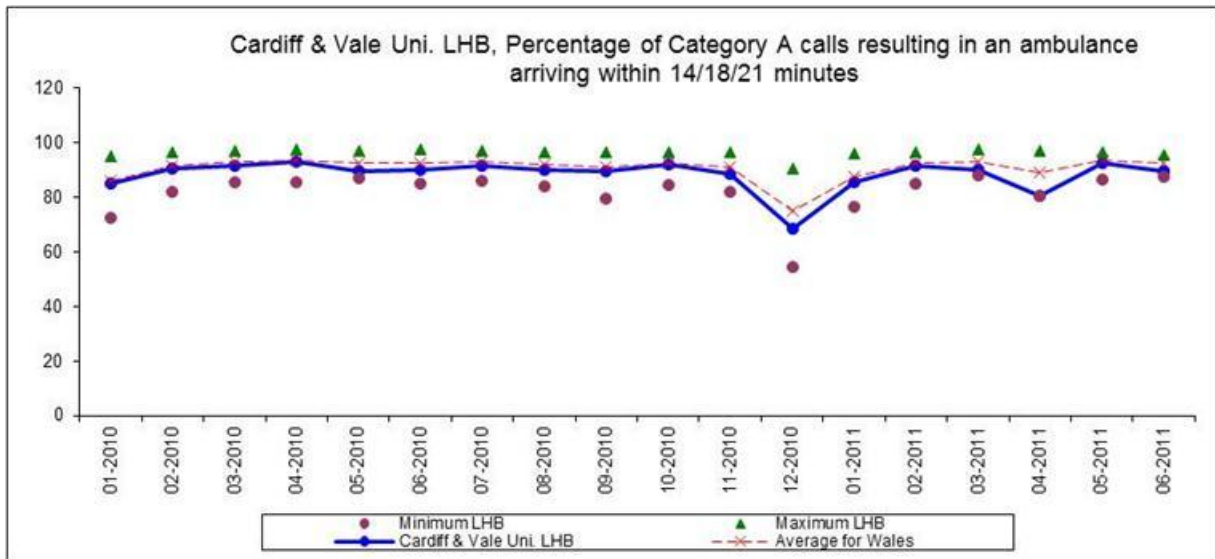


Source: Stats Wales

Exhibit 8b: Backing up initial responses with a fully equipped ambulance

The exhibit shows performance in relation to the following national target:

- Where the first response to a Category A call is not a fully equipped ambulance, to follow with such an ambulance to a level of 95 per cent within 14, 18 or 21 minutes respectively in urban, rural or sparsely populated areas.

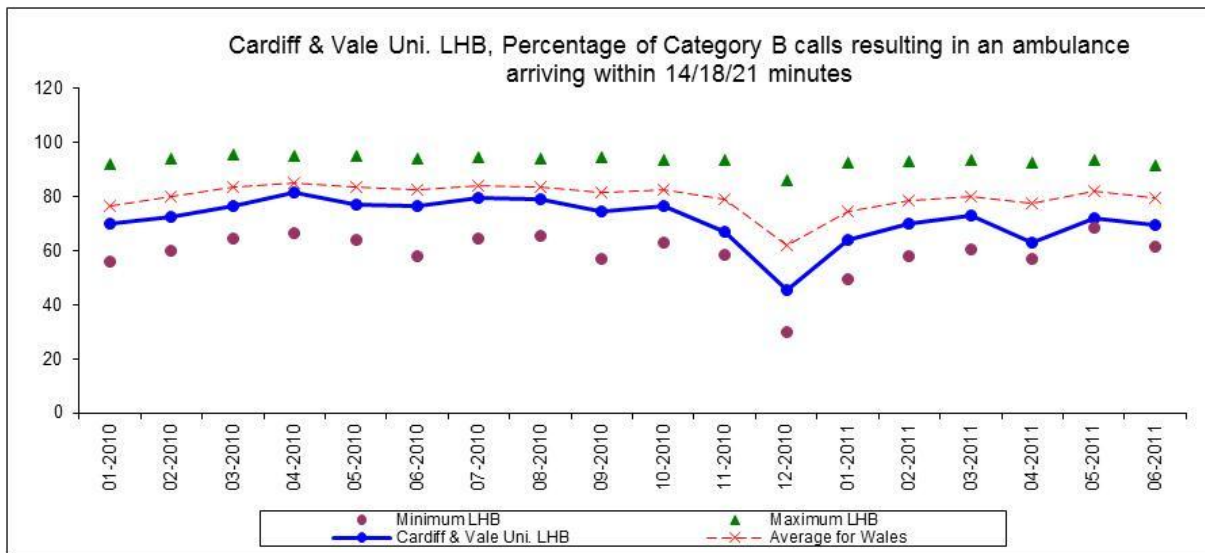


Source: Stats Wales

Exhibit 8c: Responses to Category B incidents

The exhibit shows performance in relation to the following national target:

- 95 per cent of all other emergency calls (other than Category A calls) to arrive within 14, 18 or 21 minutes respectively in urban, rural or sparsely populated areas.

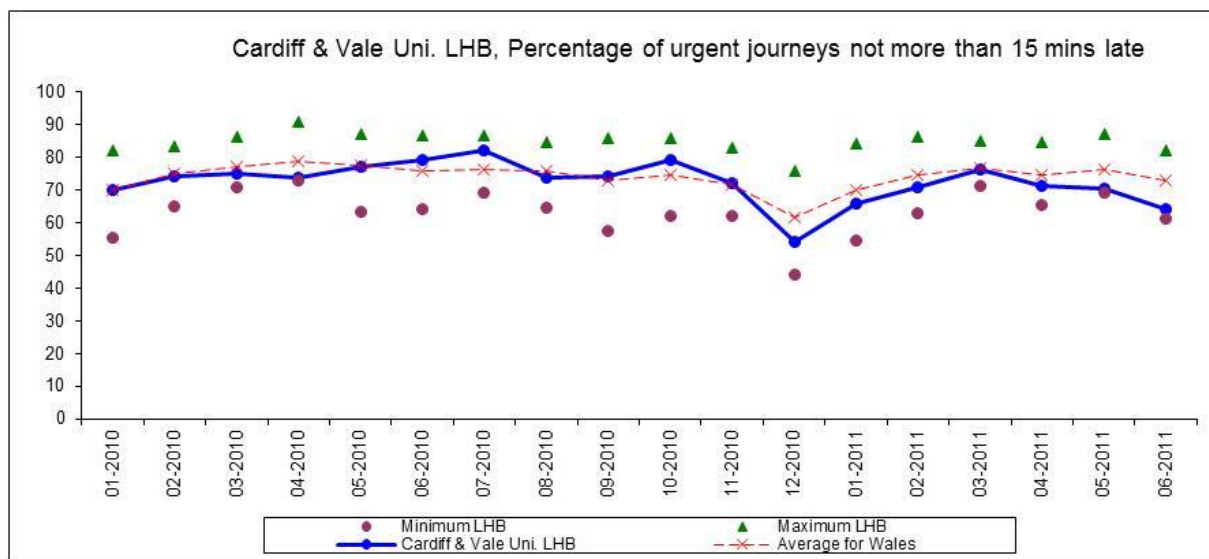


Source: Stats Wales

Exhibit 8d: Responses to urgent calls from doctors

The exhibit shows performance in relation to the following national target:

- 95 per cent of responses to doctors' urgent calls to arrive at the hospital no later than 15 minutes after the requested arrival time.

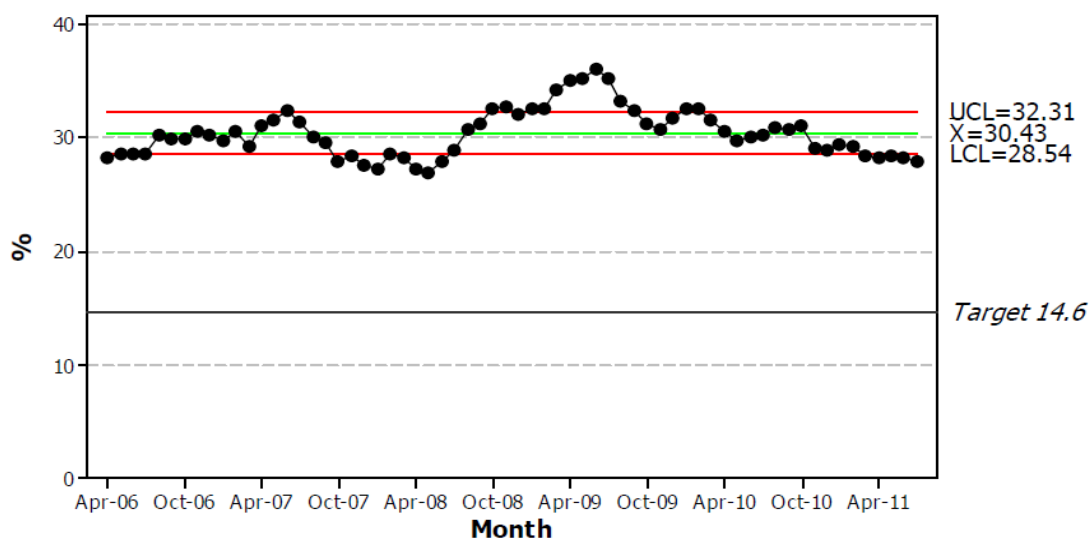


Source: Stats Wales

Appendix 9

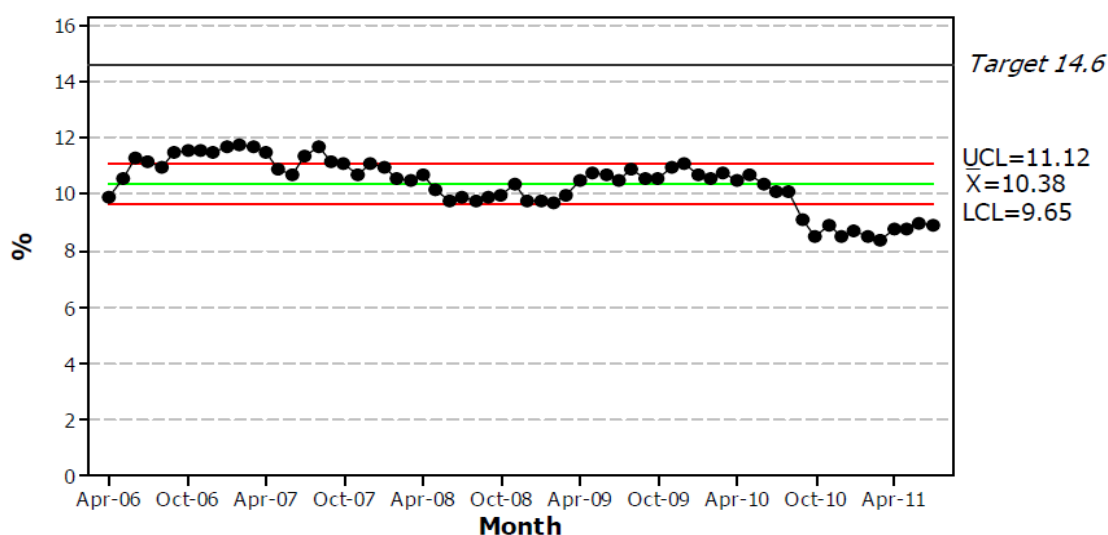
Rolling multiple admission rates for COPD, CHD and diabetes at Cardiff and Vale UHB

Exhibit 9a: Rolling 12-month multiple admission rate for COPD emergency admissions



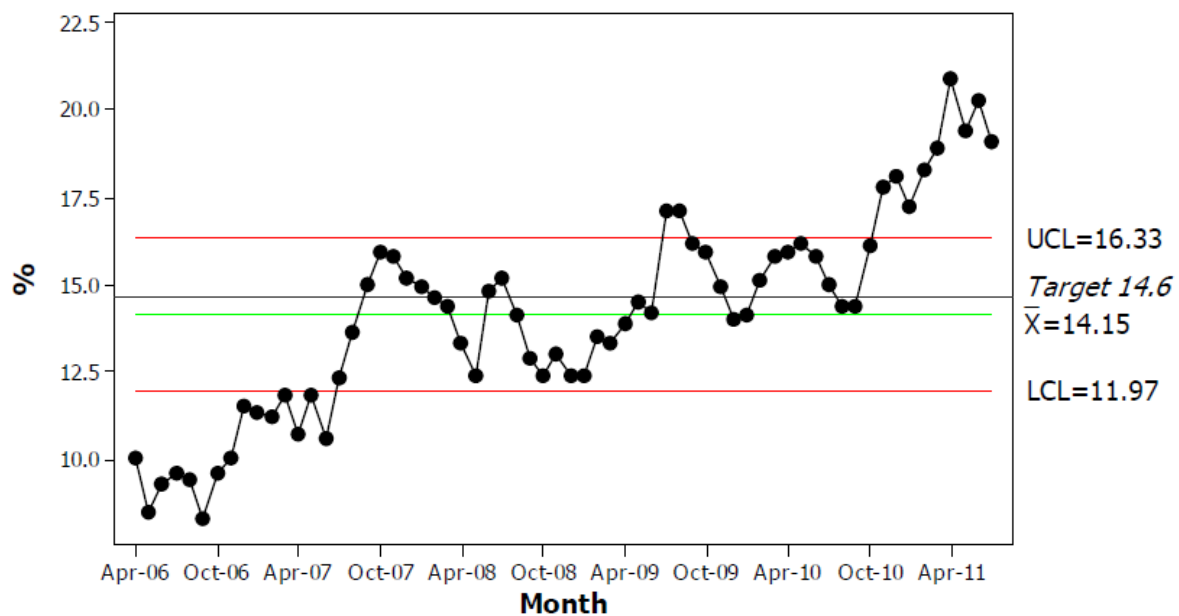
Source: Wales Audit Office analysis of data extracted from NLIAH's report 'Progress Report on the CCM Service Improvement Plan as measured through the CCM Maturity Matrix', October 2011

Exhibit 9b: Rolling 12-month multiple admission rate for CHD emergency admissions



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

Exhibit 9c: Rolling 12-month multiple admission rate for diabetes emergency admissions

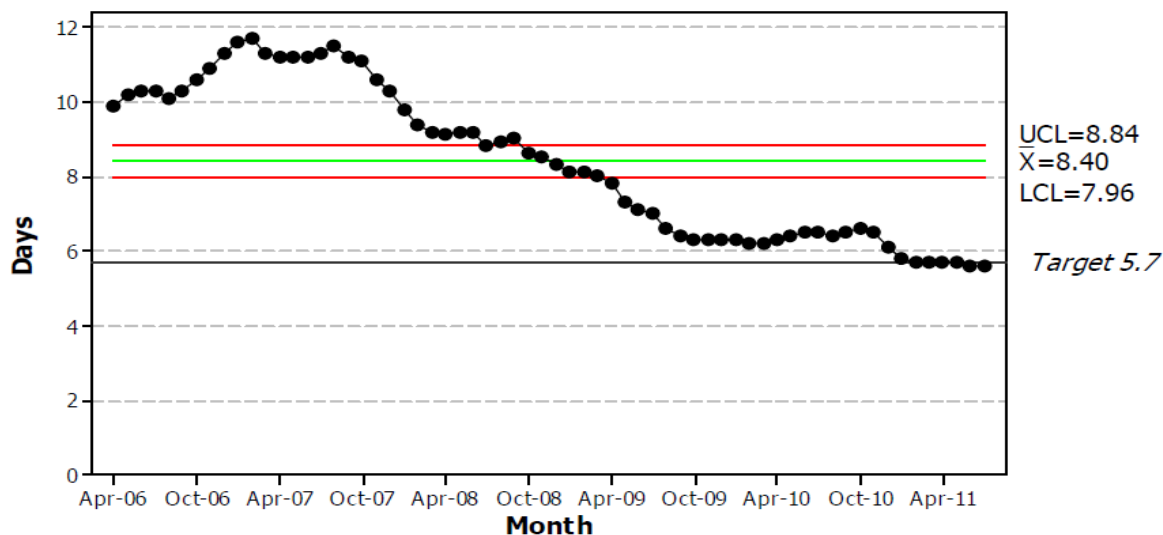


Source: Wales Audit Office analysis of data extracted from NLIH's report 'Progress Report on the CCM Service Improvement Plan as measured through the CCM Maturity Matrix', October 2011

Appendix 10

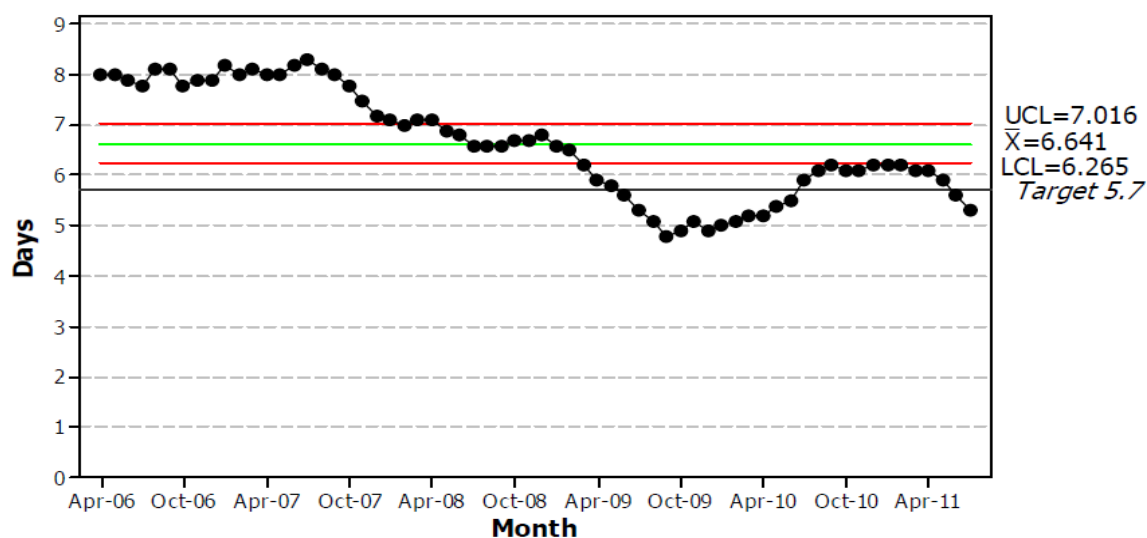
Rolling average lengths of stay for COPD, CHD and diabetes at Cardiff and Vale UHB

Exhibit 10a: Rolling 12-month average lengths of stay for COPD emergency admissions



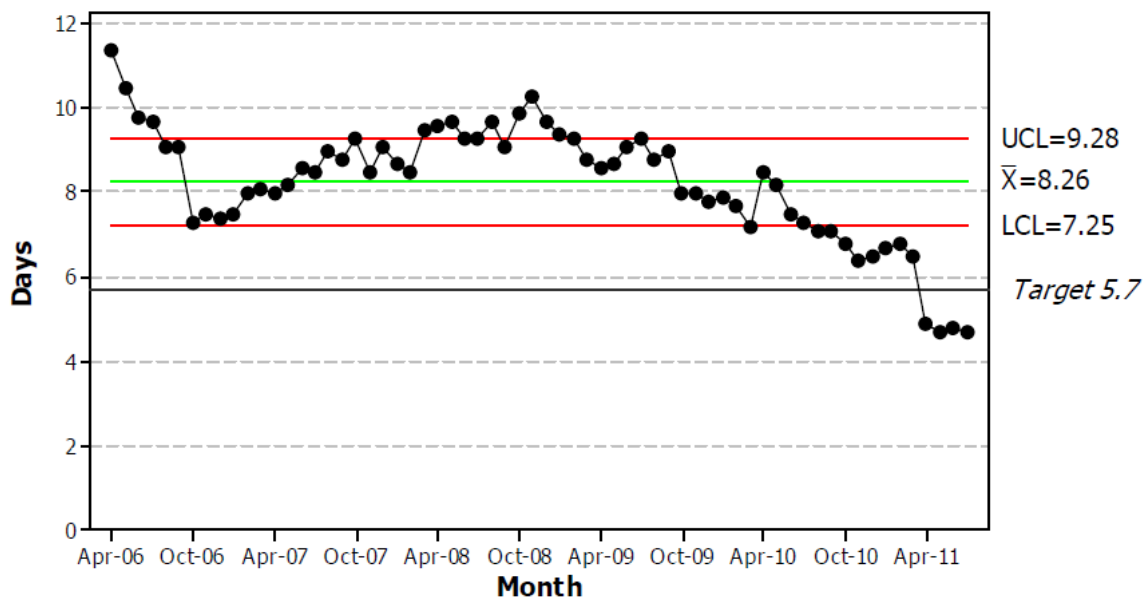
Source: Wales Audit Office analysis of data extracted from NLIAH's report 'Progress Report on the CCM Service Improvement Plan as measured through the CCM Maturity Matrix', October 2011

Exhibit 10b: Rolling 12-month average lengths of stay for CHD emergency admissions



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

Exhibit 10c: Rolling 12-month average lengths of stay for diabetes emergency admissions

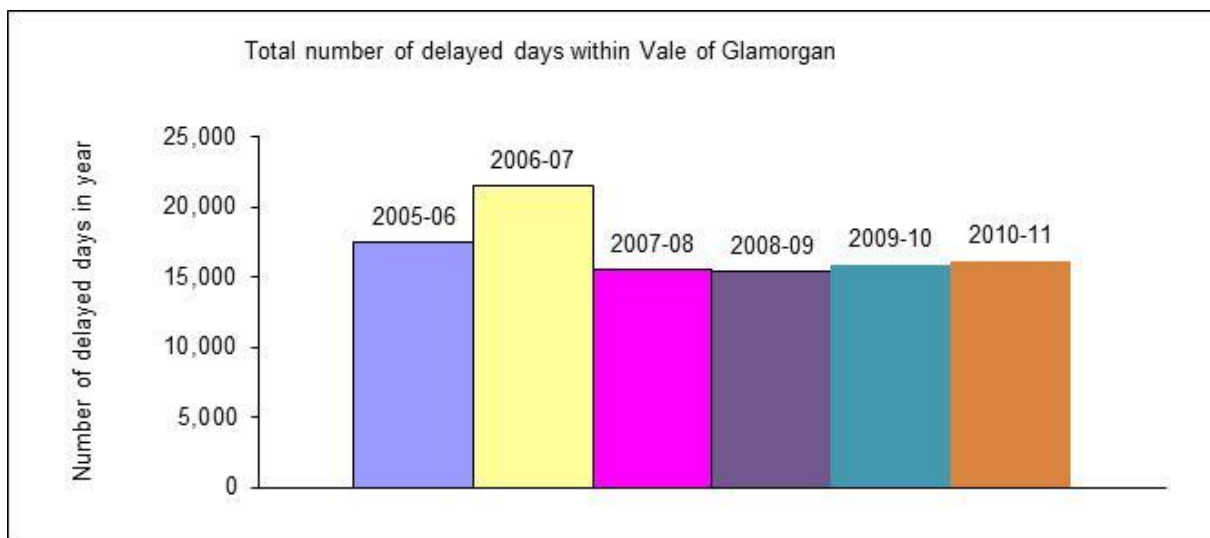
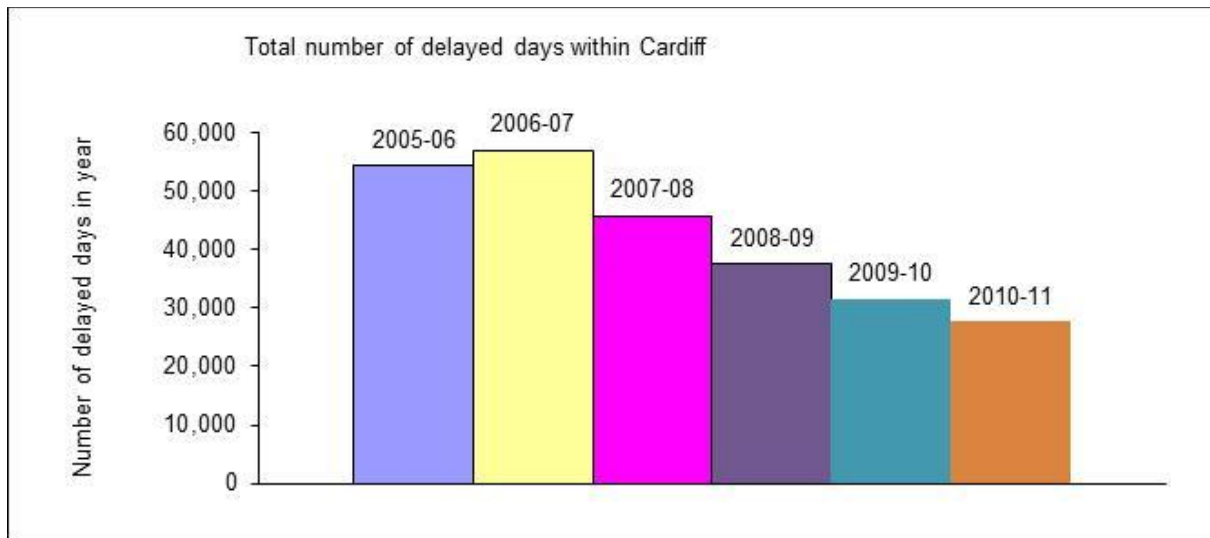


Source: Wales Audit Office analysis of data extracted from NLIH's report 'Progress Report on the CCM Service Improvement Plan as measured through the CCM Maturity Matrix', October 2011

Appendix 11

Delayed transfers of care

The exhibits show the number of bed days lost as a result of people experiencing a delayed transfer of care across the two localities within the UHB.

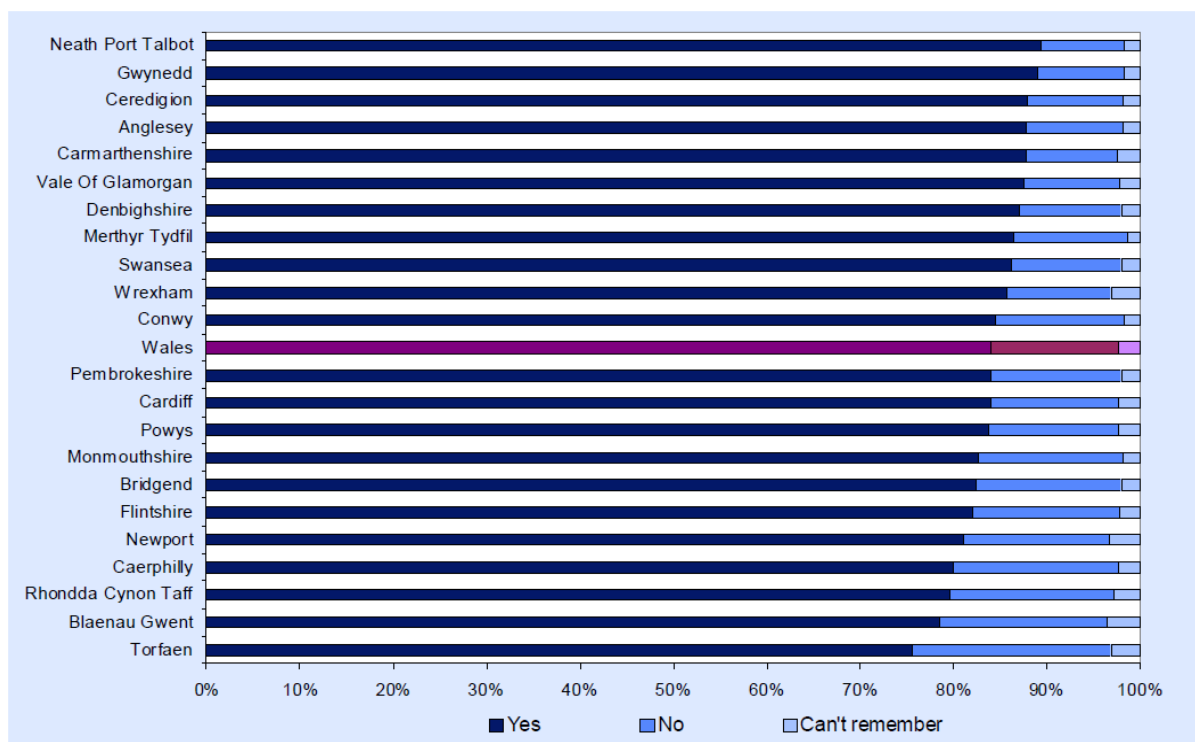


Source: Welsh Government

Appendix 12

Urgent access to primary care

As part of the Welsh GP Access Survey 2011, patients were asked whether they were able to access urgent primary care appointments within 24 hours. The exhibit shows the percentage of people that said they were able to access such appointments, those that were not and those that couldn't remember.

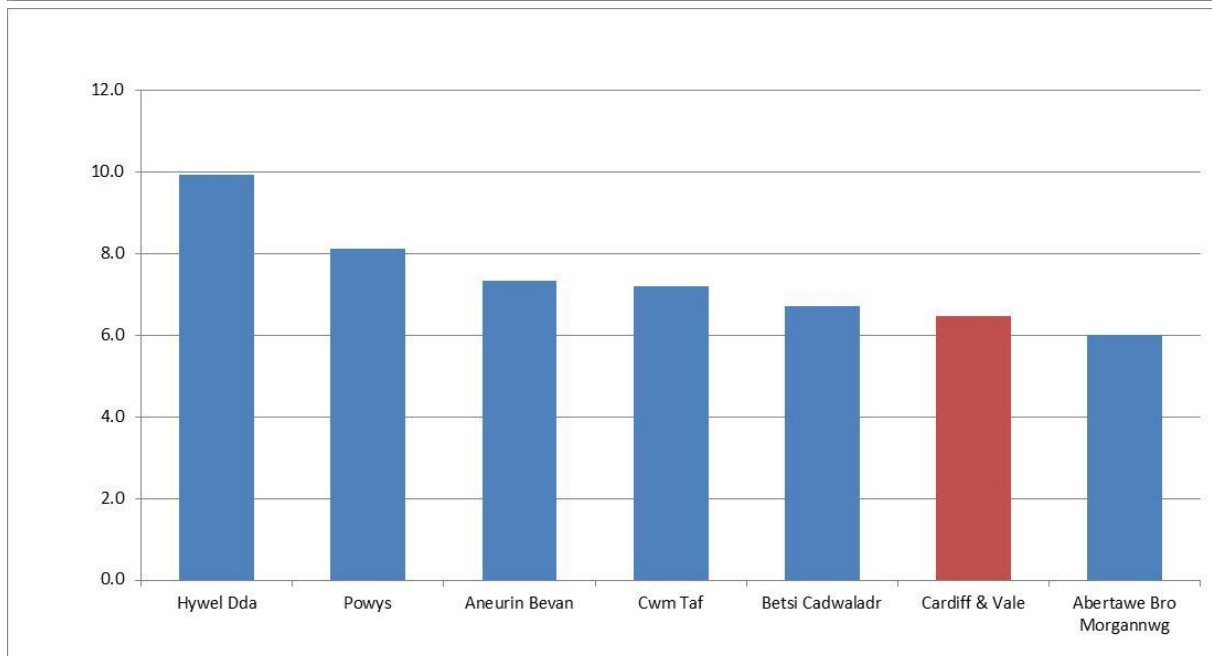
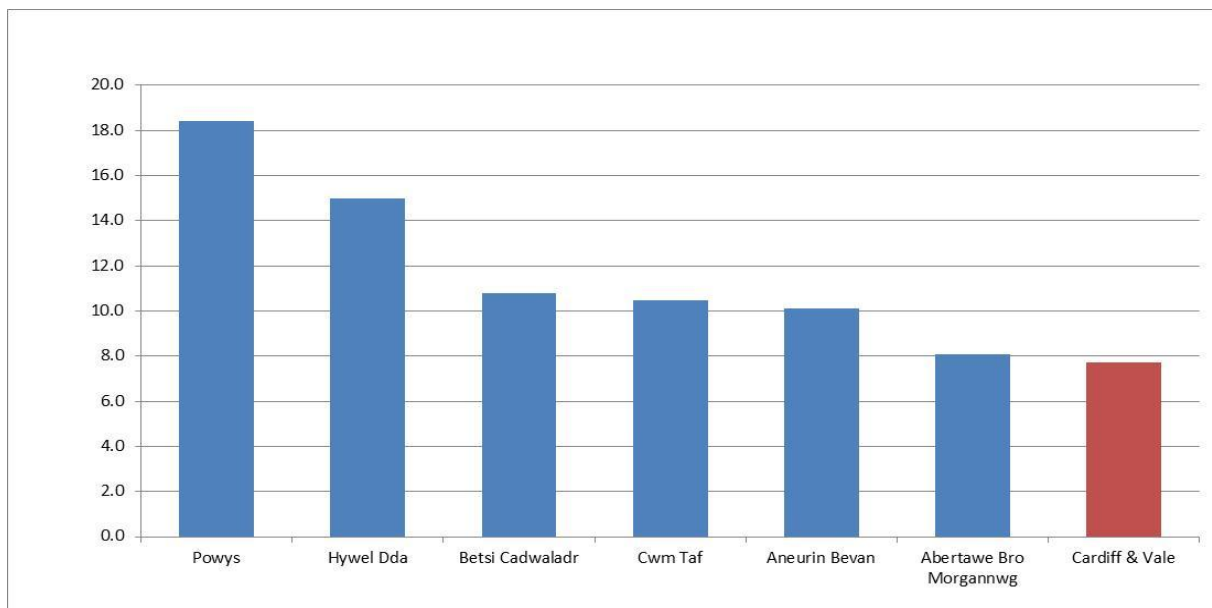


Source: Welsh GP Access Survey 2011

Appendix 13

Expenditure on out-of-hours primary care services

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



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



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