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Transforming unscheduled care and chronic conditions management

Hywel Dda Health Board

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The team who delivered the work comprised Tracey Davies, Philip Jones and Kate Febry.

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The Health Board is taking a genuine whole-systems approach to transforming services for unscheduled care and chronic conditions management and improvements are being realised. However, there are risks to service transformation which the Health Board will need to overcome.

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 for reasons 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 preventative approaches. Such a change would have the benefit of reducing the demand on acute hospital services but, importantly, it would benefit patients. Currently, too many patients are treated in hospital when they would be better cared for in the community.

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

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

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

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

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

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

7. Given that it is now more than two years since the publication of this body of work, the Wales Audit Office has undertaken follow-up audit work on chronic conditions management and unscheduled care that considers progress against our previous recommendations, but also aims to provide new insight into the barriers and enablers affecting progress. As there are a number of key interrelationships between chronic conditions and unscheduled care the work has been delivered as a single integrated review. One of the key enablers that we have focused on is clinical engagement, given its crucial importance in delivering the service transformation that is required.

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

8. Hywel Dda Health Board (the Health Board) has recognised the need to transform its model of services. The Health Board's *Right Care, Right Place, Right Time, Every Time, Five Year Framework* sets out the challenges of delivering care within a rural, geographically dispersed area. It sets out the case for change and the vision for the future service. Hywel Dda has a higher proportion of older people than the Wales average and that already high proportion is predicted to increase dramatically. The change in profile of the population will have an impact on health and social care services for which the Health Board and its partners will need to provide. The Health Board also faces particular long-standing challenges recruiting medical professionals. The Health Board and its partners face significant and sustained financial pressures, which mean the case for change and transformation has never been stronger. The Health Board launched its formal service strategy on 6 August 2012, which they believe is a critical step towards securing high quality, safe and sustainable services for its population.

Our main findings

9. Our review, which was carried out between November 2011 and February 2012 considered the following question: 'Is the Health Board securing the transformation that is necessary to create more sustainable models of care that reduce demand on the acute sector and provide better services for patients, specifically through the key interrelated areas of chronic conditions management and unscheduled care?'

10. Our main conclusion is the Health Board is taking a genuine whole-systems approach to transforming services for unscheduled care and chronic conditions management, and improvements are being realised. However, there are risks to service transformation, which the Health Board will need to overcome.

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

Part 1 – The Health Board has introduced a range of service improvements for managing chronic conditions and unscheduled care and, although performance is improving, a number of challenges remain before the required step change can be realised

1a. While accident and emergency performance compares well with the Wales average, staffing pressures remain and there are opportunities to reduce GP-led demand.

- Emergency department demand is relatively unchanged but a high proportion of GP referrals suggests that demand could be further reduced.
- The Health Board is struggling to fill vacancies in emergency departments for senior medical staff, and emergency nurse practitioner (ENP) cover is insufficient, and some emergency departments more vulnerable at night due to challenges securing appropriate cover.
- Positive actions have been taken to improve patient flow and reduce pressure within the emergency departments but a number of challenges remain and some require longer-term strategic solutions.
- Performance against the four-hour waiting time target for accident and emergency (A&E) department patients compares well with the Wales average but performance now needs to be sustained.
- While the handover target has not been met over the last 12 months fewer patients arriving at emergency departments wait longer than 15 minutes compared with other parts of Wales.

1b. Reliance on the acute sector to manage chronic conditions is reducing and positive action to tackle delayed transfers of care and to improve patient flows is taking effect.

- Reliance on the acute sector to manage chronic conditions is reducing with Hywel Dda having made more progress than some other health boards but multiple admission rates and lengths of stay for some chronic conditions remain above target.
- Positive action has been taken to improve patient flows and to reduce the impact of delayed transfers of care.

1c. The Health Board has made good progress in reshaping the way it supports people in the community to prevent unnecessary use of hospitals but more needs to be done to fully realise the benefits of the new developments.

- The Health Board is using various approaches to identify individuals at risk of unplanned admissions.
- New services have been introduced into the community but the community virtual ward (CVW) is not yet at a stage to attract significant demand away from hospitals.
- Significant progress has been made in establishing community resource teams (CRTs) in Carmarthenshire and Pembrokeshire and while progress has been slower there is now an equivalent co-ordinating structure in Ceredigion.
- Financial investment has helped to embed new ways of working in the community.
- The use of primary care contracts to support chronic conditions management is limited.
- Access to both in-hours and out-of-hours primary care is generally good although work to integrate out-of-hours within emergency departments needs to be accelerated.

Part 1 – The Health Board has introduced a range of service improvements for managing chronic conditions and unscheduled care and, although performance is improving, a number of challenges remain before the required step change can be realised

1d. While measures to support self-care are being actively promoted, more could be done to influence the way the public uses hospital services.

- Public marketing through Choose Well is being progressed but has not yet been fully implemented and more could be done to redirect patients where appropriate.
- The provision of communication hubs to signpost people to the right services varies across localities with no clear overall strategic vision.
- The Health Board is actively taking measures to promote and strengthen self-care.

Part 2 – The Health Board has a clear vision and good prospects for delivering transformational change but there are risks to its future success if it is unable to effectively engage the public

2a. The Health Board has a clear and well-understood vision but success will be reliant on workforce transformation.

- The Health Board's strategic vision is well aligned to what needs to be done to improve chronic condition and unscheduled care services.
- Workforce plans need to be developed further to support the transformation and modernisation of the Health Board's unscheduled, community and primary care workforce.

2b. Governance arrangements to support the transformation of unscheduled care services need to be strengthened and better aligned to services for chronic conditions management.

2c. Strong partnerships have been built up with key stakeholders and the Health Board is committed to engaging its clinicians but influencing the public is proving challenging.

- The Health Board is committed to engaging clinicians in service redesign and structural change has promoted and strengthened primary care engagement.
- Significant progress has been made in establishing working and integrated partnerships to support service delivery but public engagement has been challenging.

Recommendations

Reduce pressure on A&E departments	
R1	Primary care demand from GP referrals is above average at Glangwili and Withybush Hospitals' emergency departments. The Health Board should: • work in partnership with primary care to understand the reason for the higher-than-average GP referrals within these departments; and • in partnership with primary care identify how demand can be reduced and sustained.
R2	Primary care demand from self-presenters is high at Prince Philip Hospital emergency department. The Health Board should: • work with primary care to understand and address the reasons for the public choosing the emergency department over their GP practice; • actively encourage the local population to seek their primary care needs at their local GP practice as part of the wider 'Choose Well' campaign; • as part of the clinical Service Strategy be very clear about the role of the Prince Philip Hospital emergency department; and • in the short term, and in partnership with primary care, develop and implement a policy whereby patients can be referred back to their GP provided the triage score is low and the physical parameters, such as temperature and pulse, are within normal range.
R3	The number of patients not waiting for treatment in Prince Philip emergency department has doubled in recent years. The Health Board should: • assess and analyse the information available about those patients who did not wait for treatment; and • use this information to identify the actions required to reduce the numbers and to reduce the risk of individuals leaving the department before being assessed.
R4	The overnight medical and nursing staff cover in Glangwili and Bronglais emergency departments adds further pressure on the available workforce and may increase patient risks. The Health Board should: • Address the shortfalls in senior decision maker medical cover. If this is not possible, assess the effectiveness of measures put in place to mitigate the risks. If these measures are found to be inadequate the Health Board will need to urgently seek alternative solutions. • Ensure that there is adequate nursing and receptionist cover overnight at Bronglais emergency department that allows care to be safely delivered.
R5	While the Health Board has measured the proportion of time that senior clinical decision makers are present on the shop floor it will be important for the Health Board to ensure it monitors the actual, as well as the planned, hours of cover from senior clinical decision makers at Bronglais.

Reduce pressure on A&E departments	
R6	A number of GP practices responding to our survey indicated that there were inadequate support services, such as rapid diagnostics, access to consultant advice and hot clinics. The Health Board needs to explore opportunities for addressing these gaps.
Reshaping services	
R7	The Health Board needs to use the Local Enhanced Service provisions of the GMS contract more constructively to develop services that focus on prevention and early intervention for chronic disease management.
R8	As part of the overall transformation of services the Health Board needs to clarify the role, purpose and governance arrangements of the Unscheduled Care Clinical Programme Board (USCCPB). This should include: • strengthening the links to chronic conditions management, primary and community care services; and • strengthening the overall governance arrangements in terms of accountability, decision making, meeting frequency and attendance.
R9	The Health Board needs to ensure evaluation is built into all its chronic conditions and unscheduled care service developments to ensure good practice is shared and lessons are learnt. This should include the Siarad Iechyd/Talking Health involvement and engagement scheme.
Managing demand out-of-hours	
R10	The Health Board should escalate work to overcome the barriers to integrated working between out-of-hours and Glangwili Hospital emergency department.
R11	Expenditure on primary care out-of-hours per registered patient is significantly higher than the Wales average. While rurality may be a factor, the Health Board needs to: • compare and contrast expenditure across the three counties; and • critically assess the factors and consider whether costs could be reduced without detriment to service quality and care.
Managing patient flows	
R12	There are a number of barriers to ensuring the effective flow of patients within emergency departments. To improve flow, the Health Board needs to: • agree and clarify who is responsible for managing and co-ordinating patient flow during the evening at Withybush emergency department; and • routinely assess and improve the specialist assessment and responsiveness in all units.

Managing patient flows	
R13	There are a number of contributory factors, such as the absence of a seven-day working culture often resulting in insufficient weekend discharges and delays in securing take-home medication, that impede inpatient flow and the Health Board needs to put in measures to address these.
R14	The Health Board should ensure that the Acute Response Team has sufficient resources to adequately meet demand. This should include an assessment of caseload management to ensure that resources are being used efficiently.
R15	GP practices responding to our survey indicated a lack of confidence in the quality of information they received to help review referral and admission profiles. The Health Board should: • work with GP practices to agree what information would be helpful when notifying practices that patients have attended A&E departments or have been admitted to hospital; and • put in place mechanisms to ensure that information on attendance at out-of-hours and A&E is shared with CRTs.
Influencing and changing the way in which the public uses services	
R16	The Health Board should strengthen its approach to redirecting patients who attend A&E departments when more appropriate services are available by: • ensuring staff have adequate training and support to redirect patients; and • putting in place a written protocol for redirecting patients back to primary care.
R17	As part of the arrangements for fully implementing Choose Well, the Health Board needs to think carefully, how to reduce the risk of potential confusion between the National Choose Well information on the Health Board webpage and the local Choose Well information.
R18	The Health Board needs to progress its plans for developing the communications hub as a vehicle for signposting the public to health and social care services in the first instance by: • putting in place a clear development plan for the whole Health Board to take forwards its vision for the communications hub; • clearly articulating the role and function of the communications hub; and • identifying the resources needed to provide an integrated call-handling service.

Developing the workforce	
R19	The Health Board needs to be clear about the numbers of emergency department staff and job roles.
R20	As part of an integrated approach to workforce planning, the Health Board should progress its plans to review the existing primary care clinical workforce as reported in its 2011 Primary Care Report.
R21	To strengthen the ENP service, the Health Board should consider and address the following: • clarifying the role of ENPs as part of the wider model of care in emergency departments; • some ENPs fulfil their role as an ENP infrequently, which can impact on their confidence and result in them not using their full range of extended skills; • the challenge of supporting ENP training within current resource constraints; and • address the disparity in pay and practice.

Detailed report

The Health Board has introduced a range of service improvements for managing chronic conditions and unscheduled care and, although performance is improving, a number of challenges remain before the required step change can be realised

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

While accident and emergency performance compares well with the Wales average, staffing pressures remain and there are opportunities to reduce GP-led demand

Emergency department demand is relatively unchanged but a high proportion of GP referrals suggests that demand could be further reduced

13. There are around 2,000 attendances at major A&E departments[3] each day across Wales. The Welsh Government's *Delivering Emergency Care Service*s strategy highlighted a year-on-year increase in the number of patients attending hospital emergency departments. As well as the general upward trend in demand, emergency departments can also face sharp peaks in activity that, if not managed effectively, can result in congestion within the department and a slowing down in the provision of care to patients.

[3] 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.

14. The Health Board has three Type 1[4] major emergency departments located at Glangwili, Withybush and Bronglais hospitals and four minor injury units, which are located at South Pembrokeshire Hospital, Tenby Cottage Hospital, Cardigan and Llandovery hospitals[5].

15. Prince Philip Hospital in Llanelli is a Type 2[6] emergency department and does not provide a full range of emergency services. Prince Philip emergency department provides 24-hour consultant-led emergency care services but as a result of a change to the profile of inpatient services in June, emergency care services are only available for a restricted group of patients. As a result services are only available for those patients, adults and children, with minor injuries or illness and specific adult medical emergencies. Despite the restrictions on the types of conditions treated at the department, the number of attendances has remained relatively unchanged since 2007-08.

16. Across Wales between January 2010 and December 2011, there was a small rise (1.6 per cent) in the total number of attendances at major emergency departments (Appendix 1). The Health Board was one of only two Welsh health boards where the number of attendances reduced slightly over this period. Attendances reduced by 0.3 per cent.

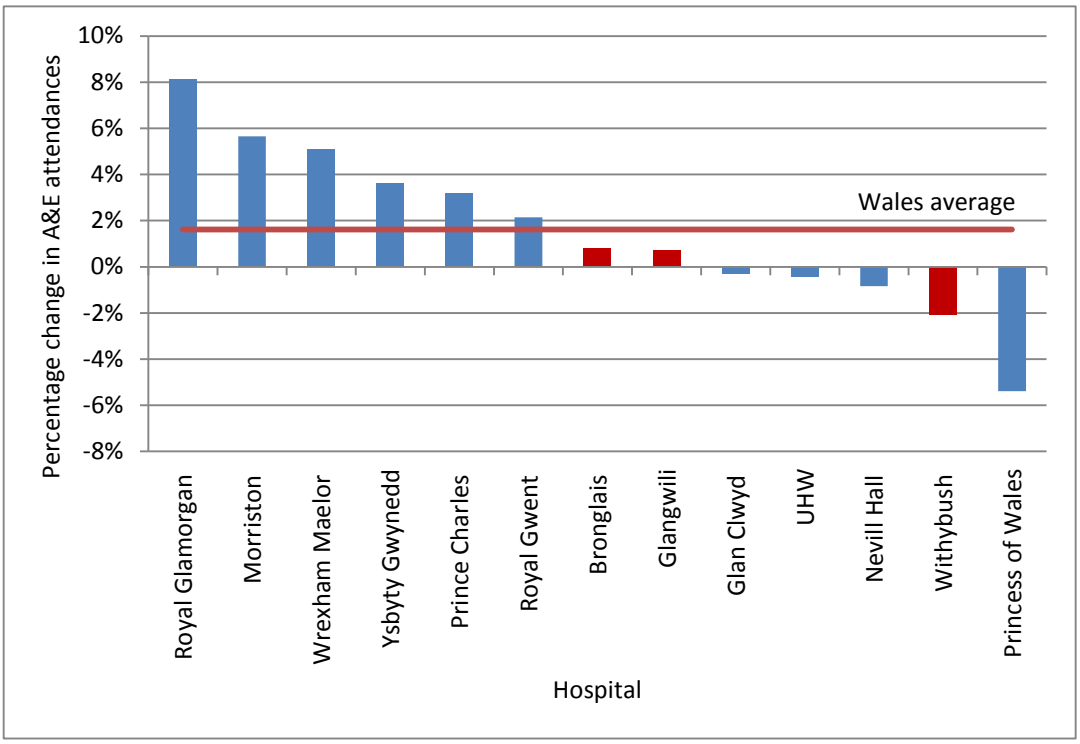
17. Exhibit 1 below shows the percentage change in attendances at each major emergency department in Wales between January 2010 and December 2011. The Health Board's main emergency department attendance rate is below the Wales average. During this period attendances rose marginally at Glangwili and Bronglais hospitals but reduced by two per cent at Withybush. Over the same period, attendance at the Health Board's minor injury units also reduced by 1.4 per cent (Appendix 2). The pattern of attendances at the Health Board's three main emergency departments is broadly similar (Exhibit 2).

[4] The Welsh Government defines a Type 1 emergency department as a consultant-led service with appropriate resuscitation facilities and designated accommodation for the reception of A&E patients. These departments must provide the resuscitation, assessment and treatment of acute illness and injury in patients of all ages, and services must be available continuously 24 hours a day.

[5] Cardigan and Llandovery hospitals have been excluded from any detailed analysis due to the very low level of activity.

[6] The Welsh Government defines a Type 2, emergency department unit as all other A&E/casualty/minor injury units, which have designated accommodation for the reception of A&E patients and can be routinely accessed without appointment, but which do not meet the criteria above for a Major A&E Department.

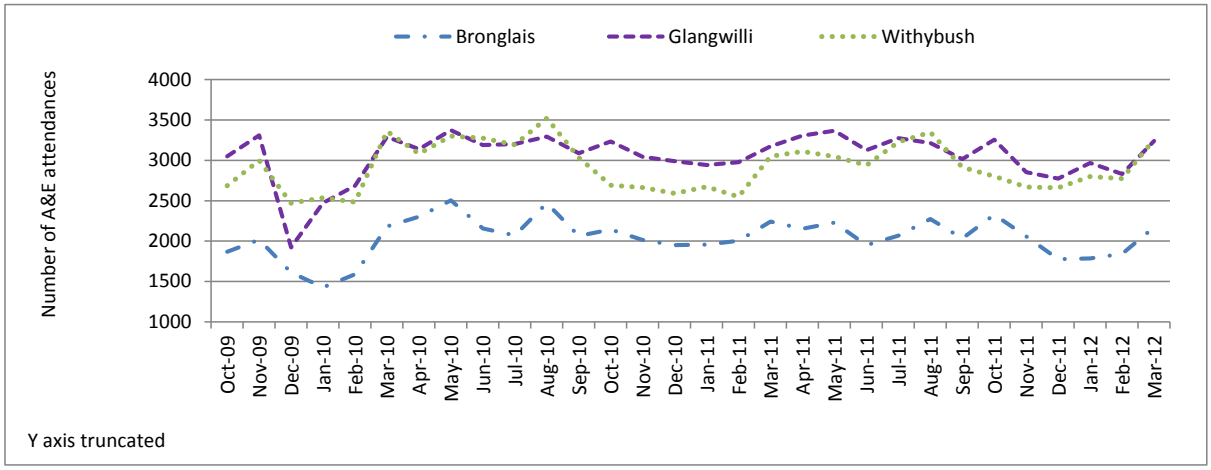
Exhibit 1: Comparative trend in demand at hospital main emergency departments between 2010 and 2011



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

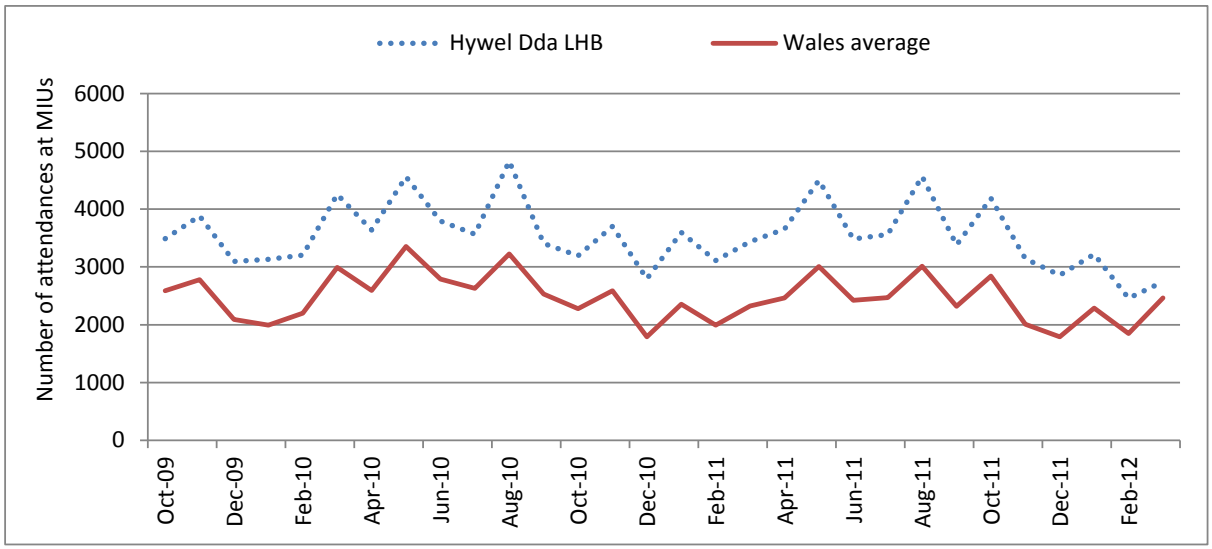
18. The pattern of attendances at the Health Board's minor injury units, including attendances at Prince Phillip Hospital, mirrors the Wales average (Exhibit 3). The number of attendances each month is much higher (40 per cent) than the Wales average because of the high number of attendances at Prince Phillip Hospital. Between April 2010 and March 2011, for example, there were 33,574 attendances at Prince Phillip Hospital's emergency department. It is difficult to compare rates of attendance at Prince Phillip Hospital with other units across Wales because of differences in definition, opening hours and types of conditions treated. For example, the number of attendances at the Neath Port Talbot Local Accident Centre totalled 35,075 during 2010-11. This unit is nurse-led and not open 24 hours a day.

Exhibit 2: Trend in monthly attendances at major accident and emergency departments at Hywel Dda Health Board, October 2009 to December 2011



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

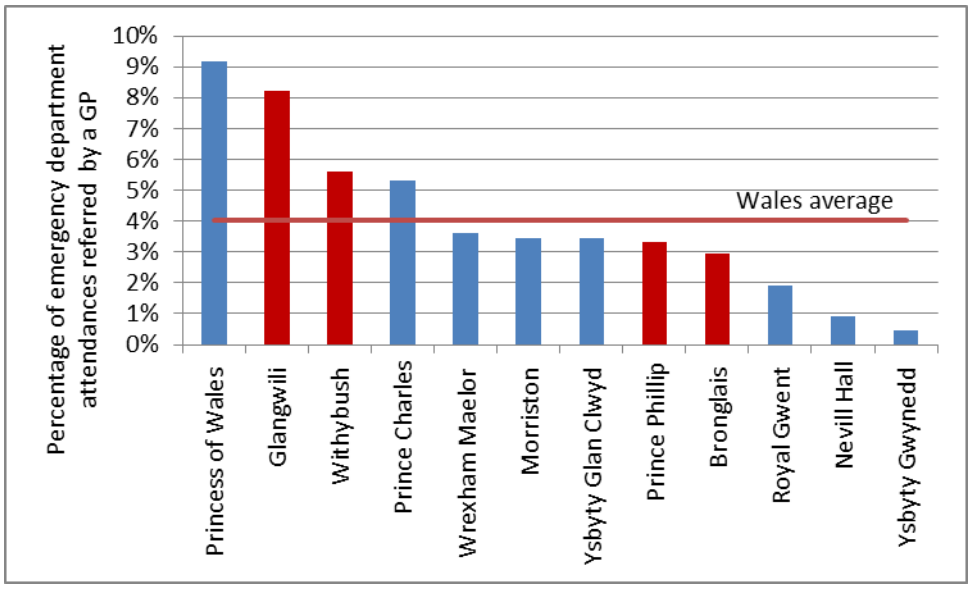
Exhibit 3: Trend in monthly attendances at Hywel Dda Health Board's minor injury units between October 2010 and March 2012



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

19. The *Ten High Impact Steps to Transform Unscheduled Care* argue that there is a need to reduce the rate at which primary care refers urgent cases to the acute hospital. A small proportion (five per cent) of attendances at Hywel Dda emergency departments are referred by a GP, which is slightly higher than the Wales average (Exhibit 4). These data do not include direct referrals to emergency assessment units (EAU). For example, 88 per cent of referrals to the EMU at Bronglais Hospital were from GPs.

Exhibit 4: Percentage of emergency department attendances referred by a GP in 2010-11



Data are not available for the Royal Glamorgan Hospital and University Hospital of Wales.

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

20. GP referrals account for eight per cent of all attendances to Glangwili emergency department, more than double the Wales average and also higher than that at Withybush emergency department (six per cent). The Health Board has suggested a number of reasons why GP demand is higher in Glangwili than the Wales average. However, most are based on perception and not as a result of formal mapping of demand and patient flows. If the Health Board is to properly understand and manage unscheduled care demand, it needs to better understand the reasons for the higher than average proportion level of GP referrals. Using the Wales average as a guide, the Health Board may be able to reduce demand further in some of their emergency departments. The Health Board needs to work with GPs to identify how demand can be reduced and reductions sustained.

21. During our fieldwork visits, staff told us that many attendances at the Prince Philip Hospital emergency department could typically be managed in primary care, for example, those with coughs, colds, rashes and bumps and lumps. A Health Board review of demand at Prince Philip Hospital emergency department found that a large proportion of attenders had problems best dealt with by their GP instead of attending the unit. There are value-for-money implications of managing these patients within the emergency department when services are already available in primary care. There is also a potential impact on the quality and timeliness of care for other patients if the emergency department is overwhelmed with patients that could be treated more appropriately elsewhere. We found that a small proportion (four per cent) of patients, who attended Prince Philip emergency department in 2010-11, did not wait for treatment. The proportion of patients not waiting for treatment had doubled since 2007-08. This may be a consequence of difficultly providing timely treatment but that is not clear from our review. The Health Board needs to understand the reasons behind patients leaving without treatment and put measures in place to minimise clinical risks or redirect patients to more appropriate services.

22. Managers were confident that the clinical service strategy would provide an opportunity to address primary care demand within the emergency department. In the short term, the Health Board needs to consider how to manage demand that could be met more appropriately in primary care. For example, Cwm Taf Health Board, working with the Local Medical Committee, implemented a policy whereby patients are redirected to their GP provided the triage score is low and physical parameters, like temperature and pulse, are normal.

23. Part of the solution to reducing unnecessary admissions or referrals to A&E 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. Seven of the 17 practices responding to our survey[7] reported undertaking work to identify patients who repeatedly attended the emergency department or other unscheduled care service. All 17 practices told us that they were notified when practice patients accessed the emergency department.

[7] In November 2011, we emailed a questionnaire survey to GP 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 Hywel Dda Health Board, only 17 of the 57 practices surveyed (30 per cent) responded, despite encouragement from the Health Board to do so. While unlikely to be representative of all Hywel Dda practices, we have used these responses to illustrate particular issues. Please note that the Health Board provided us with the names and addresses of the 57 practices surveyed although Health Board documents regularly refer to 55 GP practices.

24. The Health Board has measured emergency department demand in various ways, including an analysis of the top 10 reasons for attending. Withybush Hospital is working with one of the large GP practices to assess whether frequent attenders could have been predicted.

The Health Board is struggling to fill vacancies in emergency departments for senior medical staff and emergency nurse practitioner cover is insufficient and some emergency departments are more vulnerable at night due to challenges securing appropriate cover

25. The College of Emergency Medicine now recommends that every emergency department should have at least 10 emergency medicine consultants to provide up to 16 hours 'on site shop floor' cover, seven days a week[8]. At the time of our fieldwork, the Health Board did not meet this recommendation from the College (Appendix 3).

26. 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 proportion of time that senior clinical decision makers are present on the shop floor. Both Glangwili and Withybush departments have monitored the time senior clinical decision makers (ie, consultants and middle grades) are present. By changing rotas and recruiting staff, a senior decision maker is present in the Glangwili department for 15 hours. Withybush has a Consultant in ED for 13 hours each day Monday to Friday, with Consultant presence between 1pm to 9pm on weekends and bank holidays. This is supported with 24-hour middle grade cover. At the time of our fieldwork, the Health Board had not reviewed the proportion of time that senior clinical decision makers were present at the Bronglais emergency department. We were told that there were regular imbalances of the rota with too many senior clinical decision makers available on some days and none on other days. Since our fieldwork, the Health Board has begun to review the rotas.

27. While Withybush emergency department provides around the clock middle-grade cover by utilising locum medical staff, there are no senior clinical decision makers in the Glangwili or Bronglais emergency departments overnight. At Bronglais, junior doctors seek support from the Hospital at Night specialist doctors or the middle-grade doctor on duty for medicine. The team works alongside the emergency department, which means that they are easily accessible and on-call senior speciality support is also available. The Hospital at Night model is yet to be fully introduced to the Glangwili Hospital. In its absence, the junior doctor, who works alone from 2am until 9am, is supported by the speciality registrars and the on-call A&E Consultant. The absence of senior decision makers out-of-hours is known to increase clinical risk and result in more patients being admitted as junior staff are more risk averse. While the Health Board has put in measures to mitigate the risks, it needs to assess the effectiveness of these arrangements and consider putting in additional measures if these are deemed inadequate.

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

28. Since the end of March 2008, the total number of whole-time equivalent (WTE) consultants increased from 3 to 4.87 at the Glangwili and Withybush emergency departments (Appendix 4). However, like other health boards, Hywel Dda has experienced difficulties filling substantive consultant and middle-grade emergency department posts, particularly at Withybush Hospital.

29. The Health Board has undertaken a number of initiatives to recruit candidates including overseas recruitment. Two emergency department doctors were recently recruited from Dubai but both have since left due to inadequate exposure to trauma work. In the meantime, the Health Board continues to rely on locums to cover any shortfall in medical staffing, which carries a level of risk in respect of reliability and sustainability.

30. In November 2011, there were a number of vacancies for medical staff at Withybush Hospital. Vacancies for consultants were being filled by locums while those for middle-grade posts remained vacant (see Appendix 5). There have been no substantive, ie, permanent, consultants at Withybush Hospital emergency department for a number of years and the department is staffed by locum consultants. The numerous recruitment campaigns have consistently failed to attract suitable applicants. The reliance on locum cover at Withybush creates regular crises with the most recent in December 2011. Two of the three locum consultants resigned while the third consultant took up a six-week sabbatical. In January 2012, 2.8 WTE locum consultants were appointed with fixed term contracts for one year. During this time, the minor injury units at Tenby and South Pembrokeshire hospitals were closed temporarily in order to redeploy the ENPs and increase capacity at Withybush emergency department in the short-term. During the time that the minor injury units closed emergency department activity at Withybush rose by 3.8 per cent. The Health Board concluded that the closure of the two units had very little impact on the Withybush department.

31. The number of nursing staff deployed across the three main emergency departments increased by 10 per cent from 88.88 WTE at the end of March 2008 to 97.72 WTE at the end of November 2011 (Appendix 6). One contributory factor has been an increase in the numbers of nursing staff to support the new Withybush emergency department, which opened in July 2010. Although there has been an increase in nursing staff, there were a number of vacancies for nursing staff at Glangwili and Withybush hospitals. The nursing vacancy rate for these two departments was six per cent compared with four per cent across Wales (Appendix 7).

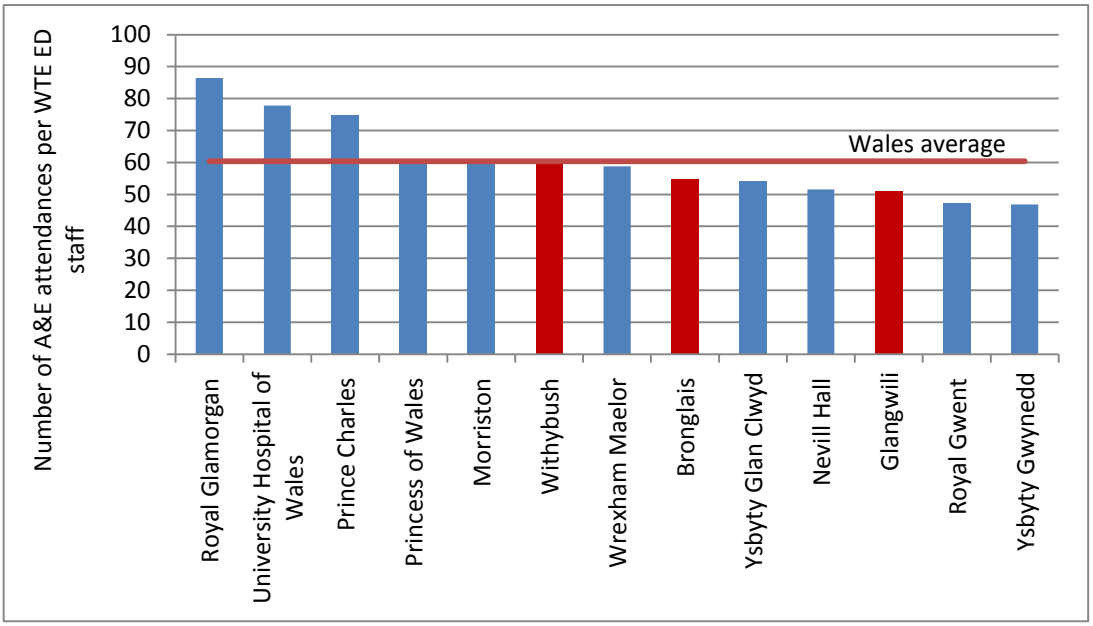
32. Data provided by the Health Board as part of this audit shows that the number of registered nurses deployed as ENPs has increased since 2007-08. However, there is a lack of clarity about the overall numbers of registered nurses practising as ENPs at two of the three emergency departments. The number of ENPs at Glangwili hospital reportedly increased from zero to one WTE but we were told that four ENPs are employed, but due to pressure of work only two actively practise as ENPs. The two 'active' ENPs covera total of four shifts (or less than one WTE) each week. One of the 'active' ENPs is a professional development nurse and the other 'active' ENP is a practice nurse. There are currently 7.86 WTE ENPs deployed at Bronglais Hospital but some staff told us that their training and qualifications as an ENP were not recognised by the Health Board. If this is correct, this means that there are fewer nurses practising as an ENP than reported.

33. Within Withybush, there is a combined ENP and medical staff approach to running the minor stream. Included within the team is a paramedic who works half time as an ENP and half time with Care on Call and operates at an extended level. The emergency department manager told us that the work of the ENPs relieved pressure in the department with patients assessed and treated in a timely way and significantly improved patient flows. Although ENP cover is provided seven days a week, the available funding does not allow cover for the full 24-hour period. However, a Health Board review of demand has shown that the ENP service is required 8am to midnight during the week, with additional support to 2am on Friday and Saturday.

34. The Health Board also employs four WTE ENPs in Prince Philip Hospital compared to zero at the time of our previous audit. In addition, Tenby Cottage Hospital employs 3.67 WTE with 3.4 WTE in South Pembrokeshire Hospital but no comparative data were available from previous years. During our fieldwork, staff told us that there were too few medical staff while nurse staffing levels were described as adequate much of the time. Nursing capacity can become constrained when the departments are working at full capacity and for some departments there is also greater pressure at night. This is particularly the case in Bronglais as the nurses have to manage emergency department patients, as well as the emergency assessment patients who often remain in the department overnight. The absence of overnight reception cover further adds to the pressure because in addition to caring for and triaging the new patients, nurses have to book presenting patients on arrival at reception.

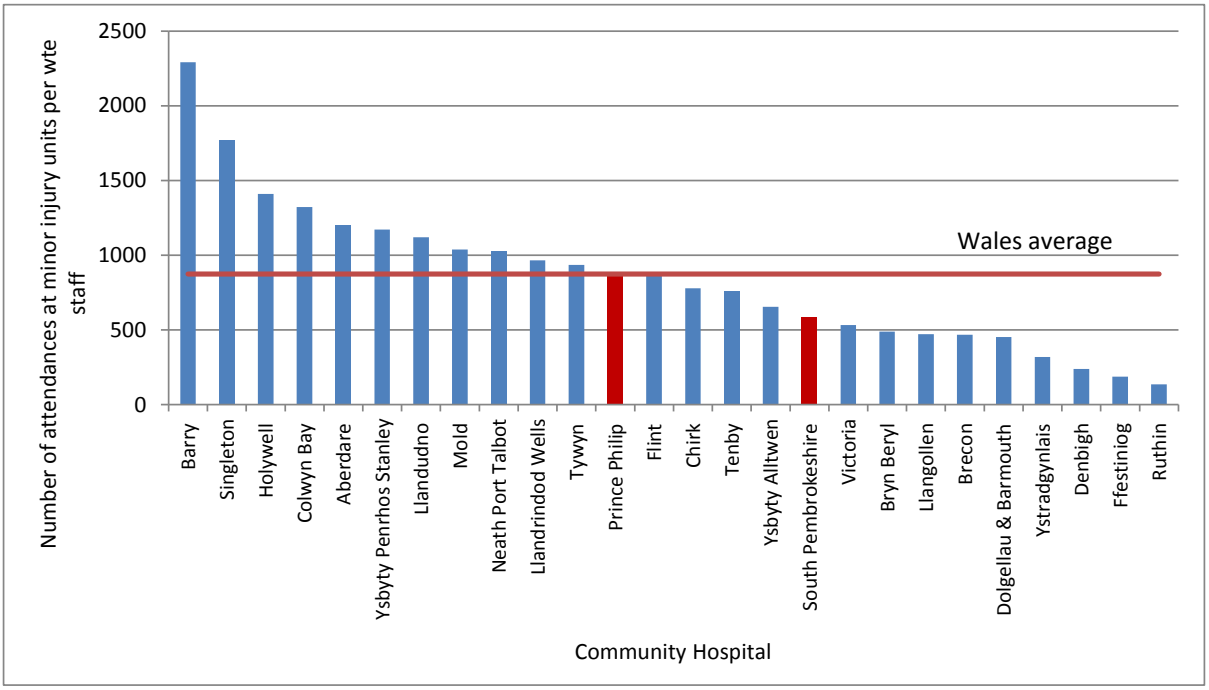
35. Workload pressure, measured as attendances per WTE staff, was at or just below the Wales average (57.9 attendances). Attendances per WTE staff at Withybush, Glangwilii and Bronglais hospitals were 59.5, 53.8 and 54.7 respectively (Exhibit 5). Meanwhile, attendances per WTE staff at the minor injury units in 2010-11 were at or below the Wales average (Exhibit 6).

Exhibit 5: Number of attendances at major A&E departments in Wales per whole-time equivalent A&E staff (including locum medical staff) in November 2011



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

Exhibit 6: Number of attendances in 2010-11 at minor injury units across Wales per whole-time equivalent staff



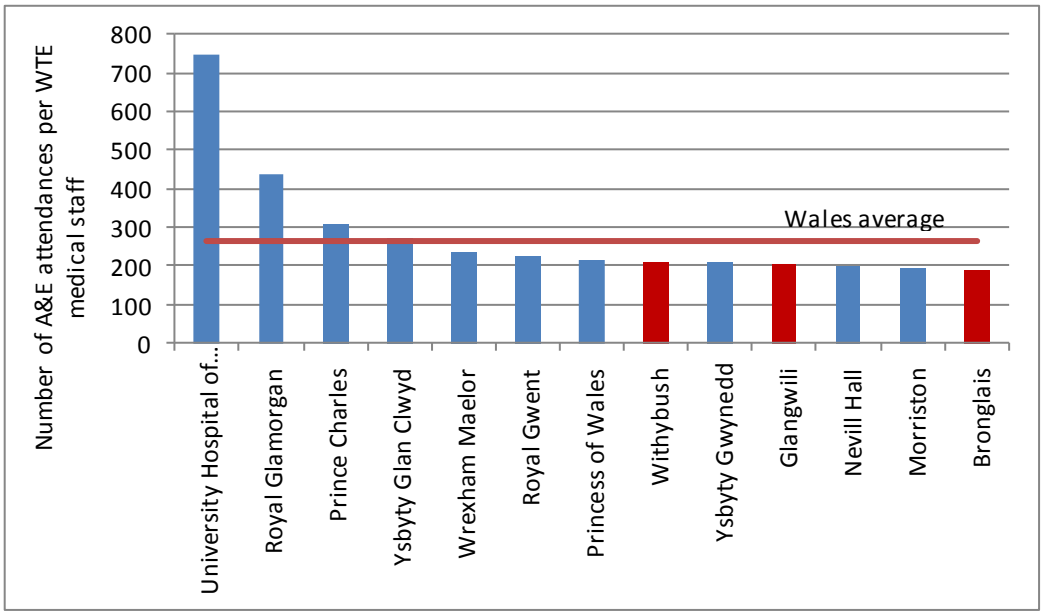
Data on workforce and number of attendances are not available for Ysbyty Cwm Rhondda.

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

36. When compared by profession the number of attendances per WTE medical staff is well below the Wales average at all three of the EDs (Exhibit 7). This suggests that when taking attendances into account there is sufficient medical staff overall but still an inability to provide sufficient around the clock senior decision making cover. Conversely, workload pressure per WTE nurse (Bands 1-9) was 83.1 at Withybush emergency department compared with the Wales average (78.3 attendances per WTE) while attendances per WTE at Glangwili and Bronglais were 73.1 and 77.3 respectively (Exhibit 8). However, the number of patients going through the Bronglais EAU are not included as part of the workload measure.

37. Interestingly, when asked, each of the departments disagreed that there were insufficient nursing staff but all agreed that there were too few medical staff. This may reflect the gaps in senior cover.

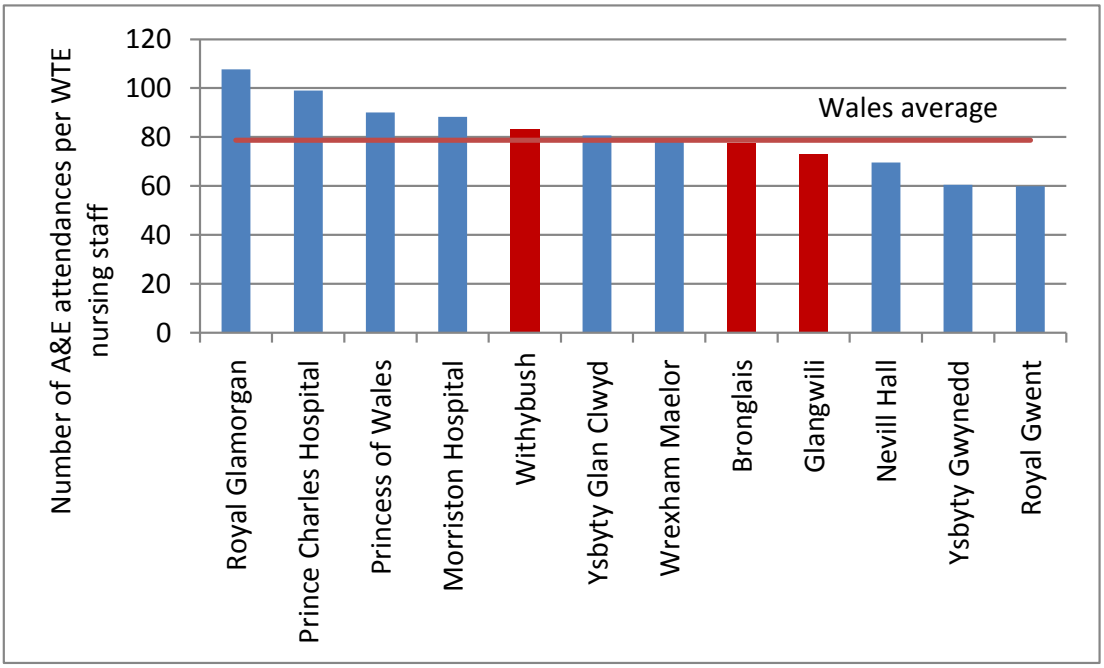
Exhibit 7: Number of attendances at major A&E departments in Wales per whole-time equivalent medical staff (including locum medical staff) in November 2011



Data are not available for the University Hospital of Wales.

Source Wales Audit Office and StatsWales

Exhibit 8: Number of attendances at major A&E departments in Wales per whole-time equivalent nursing staff (Bands 1-9) in November 2011



Data are not available for the University Hospital of Wales.

Source Wales Audit Office and StatsWales.

Positive actions have been taken to improve patient flow and reduce pressure within the emergency departments but a number of challenges remain and some require longer-term strategic solutions

38. The Health Board has taken a number of actions to address the pressures within its emergency services and improve patient flow through the departments. These include adopting a whole system approach to managing demand for emergency department services. Rather than seeing high demand as an emergency department problem, the Health Board has remodelled the way in which services are provided, and implemented changes to procedures and processes.

39. In July 2010, a new emergency and urgent care centre opened at Withybush Hospital. This new centre included a 19-bed Acute Clinical Decision Unit (ACDU) which allows more focused patient assessment and investigation. However, the layout of the department means that the resuscitation area is not in the centre of the emergency department, which staff told us increases pressures when the department is busy.

40. The number of nursing staff at the Withybush department increased to support the opening of the ACDU but 5.4 WTE nursing posts were not funded at the time of our fieldwork. This will increase financial pressures and will not be sustainable. The current staffing levels also mean that it is not always possible to have a floor co-ordinator to manage patient flows between the emergency department and the ACDU.

41. We reported earlier (paragraph 33) about the positive impact that the ENPs had on improving patient flow within the Withybush emergency department. One of the barriers to patient flow has been the long standing medical staff vacancies and the absence of a substantive consultant in emergency medicine. The absence of a lead consultant has meant that it has been more challenging to influence department practice and there are a number of examples that illustrate this. For example, during the evening no one takes responsibility for co-ordinating patient flow as it is not clear who is in charge. In addition, the lack of a lead consultant is thought by some to reduce the opportunities for effective liaison with community teams and primary care services.

42. The Glangwili emergency department is relatively new but it does not have an ACDU to help improve patient flow. In addition, there are a number of other barriers that impede patient flow in the Glangwili emergency department including the absence of around the clock senior medical staff presence and also slow specialist assessment and diagnosis from the ward teams. The Health Board believes that the 34-bed alongside ACDU due to open in summer 2012 will help resolve many of the issues currently affecting flow. The aim of the unit will be to act as a hospital hub, to include, for example Hospital at Day and Night, which will strengthen the medical assessment, support and cover provided to the emergency department.

43. A number of positive changes have been made to processes and procedures at Glangwili Hospital, which help to improve patient flow. The department implemented 'Pit Stop', a formalised triage of all major patients by a senior doctor and nurse who initiate a plan of care and direct care allocation. Pit Stop initially operated from 9am to 5pm but has been extended to 9pm. Emergency department staff and ambulance personnel were complimentary of the Pit Stop at the time of our fieldwork.

44. The Glangwili and Prince Philip departments also operates a Twilight service, five days a week from 2pm to 10pm thus enabling patients who might otherwise have to be admitted to a bed to be taken home. Once medically discharged suitable patients are referred to the service, based on their ability to get into a car vehicle. The service will provide transport to take the patients home, as well as settle them in and ensure everything is safe before leaving them. Patients are also signposted to relevant services.

45. In Bronglais Hospital, the emergency department includes an EAU. It is difficult, however, to distinguish the EAU from the emergency department as both use the same staff, and patients are cared for in the same area and the space is very restrictive. The EAU receives patients referred by their GP. Staff told us that patients are often kept in the EAU overnight and that it is not unusual to find five or more patients still in the department when the morning shift starts duty. Although bed management meetings are held in the emergency department three times a day, staff said that many of the problems arise because of a lack of available beds.

46. A new emergency department, with a 14-bed clinical decisions unit, and GP out-of-hours service is being developed as part of the Bronglais Hospital front-of-house development. The Health Board states that this new department should speed up access to treatment and help reduce inappropriate hospital admissions, as well as provide a facility that meets the needs of patients today and in 20 years' time.

47. The Health Board regularly reviews and revises medical staff rotas to increase senior doctor cover at peak times. For example, Glangwili Hospital revised its senior medical staffing rota to increase the number of senior doctors in the emergency department at peak times. This was informed by mapping medical staffing to the numbers of patients and the time when they arrived. Withybush Hospital improved its consultant cover at weekends, as well as ensuring support was available from acute medical physicians at weekends.

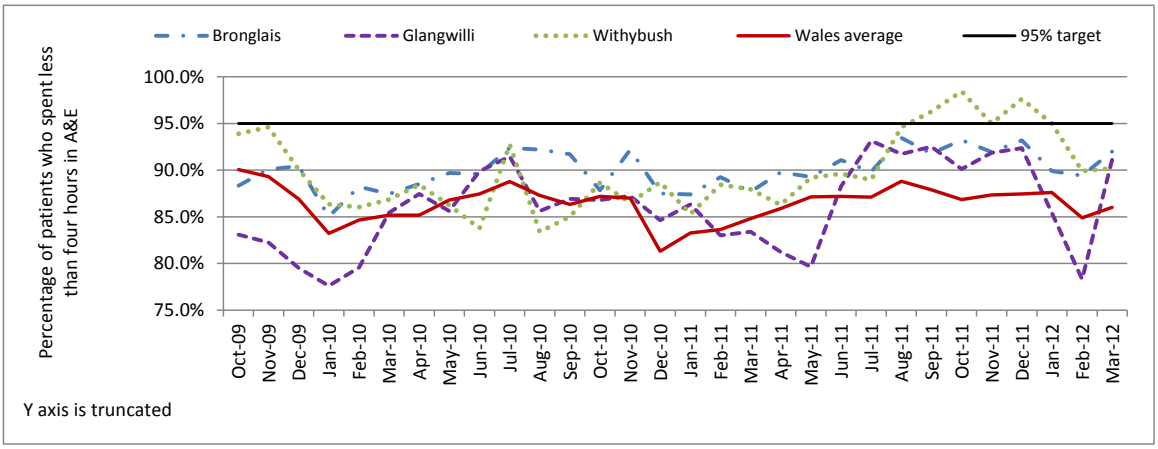
48. The development of multidisciplinary assessment and support (MAST) at Glangwili and Withybush emergency departments has improved the Health Board's ability to turn around patients at the front door and to direct patients appropriately. This is an 'in-reach' function of the locality based CRTs which operate Monday to Friday from 9am to 5pm. The Health Board has indicated that these teams have reduced admission rates and improved patient flow ensuring that patients are cared for in the right place. The MAST team includes a physiotherapist, an occupational therapist, a social worker and community nurses staffed from within the CRTs. It works on the principle of 'pulling' patients out of emergency departments and referring or signposting individuals to community services. Emergency department staff told us that the MAST team are less risk averse and by using their skills and knowledge are able to pull patients safely back into the community. Despite MAST's reported success, perceptions that there are insufficient community health and social care services that are focused on preventing people attending emergency departments persist. The Health Board is currently reviewing the effectiveness of MAST.

Performance against the four-hour waiting time target for accident and emergency department patients compares well with the Wales average but performance now needs to be sustained

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

50. The Health Board has made progress towards improving compliance with the four hour waiting time target and the steady improvement has resulted in the target being met in December 2011. Performance varies across the three main emergency departments but has been generally better than the Wales average. Withybush emergency department achieved the target in August 2011 and sustained performance until January 2012. While Glangwili and Bronglais department performance has improved they have been unable to achieve the target (Exhibit 9).

Exhibit 9: Trend in proportion of patients who spend less than four hours in the emergency department from arrival until admission, transfer or discharge



Source: Wales Audit Office analysis of data on emergency department attendances from StatsWales (statswales.wales.gov.uk)

51. 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 from December 2011 are not strictly comparable with data for the previous months. If a clinician decides that the safest place for a patient is the emergency department, the patient should remain there until it is safe to move them. This means that these patients are no longer counted as a breach. It is thought that these exclusions may give rise to a small increase in the proportion of patients waiting less than four (and eight) hours, which may explain some of the improvement in performance in December at the three hospitals.

52. Since December 2011 performance has deteriorated at all three emergency departments. The Health Board has attributed the deterioration in performance to the norovirus which led to the closure of some wards to new admissions and restricted movement of patients whose wards were affected by the virus. In addition, not all of the Health Board's emergency departments were using the revised approach and a number of data definitions were proving difficult to resolve.

53. During fieldwork it was clear that many of the staff see the four-hour target as a driver to support improvement and help manage patients in a timely way rather than simply a target to achieve. The Health Board attributes improved performance to focused attention and micro management by managers with performance seen as part of a whole-system problem rather than just an emergency department problem.

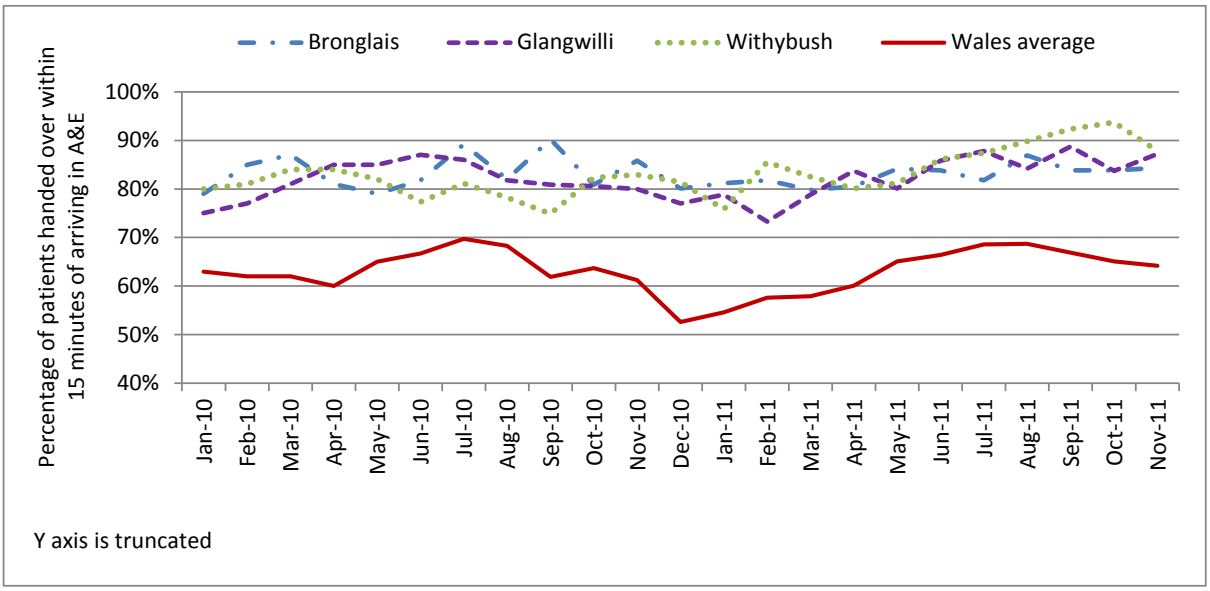
54. However, there is a risk that health boards focus too much on the four-hour threshold at the expense of looking more broadly at the timeliness of their care. For this reason, we requested information from health boards on the average waiting times in hospital emergency departments. In 2010-11, patients spent, on average, 105 minutes in the emergency department at Bronglais Hospital while patients at Glangwili spent, on average, 165 minutes in the department (Appendix 8). At Withybush Hospital, patients spent, on average, 146 minutes in the department compared with 116 minutes in 2007-08. Comparable data for 2007-08 are not available for Glangwili or Bronglais hospitals.

While the handover target has not been met over the last 12 months, fewer patients arriving at emergency departments wait longer than 15 minutes compared with other parts of Wales

55. Approximately one-quarter of patients attending emergency departments across Wales arrive by ambulance during 2010-11. When A&E and other departments experience elevated pressures, this can delay the handover of patients from ambulance crews to hospital staff. Such delays have detrimental impacts on patients who often await medical attention in the back of an ambulance or on trolleys in hospital corridors. These delays also affect the ambulance service's ability to respond quickly to other emergency calls. The Welsh Government introduced a mandatory 15-minute handover target in April 2008. More recently, the Welsh Government's *Delivery Framework for NHS Wales for 2011-12* sets out the minimum expectation that 95 per cent of all cardiac arrest, stroke and major trauma patients will be handed over within 15 minutes, while continuous improvement in handover performance is expected for all patients.

56. The handover period starts when ambulance crews notify A&E staff they have arrived with a patient who needs their care. The period ends when the crew transfer the patient's clinical care to the A&E staff. The Health Board's performance has been consistently better than the Wales average since January 2010 (Exhibit 10). The Health Board has set an interim stretch target of 95 per cent with the aim of further performance improvement. More recent data provided by the Health Board shows performance consistently above 80 per cent of patients handed over within 15 minutes but in February 2012 only 78 per cent of patients were handed over within 15 minutes.

Exhibit 10: Trend in proportion of patients handed over within 15 minutes of arrival in A&E



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

57. As with the four hour target it is important to consider the length of time and proportion of patients who have lengthy handover waits. In Hywel Dda during April and May 2011 some patients were waiting between two to three hours and a significant minority waited between one and two hours. Since that time there have been incremental improvements with just three patients waiting between one and two hours for handover in December 2011. However, performance deteriorated in February 2012, with 39 cases waiting one to two hours, eight cases waiting two to three hours and one handover took over three hours in Bronglais. Again, the Health Board attributed deterioration in performance to a norovirus outbreak.

58. A number of measures have been put in place to improve handover performance. This includes a dedicated ambulance store room at the Glangwili emergency department to help streamline turnaround by ensuring spare equipment, such as spinal boards, is available.

59. Ambulance staff that we met during our visits to each of the emergency departments described the working relationship between themselves and the staff as good or very good. They were generally positive about handover processes and were complementary of the triage process at Glangwili Hospital. However, they felt that the triage/handover process at Withybush Hospital did not always work as well as it could because nursing staff were attending to other duties. The Health Board has stated that the reason for this is that on morning shifts the triage nurse acts as the second support to resuscitation and trolley areas in periods of peak demand.

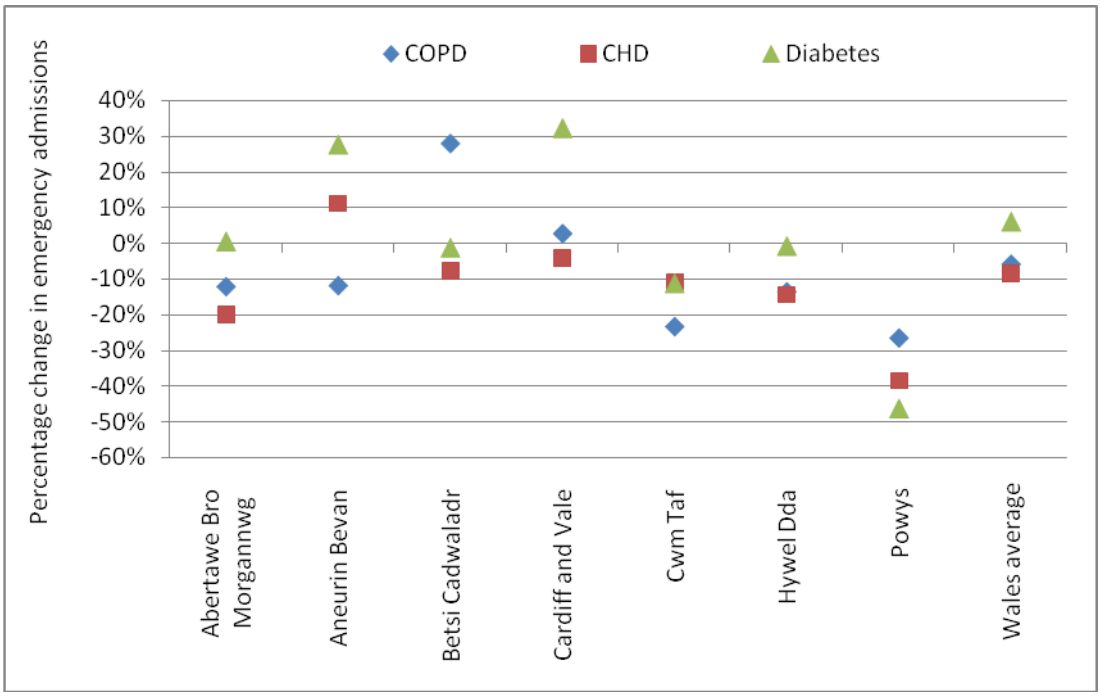
Reliance on the acute sector to manage chronic conditions is reducing and positive action to tackle delayed transfers of care and to improve patient flows is taking effect

Reliance on the acute sector to manage chronic conditions is reducing with Hywel Dda having made more progress than some other health boards but multiple admission rates and lengths of stay for some chronic conditions remain above target

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

61. Over the last five years, the number of emergency admissions for COPD and CHD fell across the NHS in Wales by six per cent and nine per cent respectively. However, the number of emergency admissions for diabetes increased by six per cent (Exhibit 11). The Health Board's performance is generally better than most other health boards. Emergency admissions for COPD and CHD reduced by 14 per cent and 15 per cent respectively. Emergency admissions for diabetes reduced by one per cent.

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



Source: Wales Audit Office analysis of data derived from the Patient Episode Database for Wales and provided by NHS Wales Informatics Service.

62. More recent Health Board data shows that for the period April 2011 to March 2012 when compared to the previous 12-month period, emergency admissions for CHD, COPD and diabetes fell by 1.5 per cent overall. For CHD they fell by 0.7 per cent, for COPD 3.7 per cent and diabetes by three per cent.

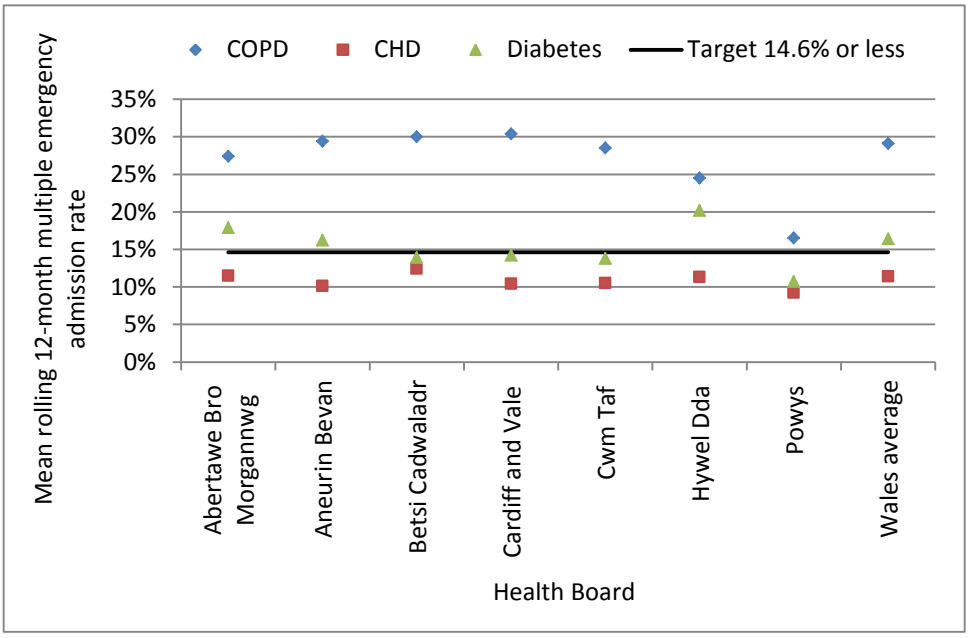
63. NHS bodies are expected to achieve a multiple admission rate ie, the proportion of repeat admissions, to 14.6 per cent or less and an average length of stay of 5.7 days or less for these three conditions. Performance against these targets is measured on a rolling 12-month basis (the performance reported for any single month therefore representing the average over the previous 12 months rather than the in-month performance). Appendices 9 and 10 show that the Health Board's performance over the last five years has been mixed. Exhibits 12 and 13 show that during this period (April 2006 to July 2011) the Health Board's mean rolling average performance was marginally better than the Wales average for COPD and CHD but not diabetes.

64. More recent health data shows that for the period 2011 to March 2012, when compared to the previous 12-month period, the overall multiple admission rate and each average length of stay target was met.

65. In summary:

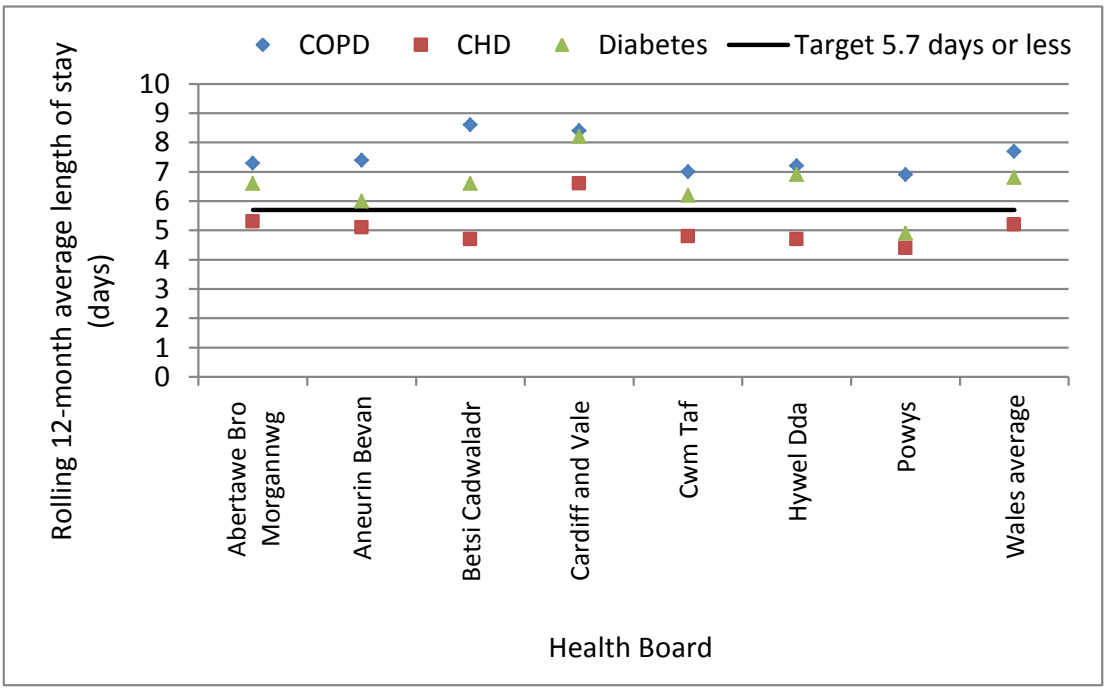
- The COPD multiple admission rate has been consistently and substantially above target throughout the last five years (approximately 26 per cent at July 2011). The average length of stay has also remained above target despite initial reductions between April 2006 and October 2008 (just under seven days at July 2011). More recent Health Board data shows that the multiple admission rate is slowly reducing now being just above 25 per cent and the average length of stay is below target at six days.
- The CHD multiple admission rate has remained below the national target throughout the last five years (12 per cent at July 2011). The average length of stay has remained relatively stable and has been consistently below target (just over four days at July 2011). More recent Health Board data show that the multiple admission rate has reduced further to 11 per cent and the average length of stay consistently remains below target.
- The diabetes multiple admission rate has been above target over the last four years (17 per cent at July 2011) despite being below target at the start of the period. The average length of stay has fluctuated over the last five years but remains above target (seven days at July 2011). More recent Health Board data shows that the multiple admission rate has improved and is just above 15 per cent and the average length of stay is below target at just over six per cent.

Exhibit 12: Mean rolling 12-month average emergency multiple admission rate between April 2006 and July 2011



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

Exhibit 13: Mean rolling 12-month average length of stay for chronic conditions between April 2006 and July 2011



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

66. Part of the 2011-12 Quality and Outcomes Framework (QOF) requires general practices to review the number of emergency admissions and look to understand the reasons for variation between neighbouring practices. The Health Board is using QOF indicators as a focus for discussion with GPs, and it is anticipating that the forthcoming expanded set of indicators will further help in that dialogue. We asked practice managers for views on the quality of the data and whether it would make a difference. Six of the 17 practice managers responding to our survey reported using the emergency admissions data that the practice received as part of the QOF process. Fewer (four) thought the data were helpful. Practices were concerned about the quality of that data on emergency admissions provided by the NHS Wales Informatics Service because of a lack of clarity over the criteria used and the way in which the data are recorded and coded. Six of the 17 practices believe the data will lead to changes in the way the practice provides services but fewer (three) think that the data will lead to improvements in patient care.

67. The Health Board is reviewing the way readmissions are coded as the information systems document a transfer of care as a code. Therefore it would become a discharge and a readmission. Similarly, a planned admission facilitated by a member of the team would be coded as an emergency admission.

68. One practice in Pembrokeshire in 2011 examined the number of emergency admissions over one year. The practice found that a fifth of the practice population aged 75 years or older were not on the chronic conditions register. Patients admitted to hospital as an emergency had at least two spells in hospital. Practice staff reviewed 30 case notes to see why individuals ended up in hospital and to see whether the admission could have been predicted. The practice concluded that it was not possible to predict admissions for these patients.

69. Minimising avoidable admissions is only possible if GPs are aware of, and have access to, adequate support services such as rapid diagnostics, access to consultant advice and hot clinics. If such services are not available, or are hard to access or to contact, GPs may be dissuaded from using them. There were mixed views from the practices responding to our survey about the support available to prevent avoidable admissions, for example:

- six of the 17 practices responding told us that they had good access to telephone or email advice from consultants;
- only one of the 17 practices told us that they had good access to rapid access clinics or hot clinics;
- five of the 17 practices reported that they had good access to diagnostic services;
- four of the 17 practices reported that they could refer patients to a good range of community services to avoid emergency admissions or hospital attendances; and
- six of the 17 practices told us that they had enough information about the range of community services available to prevent avoidable admissions.

Positive action has been taken to improve patient flows and to reduce the impact of delayed transfers of care

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

71. Between 2006-07 and 2010-11, the total number of admissions and associated bed days across the Health Board decreased by six and eight per cent respectively. During the same period the number of patients experiencing a delayed transfer of care at the Health Board rose by two per cent from 477 to 488 (Exhibit 14). Over the last five years, increases or decreases in one year have been matched by a similar decrease or increase the following year. Meanwhile, there has been a greater reduction (31 per cent) in the number of lost bed days, from 21,746 in 2006-07 to 15,079 in 2010-11. This means that the average number of bed days lost per patient (ie, the average length of time patients are delayed) has also reduced.

Exhibit 14: Trend in the number of patients experiencing a delayed transfer of care from acute and community facilities (excluding mental health facilities) at Hywel Dda Health Board

	Number of patients experiencing a delayed transfer of care	Number of lost bed days	Average lost bed days per patient
2006-07	477	21,746	45.6
2007-08	414	18,933	45.7
2008-09	485	19,201	39.6
2009-10	497	20,531	41.3
2010-11	488	15,079	30.9

Source: Data provided by NHS Wales Informatics Service.

72. The Health Board has set delayed transfers of care targets for each county to maintain focus on performance and although performance fluctuates there is an improving trend. Data from the delayed transfer of care census show that between October 2009 and March 2012 the number of patients affected in any one month is reducing (Appendix 11).

73. The Health Board has put in a number of measures to address delayed transfers of care. These include more proactive management of length of stay, for example, in Withybush Hospital weekly multidisciplinary meetings have been introduced to review patients who have been in hospital for more than 10 days. A similar approach has been adopted in Glangwili Hospital where all key stakeholders are present including a continuing care nurse, discharge liaison nurses, social services, housing and ward sisters. Patient details are reviewed to consider whether the plan of care could change. However, it is notable that the 'trigger' length of stay differs between both hospital, with 12 days at Glangwili as opposed to 10 days in Withybush Hospital.

74. Notably there has been a significant reduction in the number of medical outliers across the Health Board during 2011. There are a number of reasons for this including the improved delayed transfer of care performance, improving average length of stay for emergency combined medicine, which is consistently below the target, and improved patient flow and bed management.

75. However, bed pressures remain a regular problem. Contributory factors include the absence of a seven-day working culture, insufficient discharges at weekends, difficulties with securing transport and delays with securing take home medication. Further, there is little in place to help 'pull' patients out of wards into the community. However, recently the Ceredigion reablement team has started weekly ward rounds at Bronglais Hospital to discuss discharge planning with the ward staff.

76. 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.

77. Data published by the Welsh Government[9] show that across Wales the average number of daily-staffed beds reduced 5.5 per cent between 2009-10 and 2010-11. Across Hywel Dda hospitals, the reduction was one per cent with the biggest impact on community hospitals where bed numbers reduced by five per cent from 346 to 330.

78. A bed utilisation review of the Health Board's acute hospital beds identified that around a third of patients did not need acute hospital care but could have been cared for in a community bed or at home as the bed utilisation review concluded that not all the patients need to be in a hospital.

79. The Health Board acknowledges that they need to use their beds differently and alter the caseload to ensure that patients are cared for in the right place. In terms of the community hospital the aim is for an increased focus on 'step up' or 'step down' facilities to provide rehabilitation or supportive care. There is also an ambition for community hospitals to become locality hubs for simple diagnostic services and clinics. The Health Board envisages that partnership working with the Local Authorities, Housing Associations, GPs and the Third Sector will inform the future development of community hospitals, based on local needs. The future community hospital plans are dependent on the agreement of the Clinical Service Strategy.

The Health Board has made good progress in reshaping the way it supports people in the community to prevent unnecessary use of hospitals but more needs to be done to fully realise the benefits of the new developments

The Health Board is using various approaches to identify individuals at risk of unplanned admissions

80. The Welsh Government's chronic conditions integrated 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.

[9] http://www.statswales.wales.gov.uk/ReportFolders/reportfolders.aspx?IF_ActivePath=P,280,1033,1561

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

82. The Health Board has not been able to undertake the full chronic condition patient risk stratification because of rollout delays with the national PRISM risk stratification tool. The all-Wales risk stratification tool is unlikely to be available until at least 2013. In the meantime the Health Board identifies those most at risk and with the greatest need through a variety of mechanisms but the extent to which risk stratification currently takes place varies by locality. Approaches include using information on:

- patients who frequently attend the emergency departments;
- frequent users of the out-of-hours service registers;
- individuals that receive high cost health and or social care packages;
- the GP practice chronic disease register;
- information from falls risk assessment; and
- identification of individuals on the District Nurse caseload.

83. In Carmarthenshire, three health promotion/frailty specialist nurse posts have been established to work with GPs in order to identify frail elderly people in the community more effectively.

84. In addition, the development of the CVW and of the chronic conditions management model in general, is linked to the stratification of patients within the GP practice population into different levels of health risk. For the Carmarthenshire virtual ward pilot the criteria used varied from frequent emergency department attenders, individuals that GPs deemed to be at risk and individuals who were at risk of falling.

New services have been introduced into the community but the community virtual ward is not yet at a stage to attract significant demand away from hospitals

85. We highlighted in our previous reports on chronic conditions management that, while there were some good initiatives in place across the three predecessor NHS trusts, there was limited provision of community-based services. There was, therefore, little alternative capacity to help reduce reliance on the acute sector. Models of care were traditional with very limited specific chronic condition schemes being reported. Over subsequent years, the Health Board has undertaken a number of new initiatives which have had a positive impact on the wider unscheduled care services.

86. The CVW infrastructure is being developed across the Health Board to help facilitate a shift away from hospital bed-based care. The focus is on early identification of those in the community with complex care needs, leading to appropriate interventions and anticipatory care to reduce the risk of health deterioration, particularly among the frail elderly and those with chronic conditions. Care is case managed and co-ordinated across sectors reinforcing the principle of care in the most appropriate setting, frequently closer to, or in, patients' homes.

87. The virtual bed model was shaped by using true-case scenarios in South Ceredigion. The three Carmarthenshire localities tested the approach with results reported through the Community and Chronic Conditions Board to assist the developments across the Health Board.

88. Local arrangements are being varied to suit different populations. Decisions about how to vary arrangements are influenced by disease prevalence across the counties and localities. The Health Board has, in line with its general approach, set the broad scheme for service development, whilst empowering counties and localities to take forward their own specific arrangements. The intention is to achieve a balance between the freedom to act locally and appropriate overall corporate monitoring and management.

89. Current work on CVW projects is at different stages of development and the extent of coverage is largely limited to one or two GP practices within each area. Carmarthenshire through one GP practice in each of its three localities is managing a limited number of patients using, and testing, the CVW approach. Pembrokeshire has established a project team to drive the development of the community network including the use of the CVW model. Ceredigion working with four GP practices in the South cluster have determined the requirements for the virtual ward. This identified significant gaps in terms of the therapy resource requirements to enable them to move to the virtual ward concept. While there is a move to pull posts from acute into the community there is also recognition that additional funds may need to be secured.

90. The Health Board has recently secured Invest to Save funding of £2.7 million to support the virtual ward concept from the Welsh Government. The Health Board intends utilising this money to enable the comprehensive rollout of the CVW. The overall aim is to provide a more robust community service infrastructure to reduce acute service admissions and contain CHC expenditure by mainstreaming care rather than care defaulting to a CHC package. The Health Board is currently considering how this investment is to be utilised with recognition that implementation must be picked up.

91. A number of other developments have provided a positive impact on reducing pressure on acute services. Acute Response Teams (ARTs) have been established in each of the three counties. The teams work on a 24-hour, seven-days-a-week basis. They provide a rapid response service enabling patients to receive an intervention in the community. While the specific scope and context of services vary by county, they all focus on provision in patients' own homes and community hospitals. A wide range of professionals can refer to the ARTs, and patients and carers can also contact them directly. They all provide treatment for patients with a wide range of chronic conditions, such as undertaking blood transfusions, intra-venous antibiotic administration and other services. However, staff reported increasing difficulties in providing services within available resources, although they confirmed that they are able to utilise district nurse support when required.

92. A reablement service has been established in each of the counties. The service is for adults who are at risk of losing independence in activities of daily living following injury or due to a chronic condition or those who have an assessed need following discharge from hospital or deterioration in health. Some of these services were available at the time of our previous reviews but provision has since been extended to provide coverage throughout the week such as in Ceredigion. The Carmarthenshire reablement service is based within the CRTs across the county. Work is currently underway to look at how the service model might be further developed in the future.

93. Wider arrangements include a Chronic Condition Nurse Practitioner (CCNP) Service established in Pembrokeshire, providing generic case management for patients with most chronic conditions. Diabetes specialist nurses have been appointed to work in the community. A diabetes pathway and model of care have recently been approved for use on a Health Board wide basis. A Health Board wide service has been established for oxygen therapy, based in the community, and provided by two part-time specialist nurses in Pembrokeshire, one full-time specialist nurse in Ceredigion, and one full-time specialist nurse in Carmarthenshire. By focussing their work in the community, the specialist nurses are better able to understand patients' home environment and existing therapeutic models, and make more effective assessments of need.

Significant progress has been made in establishing community resource teams in Carmarthenshire and Pembrokeshire and while progress has been slower there is now an equivalent co-ordinating structure in Ceredigion

94. *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 CRTs will target care and support to help individuals identified as at the greatest risk of hospital admission to maintain independence in their own communities.

95. The Health Board as part of a planned approach has moved to integrate service models within the three counties, although each had a different starting point and, as a consequence, all are at different stages of development. There are relatively well-established CRTs in both Carmarthenshire and Pembrokeshire. The CRT in Ceredigion was established more recently in April 2012. Ceredigion had a lower starting point in terms of its community service base than the other two counties, and this is reflected in the current extent of co-ordination of its community-based services.

96. In March 2011, the Health Board and Carmarthenshire Local Authority approved a Section 33 Agreement for Carmarthenshire Community Health and Social Care Services. There has been a long standing history of integrated multi-agency and multi-disciplinary teams running chronic conditions services and community services together. This was further strengthened following significant investment through Wanless monies, transitional funding, and chronic conditions demonstrator site funding. The Section 33 Agreement aligns Carmarthenshire health and social care services and will support the development and implementation of integrated management and delivery of community based health and social care. The agreement covers seven functional areas, including physical and learning disability, children's, housing, public health and mental health services. It also covers adult and social care services within which the CRT sits.

97. The scope of the teams is across social care assessment and care provision, enablement services, community nursing services, and chronic conditions management services. A number of Carmarthenshire CRT services are available 24 hours a day, and are not time limited. They can respond within a couple of hours if necessary, dependent on need. Referrals can be made by a diverse range of professionals eg, paramedics, GP out-of-hours services, A&E services, and social services. Patients and carers can also contact the team through the Contact Centre.

98. In Pembrokeshire, there are four CRT sub-teams based around GP practice clusters across two localities. They are virtual multi-disciplinary teams, and are not co-located. Their focus is on vulnerable people requiring assistance due to disability, impairment, age, frailty, chronic conditions, mistreatment, neglect, harm and mistreatment. Referral arrangements are broadly the same as in Carmarthenshire. All 'customers' receive a face-to-face multidisciplinary assessment in their own home. Work is ongoing to enable full implementation of the Unified Assessment Process, to enable access to the service. All customers are being seen by the Reablement Service as part of their assessment and where changes in need are identified the Reablement Team revisit the customer to ensure their independence is maximised. Services available during the daytime on weekdays, are not time limited, and can be initiated immediately dependent upon individual need.

99. There are weekly multidisciplinary team meetings to review and assess patients and despite early concern about whether staff would attend multi-disciplinary meetings, there has been good representation. However, there is recognition of a need to strengthen therapist involvement. Also there are currently no systematic processes for identifying patients who attend the emergency department or are seen by the out-of-hours service and there was recognition that this needed to be resolved.

100. In the Ceredigion locality, there was a lower base of services, particularly in relation to therapists, than in the other two counties. Ceredigion consulted on its community structure during December 2011 and January 2012. From this a locality structure was agreed, with modernisation of community nursing and the appointment of additional therapy posts.

101. Ceredigion now has CRTs, with new therapy posts established since April 2012. Physiotherapy & Occupational Therapy Services have also been restructured to move some staff to CRTs and provide an 'in reach' model to community hospitals. There is also a restructure and modernisation of community nursing underway in Ceredigion with establishment of new community posts and virtual ward clerks.

102. Sharing information between health and social care professionals about individuals remains a challenge because information systems are not joined up. Work is ongoing to encourage information sharing within multidisciplinary teams and beyond when appropriate to do so. The WASPI[10] has provided a helpful context for information sharing.

103. There is recognition that the CRT approach will require the development of different skill sets, and that this will need to be addressed through workforce development plans. For example, district nursing services can play an important role in the CRT setting. However, there is still a traditional approach to district nursing across the Health Board, particularly in Ceredigion. There has been resistance to changing secondary care specialist nurse roles into ones which are community oriented. The intention is that when specialist nurse posts become vacant, these will be redesigned so that the roles have a greater focus on the community. It is recognised however that this can only be on an ad hoc basis.

Financial investment has helped to embed new ways of working in the community

104. 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. The Health Board and its predecessor bodies received a total of £1.38 million in transitional funding over the three years. This funding was used to help implement the chronic conditions integrated model and framework. For example, through:

[10] The Wales Accord on the Sharing of Personal Information (WASPI) provides a framework for service-providing organisations directly concerned with the health, education, safety, crime prevention and social well-being of people in Wales. In particular, it concerns those organisations that hold information about individuals and who may consider it appropriate or necessary to share that information with others in a lawful and intelligent way.

- Appointment of Locality Care Planning Service Co-ordinators across the Health Board, three in Carmarthenshire and one each in Pembrokeshire and Ceredigion. Thereafter transitional funding was mainstreamed within Ceredigion and within Carmarthenshire merged into the new Assistant Locality Manager roles. Whereas in Pembrokeshire the Care Closer to Home project manager role was implemented.
- Enabling improved multi-agency and multi-disciplinary engagement, part of which provided for the employment of three lead GPs, three lead district nurses, social services support, and care planning co-ordinators.
- Development of locality leadership roles for chronic conditions to support implementation of services in the community, which have become embedded as part of CRT establishment in Carmarthenshire and Pembrokeshire.
- Implementation of CRT work in relation to chronic conditions from Level 1 to Level 4 of the CCM triangle, such as:
  - further development of Expert Patient Programmes;
  - development of pulmonary rehabilitation in each of the three counties;
  - enhancement of the Community Oxygen Service;
  - video conference facilities to increase services offered in the community and closer to where the patient lives;
  - a Lifestyle Advisor pilot for those at risk of a chronic condition, which anticipated the incorporation of this type of skill into communication hubs;
  - Lymphoedema Service support to improve access to services across all three counties; and
  - training for community staff to support the frail and elderly across all three Counties.
- Work to support the use of specialist nurses in the community while continuing to provide an in-reach service to secondary care.

105. The Carmarthenshire chronic conditions management demonstrator site has been a driver for the whole Health Board in helping to disseminate good practice and other lessons learned. The Health Board received £341,743 over the course of three years specifically for the demonstrator work. Key aspects of this work included:

- Building the foundations of locality working through locality leadership groups with GPs, social care and nursing leads for each cluster.
- Informing the development and implementation of the service specification and establishment of the CRTs and core CCM team.
- Use of telecare/telemedicine for patients in the community with COPD. The aim of this study was to see if home telemonitors reduced healthcare use in those with COPD. The study of 40 patients concluded that tele-monitoring reduces primary care chest contacts but not hospital or special team utilisation. The project team concluded that telehealth could be offered for a time limited period for those whose COPD becomes unstable.

- A series of multi-sector, multidisciplinary and user workshops to examine and determine the information management and technology user requirements for CCM.

106. The Carmarthenshire chronic conditions management demonstrator site was regarded as an important driver for the whole Health Board in helping to disseminate good practice and other lessons learned. *Setting the Direction* is seen as providing the Health Board with a minimum standard to work towards, with the experience of the demonstrator site enabling services to raise the standard still further.

107. While specific attribution as to the impact of each element of work is difficult, there is overall evidence of a shift away from activity in the acute sector in sustained reductions in chronic conditions emergency admissions, readmissions and bed-days utilised.

108. Budgetary information provided by the Health Board also indicates increased funding (distinct from the transitional funding) for intermediate care and chronic conditions services over the last five years. In 2005-06, the combined budget for intermediate care and chronic conditions services was estimated at a minimum of £4.02 million. By 2011-12, the budget was a minimum of £7.04 million, excluding the costs of the district nursing service and CRTs.

The use of primary care contracts to support chronic conditions management is limited

109. Historically, the use of primary care contracts in creating capacity to care for and support patients in the right place has been limited. In 2006-07, the Health Board's predecessors spent £4.73 million on GMS enhanced services with 23 per cent of the expenditure used to improve primary care access and to provide a very small number of services for patients with chronic conditions, such as diabetes, or providing minor injuries services. Expenditure had reduced to £4.38 million by 2010-11 with little change in enhanced service provision.

110. The diabetes local enhanced service, for example, is provided by 49 of 55 practices across the Health Board. Other enhanced services provided by practice staff included those aimed at primary or secondary prevention, such as immunisation schemes. One hundred community pharmacies provide services to people living in the Hywel Dda area with the majority dispensing prescriptions or giving health advice to their local communities. The Health Board commissions a small number of enhanced services from community pharmacies for a more modest level of expenditure (£107,000 in 2010-11, projected to increase to £216,000 in 2011-12) to support people with chronic conditions or unscheduled care needs to self-care. These include:

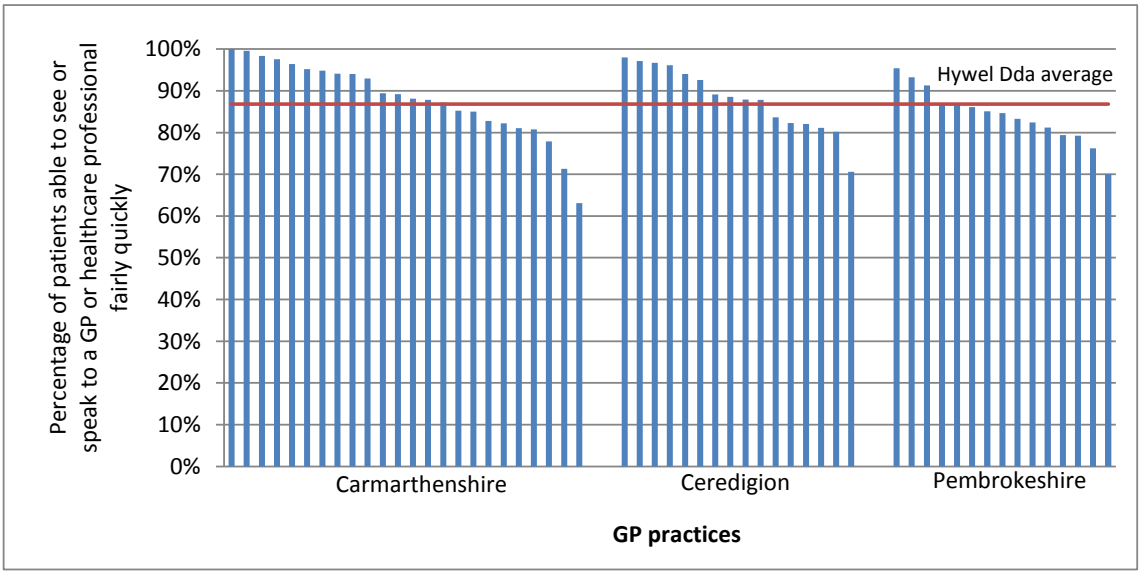
- Smoking cessation schemes – since 2009-10, the number of community pharmacies participating in smoking cessation schemes has grown; 57 community pharmacies across Hywel Dda currently participate in the scheme.
- A service to provide 'Just In Case' boxes as part of a palliative care scheme was due to commence in December 2011: 57 pharmacies will provide this service with plans to increase to 75 during the year.

Access to both in-hours and out-of-hours primary care is generally good although work to integrate out-of-hours within emergency departments needs to be accelerated

111. 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.

112. Findings from the 2011 Welsh GP Access Survey, which was conducted in February 2011, suggest that a higher proportion (87 per cent) of GP practice patients were able to see or speak to a GP or other healthcare professional on the same day or the next day compared with the average for Wales (84 per cent). However, there were large variations across practices within and between counties (Exhibit 15). The main reason cited by patients for not being able to see or speak to a GP or healthcare professional quickly was the lack of appointments while a small number were offered an appointment with a doctor that they did not want to see or speak to. The survey findings also show that 79 per cent of Hywel Dda patients were able to book an appointment with a GP or healthcare professional more than two days in advance, which is somewhat higher than the Welsh average of 74 per cent.

Exhibit 15: Percentage of patients registered with GP practices in Hywel Dda who reported being able to see or speak to a GP or healthcare professional on the same or the next day



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

113. The Health Board continues to take positive action to improve access to primary care, working closely with the Local Medical Committee. Each year, the Health Board requires practices to provide information on surgery opening times, as well as time available for face-to-face and telephone contact. During 2010-11, the extended hours enhanced service was available in 15 practices, with practices either opening earlier or closing later on weekdays, not Saturdays.

114. The Health Board also carries out a 'mystery shopper' exercise in all its GP practices to monitor and evaluate access to appointments within two working days of advanced booking. If concerns are identified the Primary Care Teams work collaboratively with the practices to design and implement an action plan.

115. The Health Board's 2011 Primary Care Annual Report outlined a number of actions for 2012 to further improve access. The actions include:

- reviewing the flexibility and availability of access during core opening hours;
- undertaking a pragmatic review of half-day closing and its impact on communities; and
- piloting a project to examine the number of patients that do not keep their appointments with the GP practice in order to improve capacity.

116. Practices themselves are also looking at ways to improve access, such as undertaking a weekly audit of the third available appointment or auditing waiting times for appointments. Nearly all (16 out of 17) practices responding to our survey told us that they had used the GP Access survey to review the way they provide urgent access. Twelve practices have also actively sought the views of individual patients or patient participation groups on how to improve access. The types of changes implemented following feedback include:

- changing the GP appointment system to match demand:
  - keeping appointments free each day for urgent or emergency appointments;
  - adjusting the mix of same-day and book-ahead appointments;
  - increasing the number of same-day appointments;
  - scheduling same-day appointments for the morning and book-ahead appointments in the afternoon; and
  - reducing branch surgery appointments and increasing capacity within the main practice.
- running a separate urgent or emergency clinic each morning;
- maintaining open access surgeries;
- telephone triage after a surgery finishes; and
- daily telephone consultations.

117. Seven practices have analysed the number and pattern of phone calls to the practice. For those practices that did analyse the number and pattern of telephone calls, more telephone lines were installed, dedicated telephone lines set up for repeat prescriptions and in one practice the reception team was restructured to deal with the demand during peak times. Ten practices told us that they had formal protocols in place to deal with requests for urgent or emergency appointments. Nearly all practices (16) indicated that receptionists received training to identify callers who needed an urgent or emergency appointment but fewer (10) had reviewed the effectiveness with which their receptionists were able to identify such cases.

118. The barriers to improving same-day or urgent access cited by practices include:

- a lack of understanding amongst the patient population about what is or is not urgent;
- patients' failure to attend appointments, even when same-day appointments have been booked;
- patients' reluctance to see the 'emergency doctor' rather than their regular GP; and
- lack of information for patients about self-management of minor ailments or injuries.

119. 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.

120. The out-of-hours service in Hywel Dda is managed and delivered differently across the three counties. In Ceredigion and Pembrokeshire, the out-of-hours service is provided 'in house'. Call handling and triage are provided by salaried staff who are based above the emergency department at Withybush Hospital.

121. In Carmarthenshire, Primecare, a commercial organisation provides the call handling, telephone triage and scheduling of appointments. These arrangements have been in place for several years and are regarded as working well, with few complaints, robust performance management and effective audit processes. The out-of-hours treatment centres are located in Glangwili and Prince Philip hospitals and are staffed and managed by the Health Board.

122. Of the 17 practices responding to our survey, 14 perceived out-of-hours services to be good or very good, while the remainder had no strong views. One practice commented that the out-of-hours service was keen to receive information on any practice patients who were likely to need particular care. The out-of-hours service also informed the practice about calls it received from practice patients in a timely manner, giving appropriate accompanying information.

123. 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. In Hywel Dda there are different models for the way that the out-of-hours services interface with the four hospital emergency departments.

124. The Health Board has established protocols to support appropriate cross referral between the out-of-hours services and the emergency departments but arrangements do vary across the Health Board:

- at Bronglais Hospital, the out-of-hours service is integrated within the emergency department and patients can be streamed to either service;
- at Prince Philip Hospital, the out-of-hours services are co-located with the emergency department but arrangements are reported to work well;
- at Withybush Hospital the out-of-hours service has been co-located with the out-of-hours service but not all aspects are yet fully integrated; and
- Glangwili Hospital, the out-of-hours service is located some distance from the emergency department.

125. While the Health Board's ambition is to integrate out-of-hours services in all emergency departments, there have been some barriers to realising this ambition. Within Withybush Hospital, the plans to fully integrate are well advanced but the reception area is not yet fully integrated. The plan is for one reception for both services with receptionists sifting attendees and ENPs streaming patients before booking and directing to the right service.

126. At Glangwili Hospital, the Health Board is trying to overcome the longstanding barriers to integration such as space allocation within the emergency department, perceived incompatible IT systems, and concerns about out-of-hours staff being drawn into looking after emergency department type patients.

127. While there are no issues with out-of-hours vacancies in Carmarthenshire, Pembrokeshire similar to other Health Boards, is experiencing significant issues with out-of-hours doctor vacancies. In addition, the lack of overnight district nurse and Acute Response Team cover is reported by the Health Board to compound the problem further. We were also informed of issues with a disconnection between out-of-hours services and the district nursing services. This was reported to lead to double call handling which is inefficient use of staff and frustrating for the patient. There are on-going discussions to try to make the process more streamlined possibly utilising the ADASTRA system.

128. The Integrated Health Record (IHR) is a summary of patients' GP records. It lets GPs and nurses working for the out-of-hours service access basic information about an individual's medical history. The IHR is seen as important for improving the safety of out-of-hours consultations, as well as speeding up decision making. Our fieldwork found that although all Hywel Dda GP practices are signed up to the IHR not all were 'live'. In Pembrokeshire and Ceredigion, most (87 per cent) practices were using the IHR. In Carmarthenshire, only half (54 per cent) the practices were using the IHR although this covered 72 per cent of the registered population.

129. In general, the Health Board sees the IHR as a popular solution with a high degree of governance controls (all patients are asked for their consent to access their record and this is recorded) and an audit programme is in place to check the audit logs for inappropriate use. However, the Health Board has been frustrated at the lack of progress in making IHR accessible to hospital staff, for example, within the emergency department. This has been outside the Health Board's control but agreement has now been secured at a national level to provide the required access.

130. Within Hywel Dda, expenditure on primary care out-of-hours totalled £5.82 million in 2010-11 the equivalent of £14.99 per registered patient. Expenditure per registered patient, other than in 2009-10, is significantly higher than the Wales average. When compared to other health boards Hywel Dda is the second highest behind Powys (Exhibit 16).

Exhibit 16: Expenditure on primary care out-of-hours per registered patient between 2005-06 and 2010-11 compared to other health boards

Local Health Board	GMS OOH spend per registered patient (£)					
	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
Abertawe Bro Morgannwg	£8.00	£7.99	£8.30	£7.76	£7.94	£8.07
Aneurin Bevan	£8.70	£9.34	£9.74	£9.88	£10.10	£10.10
Betsi Cadwaladr	£11.31	£11.12	£11.49	£9.61	£10.98	£10.80
Cardiff and Vale	£7.02	£7.63	£7.29	£7.64	£7.92	£7.71
Cwm Taf	£10.55	£8.47	£9.91	£8.15	£8.81	£10.47
Hywel Dda	**£15.19**	**£15.50**	**£15.95**	**£16.13**	**£12.25**	**£14.99**
Powys	£20.26	£20.20	£18.66	£18.48	£18.49	£18.43
Wales	**£10.42**	**£10.41**	**£10.68**	**£10.10**	**£10.10**	**£10.54**

Source: Wales Audit Office analysis of audited accounts

131. Our 2009 USC national report said that: “The cost of primary care out-of-hours services is higher in more rural and larger geographical areas with the average cost per registered patient £10.10, ranging from £7.25 in Swansea to £19.68 in Pembrokeshire. The variation in costs is similar to that seen in Scotland, with higher costs in more remote or rural areas. Apart from rurality and geographical spread and high demand, as measured by calls per 1,000 registered patients, some variation in costs might arise from differences in the scope of the contracts. For example, in Powys the contract includes medical cover for community hospitals.”

132. While rurality is likely to be a key factor for the higher costs the Health Board needs to assess whether there are any other factors and whether costs can be reduced without detriment to the quality of service and care.

While measures to support self-care are being actively promoted, more could be done to influence the way the public use hospital services

Public marketing through Choose Well is being progressed but has not yet been fully implemented and more could be done to redirect patients where appropriate

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

134. 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. The campaign 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’.

135. The Health Board has a Choose Well Communication Strategy and Implementation plan. The Health Board launched their local campaign at the same time as the national campaign. The local campaign was integrated with the winter flu campaign with a number of joint press releases, radio interviews and staff bulletins, as well as Choose Well messages on the Hywel Dda website.

136. The Health Board decided to adapt and localise the national Choose Well information prior to a mail shot to all households in the Hywel Dda catchment area. One example is the inclusion of community support advice such as pharmacists or the voluntary sector. The national Choose Well information is included on the front page of the Health Board’s website. As there are some differences between this and the local information the Health Board will need to think carefully how to reduce the risk of potential confusion.

137. The Health Board has found it challenging to fund the Choose Well campaign materials, such as leaflets and fridge magnets, as well as the distribution costs. However, funding has been secured through the use of county charitable funds. The Health Board has worked with Carmarthenshire County Council on the redesign and marketing of the campaign material of the leaflet and the Health Board has informed us that the materials will be available very soon for distribution.

138. The Health Board is keeping alive the 'Choose Well' message by displaying posters within the emergency departments at Glangwili and Bronglais hospitals, explaining who to contact in non-urgent situations. At Glangwili Hospital, the Health Board also plans to display a poster *Getting it Right* at the entrance to the emergency department to signpost patients to the most appropriate care provider. Although posters for Choose Well and the NHS Direct Wales *Think carefully before going to A&E Department* were on display at the Bronglais Hospital emergency department, these were not within prominent view. Also staff told us that they were not aware of any campaigns to raise awareness amongst the public about choosing the right service. However, staff said that when time allows they try to educate patients about the right service. We were also told of high demand from University students who are often not registered with a local GP. While there has been work to signpost students to the correct setting success has been limited.

139. In addition to posters at Glangwili Hospital, the emergency department has other systems in place to signpost and redirect patients. A flow chart within the triage area is used to guide and redirect patients towards the most appropriate setting. In the reception area, an electronic sign tells patients that if their injury is not an accident or emergency then they should see their GP or phone NHS Direct Wales. When the emergency department is busy, the tannoy system can be used to read a pre-prepared notice to patients, which is the same as the electronic sign.

140. In Withybush Hospital no signposting information was evident although staff did say that they refer any patients that attend out-of-hours to the out-of-hours doctors where appropriate.

The provision of communications hubs to signpost people to the right services varies across localities with no clear overall strategic vision

141. 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.

142. At the time of our fieldwork, communications hubs were operating within Carmarthenshire and Pembrokeshire localities. The Ceredigion locality did not have a communications hub, but the Health Board was establishing a working group to develop arrangements for a 'Single Point of Access'.

143. The hub in Carmarthenshire is the most developed. The Local Authority has a well-established communication centre for access to council services. Alongside this it operated Careline, to provide an urgent response to 'lifeline' calls. The Health Board and the Local Authority, working in partnership, expanded the service to become Careline+. It is both 'in hours' and 'out-of-hours' and is managed by the Carmarthenshire Locality Manager.

144. The service is primarily for older people and the physically disabled. There is a single phone number for receiving enquiries from the public and professionals. An online form for professional enquiries has been piloted, with a view to making it a key means of access to information. A multi-skilled Careline+ team includes social care officers and provides triage through a single point of contact before referring on to services. All referrals for the CRTs are routed through the communication hub. A strategic business case is being established for the further development of the communications hub arrangements in Carmarthenshire to provide a more comprehensive service. By ensuring simplified and consistent access for all stakeholders the aim would be to provide rapid direction of patients to the optimal care provider for any episode of care. This would be through a network of care providers, potentially including health, social care and third sector partners.

145. The Pembrokeshire locality Careline was established by Pembrokeshire Local Authority at premises within County Hall. It is managed by a Community Service Manager who works across health and social care. The service is currently only for social care although there are plans to develop the service to handle referrals to CRTs. There is a view that senior clinical decision makers are needed as part of these arrangements to triage and signpost patients. Since January 2012 a re-ablement management presence has been introduced in the hub to improve the consistency of call handling outcomes. There is also a separate out-of-hours hub which is run by the Health Board and is located above the A&E department at Withybush Hospital.

146. The Health Board worked with Pembrokeshire Local Authority in 2009-10 to establish a contact centre when there was a risk of pandemic flu. They used Careline to enable the public to get advice and to access health services. Although this collaboration was regarded as effective, subsequent joint working on communications hub development has been slow. There are concerns about whether Careline has the capacity, capability, and an appropriate customer centre ICT infrastructure to manage an increase in potential service users. Work is reported to be underway to provide direction for the future of this service.

147. There has been some discussion about the potential for joint working between Carmarthenshire, Pembrokeshire and Ceredigion in support of out-of-hours work and a single point of access. However, at present there is no clear vision or plan for the Health Board communications hub. Furthermore, there is uncertainty about the direction for local communications hubs in the medium to long term, given several regional and national issues, particularly:

- the possible development of a 111 non-emergency service phone number, to run alongside the existing 999 emergency service;
- debate about the advantages and disadvantages of regional, as opposed to local communications hubs; and
- the role of NHS Direct Wales in providing information and signposting.

The Health Board is actively taking measures to promote and strengthen self-care

148. It is essential that individuals are encouraged and supported in looking after their own health and well-being. Self-care[11] is associated with positive outcomes for individuals, as well as helping to reduce reliance on healthcare services. The Welsh Government's framework for self-care[12] set out the key elements of support for self-care, such as information and signposting, skills training for patients, telehealth and telecare.

149. Our previous audit of chronic conditions management at the Health Board's predecessor bodies in 2006 found that only a third of the community services for patients with chronic conditions included aspects of patient education or support for self-care. By 2011, all community services provided, or commissioned, by the Health Board included education and support for self-care. Since our previous report on chronic conditions, work has taken place in a variety of ways across the three counties to advance the self-care. A self-care strategy has been developed and its delivery plan includes:

- self-management education and support for patients with specific conditions;
- lay-led generic self-management educational courses;
- simplified dosing strategies and information for patients;
- home-based self-monitoring (eg, for oxygen saturations, blood pressure, anxiety levels);

[11] The self-care continuum starts 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.

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

- interactive web-based self-management programmes;
- peer support for people with long-term conditions; and
- lifestyle coaching.

150. The Health Board supports the national generic self-management education programme for patients (EPP) for people with long-term conditions and those caring for someone with a long-term condition. The programmes aim to give participants confidence to look after their own health needs while encouraging them to work collaboratively with health and social care professionals. 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.

151. Individual EPP programmes are delivered locally by co-ordinators employed by the Health Board together with volunteer lay tutors. Two-fifths of the EPP courses have been run in partnership with other services and stakeholders, such as the probation service, substance misuse services and mental health and learning disability services, to target harder to reach groups. The ability to run EPP courses has been affected by the availability of co-ordinators throughout 2011. Six EPP courses were planned for quarter three in 2011-12 but only four could be provided.

152. The Health Board supported 24 EPP courses between April 2010 and December 2011, with, on average, 12 individuals registering for each course. Just over a fifth (22 per cent) of individuals registering to attend an EPP course failed to attend or dropped out once the course got underway (Exhibit 17). All health boards submit quarterly information to the EPPC, including details about the extent of provision and local participation in these courses. The completion rate (that is the number of individuals registering for a course and completing it) was one of the highest (78 per cent) amongst the health boards; the Wales average was 63 per cent (Appendix 12). In order to achieve the expectations set out in the ministerial letter, the Health Board will need to ensure that more than four times as many individuals complete a course.

Exhibit 17: Quarterly trends in the provision of Education Programmes for Patients* at Hywel Dda Health Board

Quarter and year	Number of courses	Numbers of people registering for EPP courses	Number of people who do not attend	Number who drop out once course started	Number of registrants completing a course
Q1 - 2010-11	4	54	0	12	42
Q2 - 2010-11	4	57	5	12	40
Q3 - 2010-11	3	31	0	5	26
Q4 - 2010-11	2	25	3	4	18
Q1- 2011-12	3	37	0	1	36
Q2 - 2011-12	4	50	3	10	37
Q3 - 2011-12	4	40	2	8	30
Overall total	**24**	**294**	**13**	**52**	**229**

*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.

153. Expenditure on the EPP programme was collected for the period October 2010 to September 2011 with three health boards able to provide costs. The cost per EPP course completed at Hywel Dda was £378 which compares well but could be reduced further if completion rates increased (Exhibit 18).

Exhibit 18: Cost per EPP course completed between October 2010 and September 2011

Health Board	Cost per completed EPP course (£)
Cwm Taf	735
Hywel Dda	378
Betsi Cadwaladr	333

Source: Wales Audit Office analysis of data provided by health boards combined with data for the EPP programme.

154. The Health Board promotes its education programmes on its website and recent information shows that the Health Board offers four different programmes to support individuals' needs.

155. In addition to the EPP courses, the Health Board is using assistive technologies, such as telemedicine and telehealth, to support individuals in the management of their chronic condition. Telehealth monitoring equipment is being used for COPD patients to provide alerts of a deterioration or exacerbation in condition. This enables earlier access to treatment and subsequent reduction in severity.

156. In Carmarthenshire the Telecare service working across health and social care supports individuals to remain within their chosen environment for as long as possible. The service works alongside the CRTs and is being used by over 1,000 individuals in the community.

157. Although successful in the first round the Health Board was unsuccessful in its bid to become one of five pilots for the Delivering Assisted Living at Scale (DALLAS) programme. The programme covering the Hywel Dda and Powys communities would show how assisted living technologies and services could be used to promote well-being and enable people to live independently.

158. A number of community-based services also incorporate patient education and support for self-care, as well as promoting healthy lifestyles, such as the pulmonary rehabilitation services and the weight management programmes.

The Health Board has a clear vision and good prospects for delivering transformational change but there are risks to its future success if it is unable to effectively engage the public

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

The Health Board has a clear and well-understood vision but success will be reliant on workforce transformation

The Health Board's strategic vision is well aligned to what needs to be done to improve chronic condition and unscheduled care services

160. The Health Board's *Right Care, Right Place, Right Time, Every time, Five Year Framework*, was published in September 2010. The framework sets out a vision for how healthcare should be provided in the future with a shift from acute to community care and towards prevention and self-care. It clearly sets out the challenges and health needs faced by the Hywel Dda community, the challenges of delivering services in a largely rural, wide geographical area and the case for change. Within the framework stakeholder communications and engagement is a prominent theme for developing stronger partnerships. The framework was published following consultation with a wide range of stakeholders.

161. The Health Board's vision for an integrated approach to the provision and delivery of services is reflected in each of the local authority partners, Health, Social Care and Well-being Strategies. Each of the strategies set out a range of actions that will support the delivery of the Health Board's strategic aims. The vision is to provide 80 per cent of NHS services locally, through primary, community and social care teams working together through community resource centres.

162. In May 2011, Hywel Dda launched a business plan that outlines the Health Board's priorities for the next three, five and 10 years' time which aligns to the principles in the Health Board's five-year framework. The plan makes a commitment to improve the health of its population through a number of initiatives. It draws on Needs Assessment information provided by Public Health Wales and the Health Social Care and Well-being Strategies. Each county will be expected to produce forward plans to support operational delivery of the business plan which will be developed in conjunction with key partners including the Local Authorities and the Third Sector. The plan does not describe how the Health Board will deliver a reformed health service rather it describes the outcomes for its population.

163. The Health Board's original intention was to translate the five-year framework into a more detailed operational and financial strategy but after further consideration decided to apply a forward-looking 'route map'. This comprised four stages aimed at developing a Clinical Services Strategy. The stages of this route map would be informed both by external service and financial imperatives and internally through a range of other strategies including clinical and stakeholder consultation. The process of developing the route map commenced with a series of workshops involving a range of internal and external stakeholders to help inform the direction of travel.

164. In supporting the strategic vision the Health Board developed mechanisms for engagement and managing future service change, and has developed a three-year communications strategy, a consultation plan and established a Transitional Board. The Health Board launched its listening and engagement phase 'Your Health-Your Future' for the Clinical Services Strategy early in 2012 prior to formal consultation late in 2012. The supporting documents reiterate that change is needed and to achieve this aim significant investment in primary and community care facilities and services is required. The overarching vision is to provide 80 per cent of NHS services locally, through primary, community and social care teams working together from community resource centres.

165. During our fieldwork most people that we interviewed strongly supported the strategic direction of travel but there was frustration from executive down to operational level around the time it has taken to secure and agree the detailed plan. Moreover, the absence of a definitive strategy has restricted decision making about future service provision. Nonetheless, as discussed in the first part of this report progress has been made with regard to progressing general arrangements to facilitate a shift of care from the acute sector into the community.

166. The successful delivery of the strategic vision would undoubtedly benefit both unscheduled care and chronic conditions management. In the meantime, the Health Board has set out other, lower-level strategies in relation to chronic conditions and community services. The vision for the Health Board is embodied in the ABC of Integrated Community Services which was agreed in March 2010. This was a response to a number of national strategic documents which predated '*Setting the Direction'.*

167. The Health Board's predecessor organisation, Hywel Dda NHS Trust had developed an *Unscheduled Care Services Delivery Strategy 2009-2011* which outlined the key aims, deliverables and actions. In anticipation of the new clinical service strategy the Health Board has not updated this unscheduled care strategy. Instead, it is aligning its framework to the *Ten High Impact Changes for Unscheduled Care Transformation Plan*. This plan forms a key aspect of the workload of the Health Board's USCCPB which is discussed later in this report.

Workforce plans need to be developed further to support the transformation and modernisation of the Health Board's unscheduled, community and primary care workforce

168. 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.

169. While the Health Board acknowledges the challenges to sustaining emergency department services across four sites, given the difficulties recruiting appropriate medical staff there is not an overall Health Board wide emergency department workforce plan or staffing model. We reported earlier (paragraphs 25 and 26) that the Health Board's major emergency departments fell short of the College of Emergency Medicine recommendations. In addition, in common with other health boards, Hywel Dda has found it difficult to recruit to consultant and middle-grade posts in its emergency departments particularly in Withybush where there has been significant reliance on locum cover.

170. The Health Board's USCCPB acknowledged the urgent need to develop a safe, sustainable 24-hour staffing model for the four emergency departments at the time of our audit. To support this each department has been required to map their 24-hour staffing and take into account the available community resources that support its activity, such as MAST. However, we found discrepancies in the emergency department staffing data submitted to us as part of the audit, which relates to problems categorising job roles. This suggests that there needs to be greater clarity around job roles and numbers.

171. The Health Board acknowledges in its 2012 workforce plan that imaginative solutions are required to sustain provision of emergency department services and make posts more attractive to potential medical applicants which could include:

- service redesign;
- changes to medical emergency rotas, including cross cover across specialities and across sites; and
- a move away from a medical model and use of advanced practitioners to modernise teams.

172. Currently, ENPs are used to varying degrees. The Health Board recognises that in general it is a very traditional model and that in all areas extended scope nurses could be used more widely. Advanced nurse practitioners are seen as a potential solution to some of the medical staffing problems and also to improve patient flow in the emergency departments particularly for the minor injury streams. However, the Health Board has not developed a plan that shows what it wants to achieve from its ENPs and how it is going to achieve it. Also in paragraph 32 we noted confusion over the numbers actually practising as an ENP and that not all were fully trained to actively carry out the role.

173. There are a number of operational barriers to effectively utilising the extended nursing skills within the emergency departments which include:

- an inability to practise skills due to workforce pressures which can also impact on confidence and deskill staff;
- insufficient ENPs to provide the required cover and difficulty releasing staff to support the required additional training;
- disparity in pay and practice; and
- cultural and behavioural barriers with a very medically driven model.

174. Although the Health Board is actively training ENPs the barriers highlighted above will need to be overcome before the Health Board can realise the ambition of using the ENPs more widely.

175. The rebalancing of the care system set out in *Setting the Direction* will require an increased capacity within the community. Workforce plans that consider the number and type of staff in the community will therefore be vital to success. The Health Board recognises that to date its workforce plans do not adequately reflect the required workforce changes to allow care to be shifted from secondary into primary and community care. The view is that this cannot be finalised until the service strategy is agreed and enacting the service redesign plans would require 'invest to save' pump priming.

176. The Health Board's 2012 Workforce Plan recognises a number of challenges including the need to shift care into the community whilst sustaining service delivery and the impact of rurality on flexible use of staff amidst significant financial challenges. The plan highlights a number of modernisation activities which include workforce redesign and practice. Examples include the planned re-alignment of therapy workforce to support the Virtual Ward and community driven services. In addition, the Workforce Development Group has established a task and finish sub-group, on a Health Board-wide basis, to look at the skills of nurses in acute settings and to consider how the focus of their work can be re-oriented towards the community.

177. The Health Board is developing a specific workforce sub-group to act as a vehicle for all community workforce planning changes and to ensure alignment with strategy. It is acknowledged that flexibility and a need to look beyond traditional roles would be required, for example, different skills exist between community and practice nurses, but the skills available should be viewed in the whole. The sub-group would also be the vehicle used to progress the Community Nursing Strategy. The purpose of the group would be to articulate the key actions needed to deliver what is required. While it was noted that there was the potential to gain some quick wins it was acknowledged that other work would take months and years to be realised. However, work has already been undertaken to identify numbers, skills, education and roles required for workforce transformation.

178. Whilst general practitioners are independent contractors and are generally not directly employed by the Health Board, there is a role for the Health Board in working with primary care to ensure its communities have an appropriate primary care workforce. However, the Health Board acknowledges that there has been limited work undertaken that analyses the contribution of primary care contractors and their teams. The Health Board should progress its plans to review the existing clinical workforce within primary care, as reported in the 2011 Primary Care report.

179. The Health Board acknowledges that the new models require workforce redesign and different skill sets and it sees workforce skills as a key risk and the main barrier to the development of services. This forms an important aspect of the Health Board's workforce development and is reflected within the 2012 workforce plan with explicit reference to the need for NLIAH to support Assistant Practitioner and support worker development locally.

Governance arrangements to support the transformation of unscheduled care services need to be strengthened and better aligned to services for chronic conditions management

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

181. The corporate agenda for chronic conditions management is led by the Executive Director of Therapies and Health Science who has been highly active at a national level in the development of the *High Impact Changes for Chronic Conditions* initiative. This is being used locally as a further driver towards change, with a local action plan reporting template having been agreed by the Care and Chronic Conditions Management Board (CCCMB) in February 2012.

182. The Health Board has a well-established Community and CCCMB Steering Board. Recently, the CCCMB's terms of reference were reviewed and amended. The CCCMB is responsible for reviewing progress and promoting the delivery of the relevant national and organisational strategies and plans in relation to community services and chronic conditions management.

183. The CCCMB meets bi-monthly. The CCCMB is chaired by the executive lead for chronic conditions. Membership includes four other executive directors, namely the Medical Director, the Director of Nursing, the Director for Primary, Community and Mental Health Services and the Director of Strategic Partnerships. The group is largely community focused. The terms of reference clearly identify the governance arrangements, including reporting arrangements, meeting frequency and key relationships. This group reports to the Integrated Governance Committee, which provides assurance to the Board. When the group meets, there is multi-disciplinary representation, including GPs and voluntary sector representatives. The CCCMB has a clear work programme with good focus and despite being a large group, attendance is generally good.

184. The corporate agenda for unscheduled care is led by the Director of Performance, Planning and Delivery. The Health Board has established an USCCPB. The USCCPB reports to the Clinical Advisory and Assurance Group (CAAG). The chair of the USCCPB is also a member of the CAAG. The CAAG supports the senior management team in translating strategy and vision into implementation at a local level, and receives clinical pathway work. The CAAG is a cross-county, multidisciplinary and multiagency group but it is not a decision making group. However, the CAAG meetings were suspended whilst members worked on the Clinical Services Strategy in a wider group. While CAAG was re-established in July 2012 it is unclear where the USCCPB reported to in its absence.

185. The USCCPB terms of reference were drafted in 2010 but are incomplete and not finalised. Consequently, the arrangements for governance, reporting, meeting frequency and key relationships are unclear. The current terms of reference state that the USCCPB is responsible for the development of an unscheduled care strategy and to assess the Health Board's current service models against best practice and all-Wales recommendations. The group is also responsible for developing and redesigning clinical pathways to improve quality and efficiency.

186. The USCCPB is chaired by the clinical lead for unscheduled care, who is an emergency department consultant. The group has wide membership with key stakeholders from the Health Board's corporate centre, including five assistant directors, the counties, the ambulance service integrated health and social care leads and the CHC. However, GPs are not members of this group, which is a critical omission.

187. Findings from our review indicate that although there have been a number of achievements as a result of the work of the USCCPB, such as the development of a patient flow diagram from A&E to out-of-hours, the group has struggled to be clear about its aim. Some members believe that progress has been slower than expected but that the group is beginning to focus more on the strategic issues. The USCCPB chair expects the focus on strategic issues to continue when the Health Board's clinical service strategy is finalised. There are, however, a number of barriers that are affecting the group's effectiveness.

188. The USCCPB appears to have less of a corporate focus than the CCCMB. Notwithstanding the clinical service strategy, a number of the issues discussed within the group appear to require corporate solutions. While the counties have a key role to play in improving unscheduled care services in their area some issues can only be resolved at a corporate level, for example, medical staffing. Moreover, meeting attendance fluctuates and on occasion has dropped to as few as eight members. Some members consistently fail to attend. The non-attendance has had a negative impact on decision making as some issues remain outstanding when key individuals fail to attend. Key factors for non-attendance are thought to be due to meetings being cancelled at short notice and then rescheduled, a plethora of committees and a degree of overlap between some committees. Additionally, concerns have been expressed by some managers that the regular cancellation of USCCPB meetings compromises their ability to escalate concerns and manage aspects of unscheduled care. To improve the effectiveness of this group the terms of reference need to be revisited and governance arrangements need to be strengthened.

189. There is a clear inter-relationship between unscheduled care and the management of patients with a chronic condition, yet the CCCMB terms of reference do not identify the USCCPB as a key relationship. While the Integrated Governance Committee is the key assurance forum we believe that the Health Board needs to consider how it can strengthen the linkages between its chronic conditions and unscheduled care forums to support transformational change.

190. At Board and Committee level the Health Board reports on a wide range of performance indicators largely comprising the Delivery Framework Tier 1, Tier 2 and Focus Areas of performance. Where information is available performance is reported at both a Health Board and county level. At an operational level, broader, more detailed measures are considered such as medical outliers, bed closures and the numbers of patients who have been an inpatient for 15 days or more.

191. Previously the key driver for unscheduled care was the LDP and its action plan but this has now been replaced with the *Ten High Impact Steps to Transform Unscheduled Care* which covers all the key areas. Each county is now using this to monitor progress and report back to the USCCPB.

192. Previously the Long Term Delivery Plan (LDP) was drawn up against the CCM framework but the new LDP has been aligned to the Ten High Impact Changes. The delivery of *Setting the Direction* is county driven with an overarching push at executive level. The CCM Ten High Impact Changes are seen as a key output from *Setting the Direction*. The CCCMB provides focus and the maturity matrices provide monitoring mechanisms, and actions are often driven through task and finish groups.

193. In last year's Structured Assessment and subsequent Annual Audit Report we noted that primary and community care service performance management needed to be strengthened. As part of the CCM transitional funding, work was undertaken to consider expenditure, achievements and outcomes. Core outcome indicators were developed to assess the impact of the funding but it is not clear if this has continued. Also Carmarthenshire Health and Social Care Board has worked with Results Based Accountability to help inform and develop a performance framework for the community resource team.

194. The Health Board acknowledges that the service redesign plans bring with them a requirement for strengthened multi agency governance arrangements including performance management and this will form part of the Health Board's work programme going forward.

Strong partnerships have been built up with key stakeholders and the Health Board is committed to engaging its clinicians but influencing the public is proving challenging

The Health Board is committed to engaging clinicians in service redesign and structural change has promoted and strengthened primary care engagement

195. 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.

196. The Health Board sees clinical engagement as a critical enabler in addressing challenging service configuration issues and ensuring future sustainability. It has invested a significant amount of time and effort in developing and agreeing the clinical service strategy, and clinical engagement has been a key plank in informing and agreeing the strategy.

197. The process of developing the strategic direction commenced with a series of workshops involving a range of stakeholders to help inform the direction of travel. Seven clinical 'Think Tanks' were established to engage with clinicians. For the clinical areas chosen, clinicians were presented with all the key demand factors and constraints, such as finance and skills shortages facing their service. Clinicians were asked to examine their current service and to consider what a future service could look like. This was followed by a two-day workshop with senior clinicians including doctors, nurses and therapists. Additional clinically driven option workshops followed.

198. Clinicians told us that the process of developing the Clinical Services Strategy has contributed to a better understanding of the issues and reinforced the need for strategic change. Senior clinicians told us that they felt engaged in the service reviews and the development plans to modernise services. However, some other clinicians and managers did not feel as closely involved in this process. The Health Board recognises that they needed to do more to influence and inform this level of staff and work is underway to strengthen understanding and ownership of strategic solutions throughout the organisation.

199. With much of the planned transformation relying on rebalancing care towards primary and community services, it is vital that primary care practitioners are fully engaged. Clinical engagement with GPs is considered to be much better now and GP leads are clearly seen to have been a positive development, especially in Carmarthenshire. The chronic conditions demonstrator in Carmarthenshire brought people together to discuss and share experiences. The GP lead roles are seen as creating opportunities for the first time in many years to sit down with hospital staff to improve the dialogue. The Health Board recognises that time commitment is a barrier to effective clinical engagement and that it needs to demonstrate that GP involvement will result in change.

200. There are a number of examples of good engagement with GPs including:

- across all counties the virtual ward development exemplifies good engagement and partnership working between GPs, specialists, nurses and social workers; and
- in Ceredigion, the Chronic Conditions Board is chaired by a GP, and GPs are leading the pilot of the Virtual Ward.

Significant progress has been made in establishing working and integrated partnerships to support service delivery but public engagement has been challenging

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, health boards, local government, the ambulance service and many more.

202. Partnership working is seen by the Board 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. There is much evidence of partnership working in practice and in development. The commitment to partnership working is demonstrated by the appointment of a Director of Strategic Partnerships to support integration and improve partnership working.

203. Earlier in paragraph 96 we reflected on the Carmarthenshire Section 33 agreement for all community services. It involves integrated and shared posts and integrated budget management aimed at reducing duplication. The future aim is to pool budgets and put in place a single management structure. The structure is based on a mix of health and social care professionals and a number of the posts within the senior management tiers are based on a 50:50 split between the Local Authority and the Health Board.

204. In addition, Carmarthenshire Local Service Board, in agreement with each of its strategic partners including the Health Board, developed an *Integrated Community Strategy for Carmarthenshire 2011-2016*. This document streamlines and reduces the previously separate plans and strategies into one document. The integrated strategy demonstrates the commitment of all partners to work together to drive forward improvements. A Section 33 agreement is in place for the South Pembrokeshire Hospital Health and Social Care Resource Centre. This formalised the joint working arrangements that had been in place since 2003. The agreement will provide the framework for taking forward the future service development of health and social care in the community to prevent dependency, promote independence and safety for the clients and their carers.

205. To varying degrees across the three counties there has been a history of working in partnership with the voluntary sector. However, there was recognition that this needed to be strengthened as the previous arrangements were complex, excluded certain groups and often contributed to duplication. As a result, the Health Board redefined the way they work together and developed a new strategic direction for its joint work with the third sector in supporting health, social care and well-being. It provides a platform for working in partnership with the voluntary sector through its document – A *Co-design Future: The Third Sector Role in Health and Social Care in Hywel Dda of Services Strategy*. This strategy establishes the principles and processes for working in partnership with the voluntary sector to co-design where the voluntary sector can most effectively support health and social care services and how those services can be funded.

206. The Health Board has developed good strategic and operational working relationships with the ambulance service. Both organisations have worked together to align their strategic plans to ensure that the Clinical Services Strategy and Five Year vision are delivered in partnership, both in terms of emergency and non-emergency transport. In January 2012, the Health Board and the ambulance service signed up to a joint paper *Time to Deliver in Hywel Dda* which demonstrates both organisations' commitment to improving patient transport in Hywel Dda. This was followed by a Strategic Decision Day held on 30 January with key stakeholders to identify the changes needed to the non-emergency patient transport system and to agree how these changes would be implemented. By improving arrangements for non-emergency transport, improvements around timely patient discharges should also be realised.

207. The Health Board has over recent years actively engaged with and involved the Community Health Council (CHC) but the relationship has been challenging. Recently the Health Board and CHC representatives have met to consider how the two organisations can work together more effectively.

208. The Health Board is committed to engaging the public and its users and there have been a number of positive developments to strengthen its effectiveness. These include:

- The launch of SiaradIechyd/Talking Health in June 2011 which is an involvement and engagement scheme that gives local people an opportunity to have their say in how local health services are planned, developed and delivered. Members will receive regular newsletters and updates on their health services and will be able to take part in ongoing discussions about health matters through events, readers' panels, interest groups, surveys and volunteering. It is too early to say whether the approach is successful.
- A large scale engagement exercise around the Clinical Services Strategy aimed at giving citizens the opportunity to understand the challenges and help shape the future. This has included independent analysis of the public feedback to inform the final strategy and service options.
- Gathering the public's views through Citizens' Panels which are joint initiatives between the Council, Police and the Health Board. The changes to non-emergency transport highlighted in paragraph 206 arose from citizen panel feedback.
- Patient stories are being used to learn from patient experiences and improve services. A major pilot scheme was launched in Ceredigion where staff have been trained to facilitate the process and this is going to be rolled out across the Health Board.

209. Changes to the pattern of hospital services are a highly emotive and controversial issue. Effective involvement and engagement with the public and other stakeholders will be a critical success factor in implementing plans. The Health Board has engaged with the public on a scale not adopted previously. It acknowledges that it has learnt lessons from this process and as a result has evolved its approach. The Health Board has demonstrated a willingness to listen and learn shown through its use of independent companies to evaluate the approach and the public feedback. Yet despite all of its efforts community groups are protesting at proposed service changes, even when the proposals are not yet in the public domain. The Health Board recognises that there will be differing expectations both internally and externally which they will need to manage and that where it is not possible to deliver expectations that they make a strong case for change. The Health Board launched its formal consultation on 6 August 2012.

Appendix 1

Number of attendances at major A&E departments

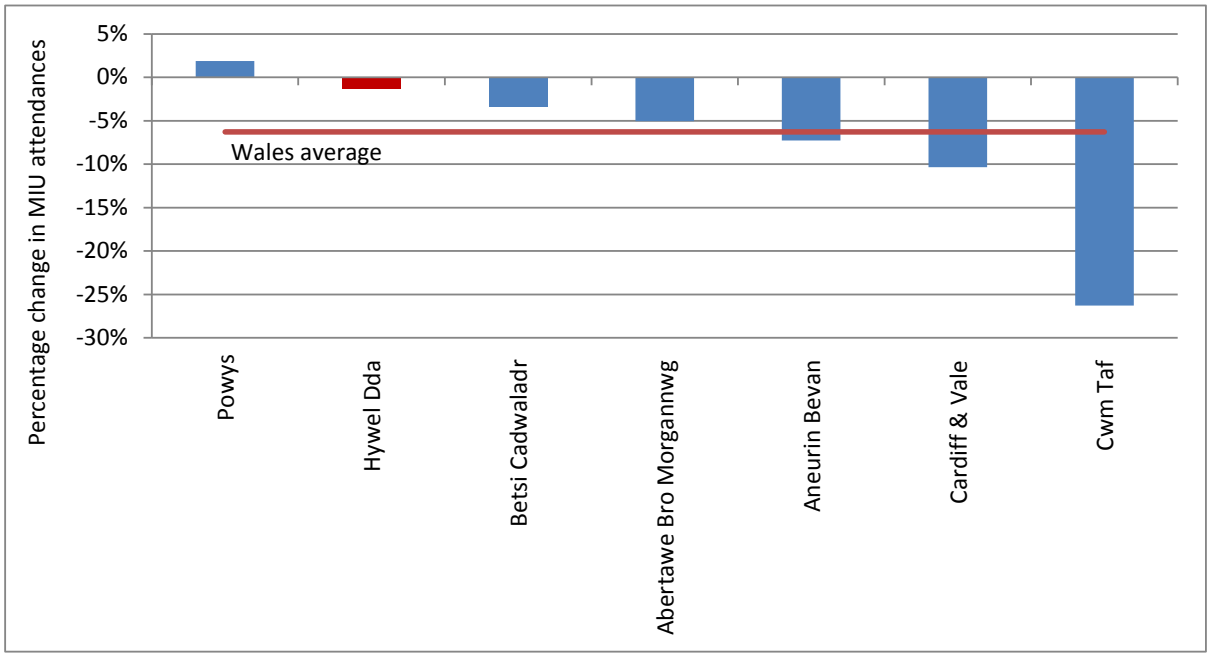
Change in the number of attendances at major A&E departments across Wales between 2010 and 2011.

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 StatsWales.

Appendix 2

Percentage change in the number of attendances at minor emergency departments and minor injury units across Wales between 2010 and 2011



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

Appendix 3

Hours when a consultant in emergency medicine was available in emergency departments in November 2011

Health Board	Hospitals	Time when a consultant in emergency medicine is available on the 'shop' floor	
		Weekdays	Weekends
Abertawe Bro Morgannwg University LHB	Morriston Hospital	9 am to 5 pm	9 am to 4 pm
	Princess of Wales Hospital	9 am to 9 pm	9 am to 9 pm
Aneurin Bevan LHB	Nevill Hall Hospital	9 am to 11 pm	Up to six hours
	Royal Gwent Hospital	8 am to 8 pm	9 am to 4 pm
Betsi Cadwaladr University LHB	Wrexham Maelor	8 am to 10 pm	9 am to midnight
	Ysbyty Glan Clwyd	9 am to 9 pm	9 am to 5 pm
	Ysbyty Gwynedd	9 am to 8 pm	12 pm to 3 pm*
Cardiff and Vale University LHB	University Hospital of Wales	N/A**	N/A
Cwm Taf LHB	Prince Charles Hospital	9 am to 5 pm	N/A
	Royal Glamorgan Hospital	9 am to 5 pm	N/A
Hywel Dda LHB	Bronglais General Hospital	9 am to 5 pm	No cover
	Glangwili General Hospital	9 am to 5 pm 9 am to 7.30 pm (Monday to Wednesday)	9 am to 3 pm
	Prince Philip Hospital	9 am to 5 pm	No cover
	Withybush Hospital	9 am to 10 pm	1 pm to 9 pm

* Actual hours longer in practice.
** N/A – data not provided by the Health Board.

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

Appendix 4

Changes to emergency department medical staff at Hywel Dda Health Board between March 2008 and November 2011

The table shows the comparisons of consultant, middle grade and junior medical staff between March 2008 and November 2011 at the Health Board's level 1 and level 2 emergency departments.

Hospital	Consultant (WTE establishment)	Middle grade (WTE establishment)	Junior (WTE establishment)
Bronglais			
March 2008	1	1	7
November 2011	1	3	7
Glangwili			
March 2008	1	3	8
November 2011	2	5	8
Prince Philip			
March 2008	2	4	4
November 2011	1	3	7
Withybush			
March 2008	2	7	8.41
November 2011	2.87	7	7

Source: Wales Audit Office analysis of data provided by Hywel Dda Health Board or its predecessor bodies.

Appendix 5

Medical staffing within emergency departments

This table shows the numbers of filled and vacant posts for A&E medical staff at end November 2011 across Wales.

Hospital	Consultants*		Middle grade doctors		Junior doctors/trainees	
	In post	Vacant	In post	Vacant	In post	Vacant
Morriston	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	3	0	7	0
Glangwili General	2	0	4	1	8	0
Prince Philip	1	0	3	0	7	0
Withybush General	0 (+2)	2.87	3.8	3.2	7	0
University Hospital of Wales	N/A	N/A	N/A	N/A	N/A	N/A

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

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

N/A – Data not available.

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

Appendix 6

Change in the profile of pay bands of nursing staff deployed in emergency departments at Hywel Dda Health Board between March 2008 and November 2011

Hospital	Pay bands	March 2008	November 2011
Bronglais General Hospital	1 to 4	5.36	4.68
	5 to 9	19.6	21.93
Glangwili General Hospital	1 to 4	3.13	3.2
	5 to 9	32	35.8
Prince Philip Hospital	1 to 4	0	3.05
	5 to 9	25.13	23.83
Withybush Hospital	1 to 4	4.48	2.69
	5 to 9	24.31	29.42
Total		**114**	**124.62**

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

Appendix 7

Number of filled and vacant nursing posts by pay band at major A&E departments at the end of November 2011

Hospital	WTE number of nursing staff				Vacancy rate (%)
	Bands 1 to 4		Bands 5 to 9		
	Filled posts	Vacant posts	Filled posts	Vacant posts	
Morriston Hospital	9.05	0	67.05	6	7
Princess of Wales Hospital	9.2	0	44.4	0	0
Nevill Hall Hospital	9.87	0.53	42.93	0.56	2
Royal Gwent Hospital	24.26	0.46	89.3	2.51	3
Wrexham Maelor Hospital	1.73	1	66.6	0	1
Ysbyty Glan Clwyd	7.44	0	45.02	0.8	2
Ysbyty Gwynedd	7.57	0.43	50.95	3	6
Prince Charles Hospital	5.6	0.4	35.9	3.2	8
Royal Glamorgan Hospital	7.91	0.24	44.76	5.65	10
Bronglais General Hospital	4.68	0	21.93	0	0
Glangwili General Hospital	3.2	0	35.8	2.8	7
Withybush General Hospital	2.69	0	29.42	2	6
Wales	**93.2**	**3.06**	**574.06**	**26.52**	**4**

Data for the University Hospital of Wales are not available.

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

Appendix 8

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

Hospital	Average time patients spent in A&E departments from arrival to departure (minutes)	
	2007-08	2010-11
Morriston Hospital	138	198
Princess of Wales Hospital	110	117
Nevill Hall Hospital	109	169
Royal Gwent Hospital	147	210
Wrexham Maelor Hospital	127	124
YsbytyGlan Clwyd	138	156
Ysbyty Gwynedd	106	147
Prince Charles Hospital	136	171
Royal Glamorgan Hospital	94	N/A
Bronglais General Hospital	N/A	105
Glangwili General Hospital	N/A	165
Withybush General Hospital	116	146
University Hospital of Wales	N/A	N/A

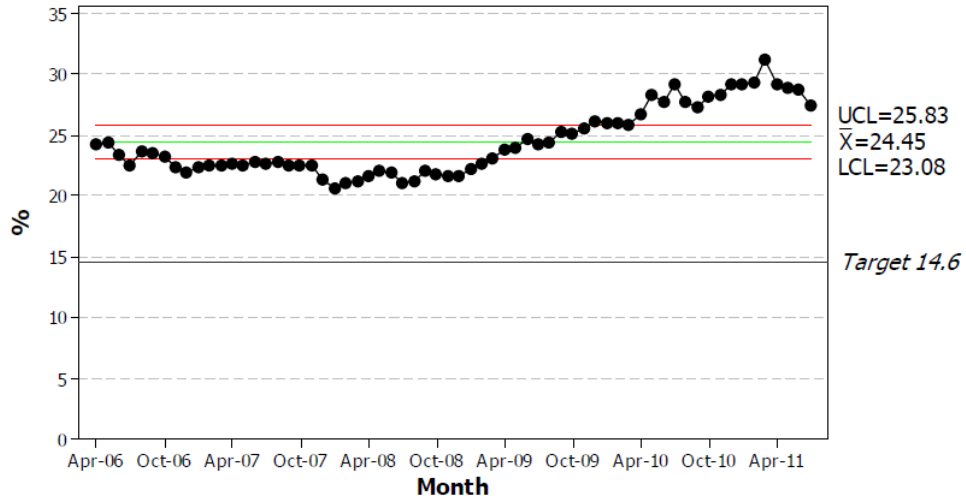
N/A– Not available

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

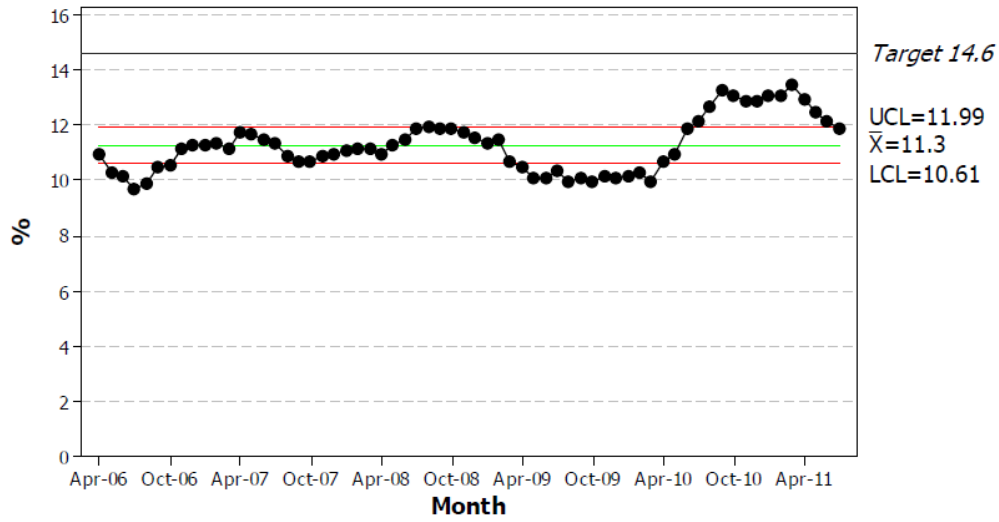
Appendix 9

Rolling Multiple Admission Rates for COPD, CHD and Diabetes

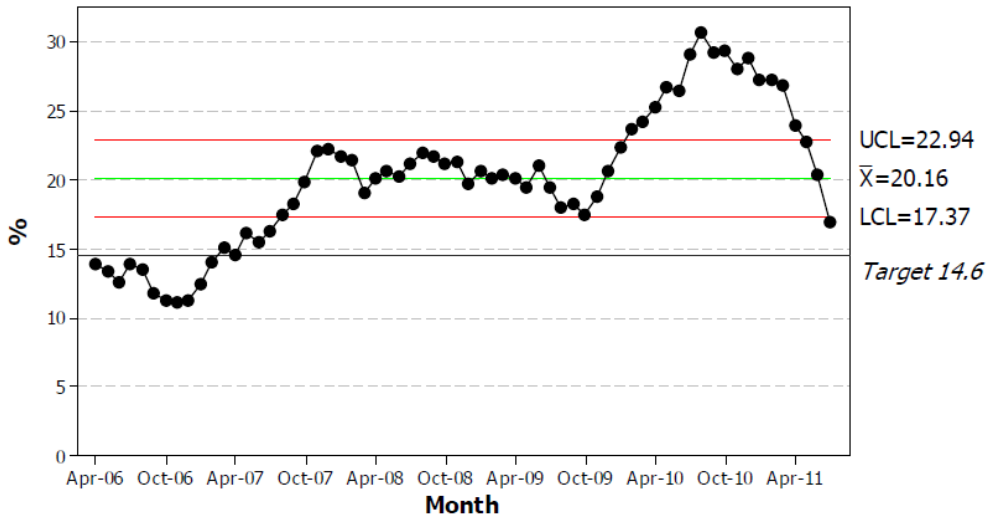
Rolling 12-month multiple admission rate for COPD emergency admissions



Rolling 12-month multiple admission rate for CHD emergency admissions



Rolling 12-month multiple admission rate for diabetes emergency admissions

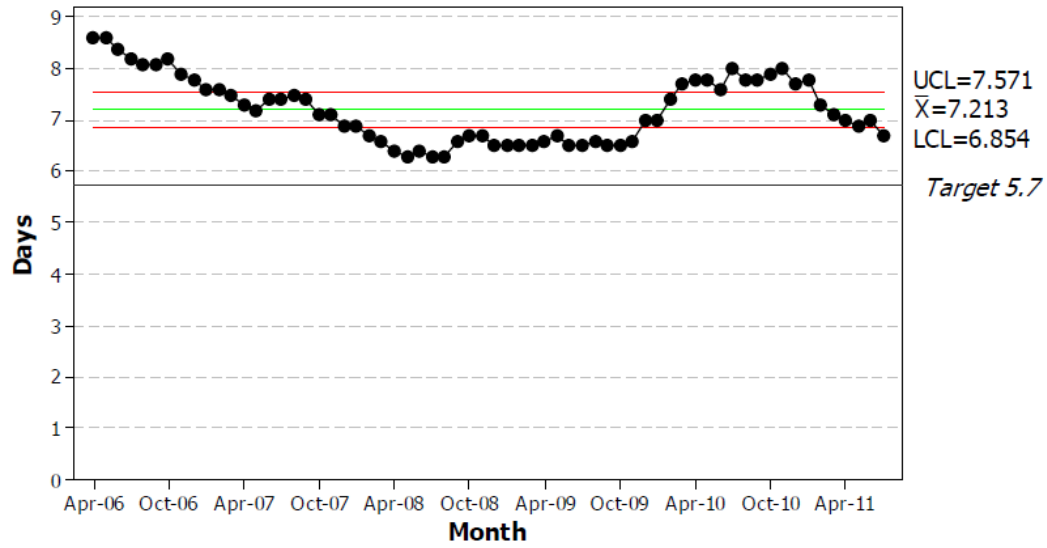


Source: National Leadership and Innovation Agency for Healthcare, Progress Report on the Chronic Condition Management (CCM) Service Improvement Plan as measured through the CCM Maturity Matrix, Appendix 4, October 2011.

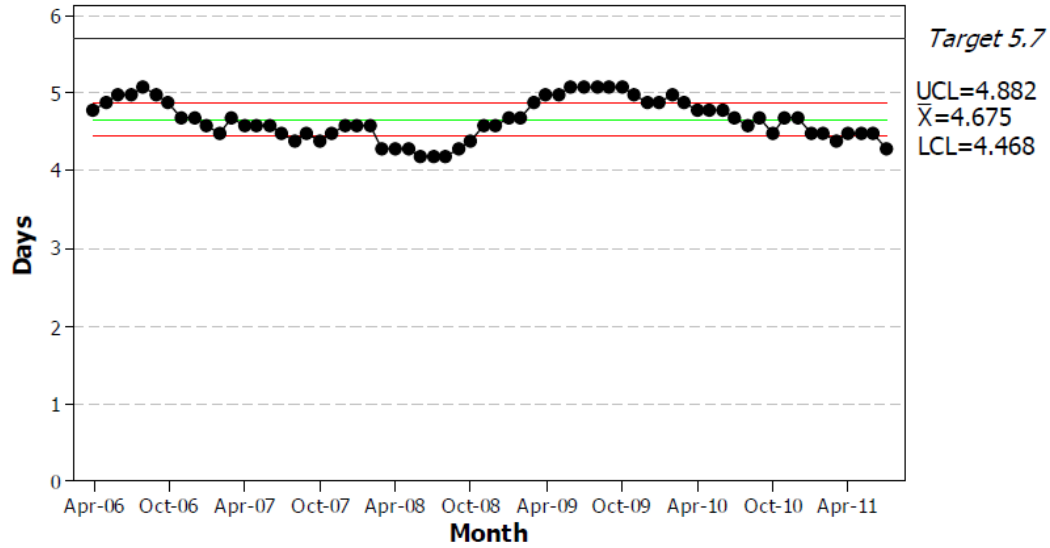
Appendix 10

Rolling 12-Month Average Lengths of Stay

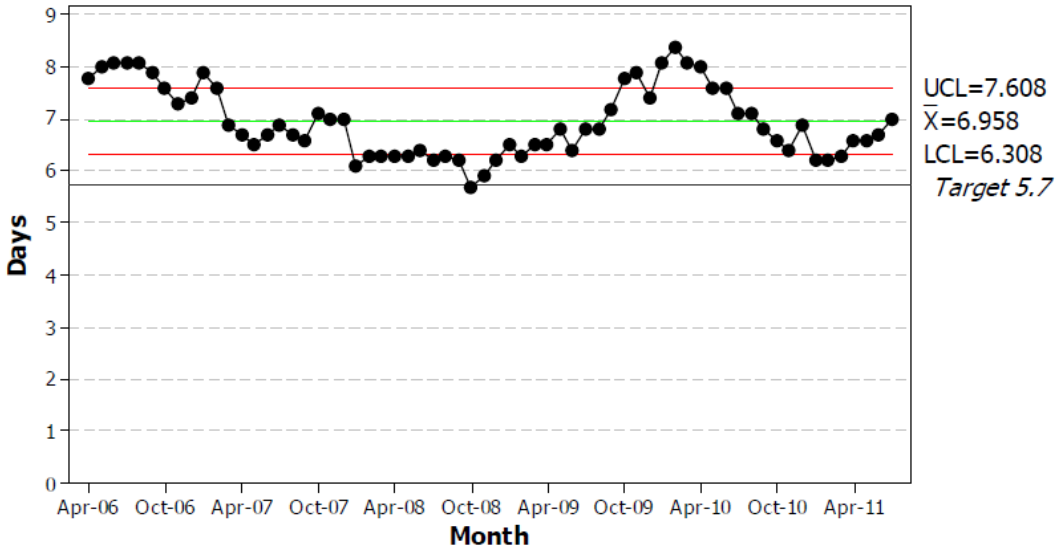
Rolling 12-month average length of stay for COPD emergency admissions



Rolling 12-month average length of stay for CHD emergency admissions



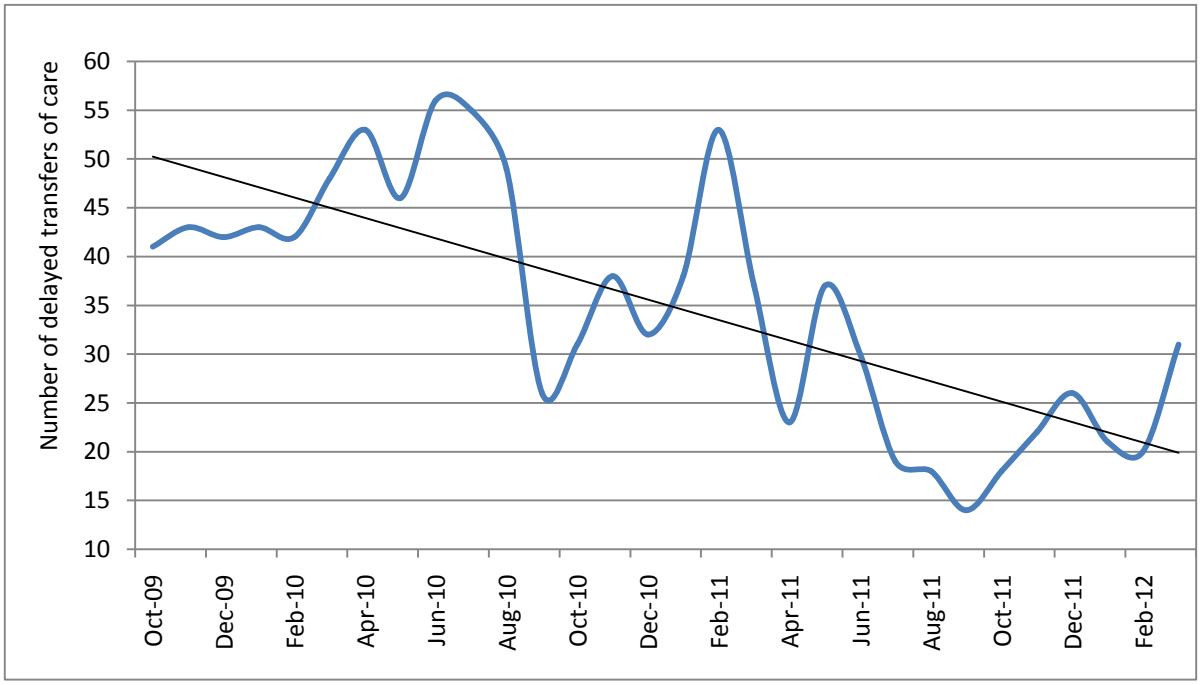
Rolling 12-month average length of stay for diabetes emergency admissions



Source: National Leadership and Innovation Agency for Healthcare, Progress Report on the Chronic Condition Management (CCM) Service Improvement Plan as measured through the CCM Maturity Matrix, Appendix 4, October 2011.

Appendix 11

Trend in the number of delayed transfers of care from Hywel Dda's acute and community facilities between October 2009 and March 2012



These data exclude mental health delayed transfers of care.

Source: Wales Audit Office analysis of data derived from StatsWales

Appendix 12

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

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

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

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