WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Transforming unscheduled care and chronic conditions management

Cwm Taf Health Board

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The team who delivered the work comprised Elaine Matthews and Gabrielle Smith.

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While the Health Board has a clear vision and commitment to partnership working to transform unscheduled care and chronic conditions management, rising demand, a shortfall in capacity and ongoing challenges in educating the public about the appropriate use of services and self-care are constraining progress.

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

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

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

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

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

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

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

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

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

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

8. People living in the Cwm Taf Health Board (the Health Board) area have some of the highest levels of incidence of chronic conditions in Wales, as well as high levels of socioeconomic deprivation. Our previous work on CCM at the Health Board's predecessor bodies found higher-than-expected numbers of emergency admissions with COPD and other respiratory-related conditions, the most common causes of hospital admission. The prevalence of chronic conditions increases with age and population projections for the Cwm Taf area indicate that by 2033 the number of people aged 65 years or older will grow by 50 per cent. In the current economic climate, the projected increase in the economically and care-dependent population poses particular challenges for the Health Board, which needs to make cost savings totalling £100 million over the next three years.

Our main findings

9. Our review, which was carried out between October 2011 and January 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 CCM and unscheduled care?'

10. Our main conclusion is: While the Health Board has a clear vision and commitment to partnership working to transform unscheduled care and chronic conditions management, rising demand, a shortfall in capacity and ongoing challenges in educating the public about the appropriate use of services and self-care are constraining progress.

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

Part 1 – Rising demand, a shortfall in capacity and slow progress in educating the public about the appropriate use of services and self-care have constrained the rebalancing of unscheduled care and chronic conditions management services

1a. Accident and emergency (A&E) departments remain under significant pressure and, despite positive actions to alleviate pressure, achievement against targets is not evident:

- A&E departments are under pressure with increasing numbers of attendances and comparatively fewer staff than in other health boards;
- despite a number of positive actions to manage pressures in A&E departments, improvement against targets is not evident;
- performance against the four-hour waiting time target for A&E department patients has been consistently poor; and
- many patients arriving at A&E departments by ambulance wait too long to be handed over to the care of hospital staff.

Part 1 – Rising demand, a shortfall in capacity and slow progress in educating the public about the appropriate use of services and self-care have constrained the rebalancing of unscheduled care and chronic conditions management services

1b. The Health Board is reducing its reliance on the acute sector to manage chronic conditions and positive action to tackle delayed transfers of care appears to be taking effect but multiple admission rates and lengths of stay for some chronic conditions remain above target:

- reliance on the acute sector to manage chronic conditions is reducing with Cwm Taf having made more progress than most other health boards but multiple admission rates and lengths of stay for some chronic conditions remain above target; and
- although there had been a rise in the number of patients experiencing a delayed transfer of care, positive action to tackle the problem appears to be taking effect.

1c. The Health Board has made good progress in strengthening the way it seeks to support people in the community and prevent unnecessary use of hospitals:

- the Health Board is beginning to test new ways to identify individuals at risk of unplanned admissions and support them in the community;
- service redesign and investment is helping to shift the location of care from hospital to community;
- the Health Board and some GP practices are taking positive action to improve access for patients during core hours but demand for out-of-hours services is rising and the reasons are not yet clear; and
- the Health Board is now making more use of primary care contracts to support patients with chronic conditions and unscheduled care needs.

1d. The Health Board has had limited success so far in changing the way that the public uses services, and the uptake and completion of dedicated self-care programmes is still too low:

- the Health Board continues to promote 'Choose Well' but the campaign appears to have had little impact so far on the way in which the public uses services;
- plans for the communications hub to signpost people to the right services are still in their infancy; and
- support for patient education and self-care has improved but the uptake and completion of dedicated self-care programmes is still too low.

Part 2 – The Health Board has a clear vision for the future management of chronic conditions and unscheduled care, supported by revised governance arrangements and a clear commitment to partnership working

2a. While the Health Board has a clear vision for the management of chronic conditions and unscheduled care, it needs to be supported by robust workforce plans:

- the Health Board has a clear and consistent approach to the delivery of services for chronic conditions and unscheduled care but successful delivery will depend upon effective public engagement and clarity on service planning;
- service evaluations are more common and are helping to shape service developments; and
- the Health Board has plans in place to increase workforce capacity in A&E departments, and similar plans need to be developed to address the shift required for community services and expected retirements in primary care.

2b. The Health Board has revised its governance arrangements for chronic conditions management and unscheduled care, and is now better placed to deliver planned service changes.

2c. The Health Board is committed to building strong partnerships with key stakeholders but efforts to engage clinicians in primary care have not been wholly effective:

- the Health Board is committed to engaging clinicians and placing them at the centre of service redesign but efforts to engage clinicians in primary care have not been wholly effective; and
- the Health Board has developed strong relationships with its local authority partners, which is supporting service integration.

Recommendations

Managing pressures in A&E departments

R1 Given the rising number of attendances at A&E departments, the Health Board should:

- continue working to promote the appropriate use of minor injury units amongst the local population, as well as clinicians in primary and community care;
- estimate what proportion of attendances can be treated more appropriately by other services and whether these services are available to meet the demand; and
- resume its collaboration with the ambulance service to progress the work underway in 2011 to develop alternatives to conveying 999 calls to A&E departments.

R2	A small proportion of patients attending minor injury units have a more serious condition and need to be transferred by ambulance to the main accident emergency department but their transfer is often delayed. The Health Board should work in collaboration with the ambulance service to: • review the number of times these delays occur and assure themselves that there have been no adverse outcomes as a result of delays in transferring these patients; and • agree protocols for managing patients who require transfer to the main A&E department, including the minimum waiting time before transfer.
R3	Unplanned follow-ups account for a high proportion of attendances at Prince Charles Hospital. The Health Board should: • identify whether a high proportion of unplanned attendances also affect A&E services at the Royal Glamorgan Hospital; • record and analyse the reasons for unplanned follow-up attendances so that the rate of unplanned follow-ups might be reduced; • consider providing patients with written information about where to seek ongoing healthcare following treatment and discharge from the A&E departments; • actively encourage the local population to seek wound care or minor injury services from their GP practice as part of the wider 'Choose Well' campaign; • evaluate the impact of the wound care/minor injury local enhanced service on reducing demand in A&E departments or minor injury units, and take the appropriate action to discontinue the service if it is not effective; and • roll out the 'Phone First' telephone triage system to Ysbyty Cwm Cynon when reasonably practicable to do so.
R4	Patients arriving at A&E departments by ambulance wait too long for handover with many discharged without follow-up. The Health Board should: • review the patient handover audit carried out jointly with the ambulance service in July 2011 to assess whether the necessary actions have been taken to address the audit findings; • consider re-auditing the patient handover process in collaboration with the ambulance service; and • in collaboration with the ambulance service, explore ways to manage patients waiting to be handed over in ways that would free up ambulance personnel while maintaining patient safety.

R5	The *Elastic Ward Policy* is part of the Health Board's emergency escalation plans but is rarely activated despite reported pressures. The Health Board should review: • the number of times the policy has been activated since introduction; • whether the threshold for activating the policy is consistently applied; • the impact of the policy in relation to the number of patients transferred from A&E departments to a ward and whether there were any adverse consequences; and • possible reasons for perceived non-compliance with the policy.
R6	The Health Board should review the arrangements for consultant cover in the clinical decision units given the reliance on the medical on-call rota to provide this cover.
Managing demand out-of-hours	
R7	The number of attendances at primary care out-of-hours centres is rising. The Health Board should complete its work: • exploring the reasons for the rise in demand; • assessing whether the demand is uniformly spread across GP practices or associated with a few individual practices; and • take action to reduce demand for GP out-of-hours services.
Managing patient flows	
R8	There is a perceived lack of community services to support the discharge of frail, elderly people from A&E departments during the evenings and at weekends or alternatives to hospital referral. The Health Board should: • record and analyse the number of patients admitted via A&E who could have been safely sent home if patient transport or community services were in place. This will allow the Health Board to assess whether the perceived lack of alternatives to admitting patients is 'real'; and • where alternatives to admission are available, ensure these are effectively publicised amongst staff in A&E departments and GP practices.
R9	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 regularly review the quality of the information, including timeliness, about patients attending A&E departments or admitted to hospital, so that it can be used to improve patient care.

Developing the workforce	
R10	The Health Board should strengthen its workforce plans to reflect the potential changes expected in relation to the shift in services from acute to primary and community settings and the likely impact that retirements will have on the primary care workforce.
Influencing the way in which the public uses services	
R11	As part of the arrangements to publicise 'Phone First', the Health Board should continue with its communication strategy to promote public awareness about when it is appropriate to use A&E services and minor injury units.
R12	The Health Board should strengthen its approach to redirecting patients who attend A&E departments and minor injury units 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.
R13	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 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.
Supporting individuals to self-care	
R14	The uptake and completion of programmes designed to educate patients and support self-care could be improved. Now that the Health Board has taken the Education Programme for Patients back in-house, it should: • continue its work to understand the reasons for non-attendance on patient education programmes in order to maximise uptake and improve the cost-effectiveness of the programme; • actively promote programmes to educate patients and support self-care amongst the professionals in regular and frequent contact with patients; and • seek to find alternative ways to support patients to self-care.
R15	As part of the *Setting the Direction* performance monitoring framework, the Health Board should develop a suite of indicators that measure the impact of patient education programmes on patient outcomes, in addition to monitoring uptake and completion rates.

Supporting individuals to self-care	
R16	The Health Board should assess whether there is scope to expand the provision of minor ailment services through community pharmacies, and whether this would provide an appropriate and cost-effective alternative to providing such services in A&E departments, minor injury units or in general practice.
Performance monitoring	
R17	The Health Board should continue to ensure that progress on implementing *Setting the Direction* is formally reported to the Board.
Clinical engagement	
R18	The Health Board should strengthen its arrangements for engaging clinicians in primary care because efforts to engage them have not been wholly effective.

Detailed report

Rising demand, a shortfall in capacity and slow progress in educating the public about the appropriate use of services and self-care have constrained the rebalancing of unscheduled care and chronic conditions management services

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.

A&E departments remain under significant pressure and despite positive actions to alleviate pressure, achievement against targets is not evident

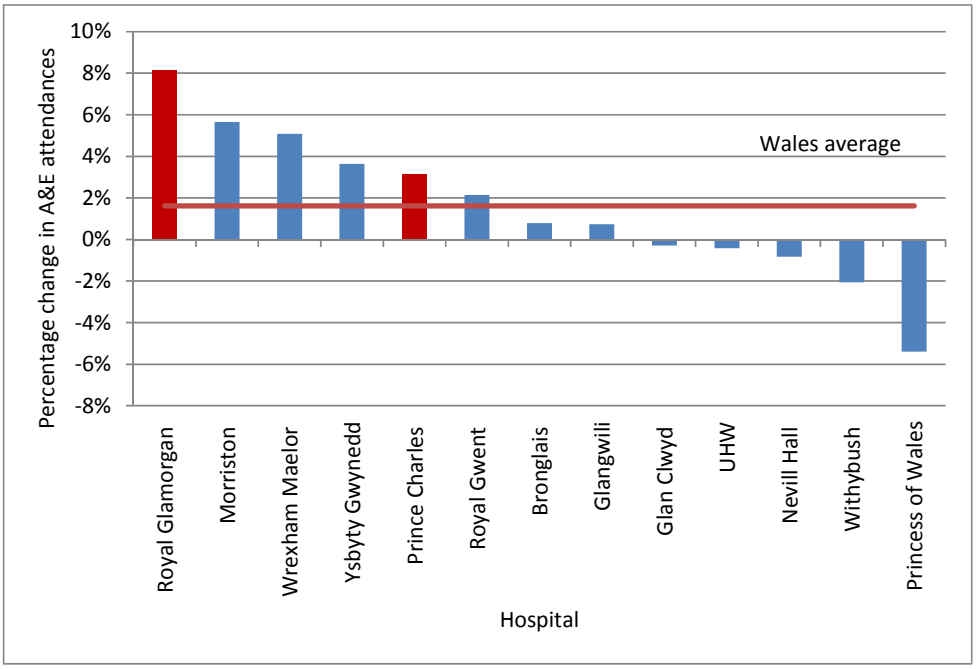
A&E departments are under pressure with increasing numbers of attendances and comparatively fewer staff than in other health boards

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. Between 2010 and 2011, there was a small rise (1.6 per cent) in the total number of attendances at major A&E departments across Wales (Appendix 1). The Health Board experienced by far the biggest increase (5.8 per cent) with more than 6,000 extra attendances. Exhibit 1 shows the percentage change in attendances between 2010 and 2011 at each major A&E department in Wales. At the Royal Glamorgan Hospital, the number of A&E attendances increased by 8.1 per cent from 55,808 to 60,345 (equivalent to 12 more attendances each day). At Prince Charles Hospital, the number of attendances increased by 3.2 per cent from 49,455 to 50,011 (equivalent to four additional attendances each day).

Exhibit 1: Percentage change in the number of attendances at major A&E departments between 2010 and 2011



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

15. Unplanned follow-up attendances at A&E may be one reason for the increase in A&E attendances. Based on incomplete information provided by health boards, the proportion of unplanned follow-up attendances at A&E departments is relatively small across Wales (six per cent). However, at Prince Charles Hospital, just over one in five A&E attendances is an unplanned follow-up (Exhibit 2) suggesting that for some individuals there is either a real or a perceived lack of alternative services to meet their unscheduled care needs. The high proportion of unplanned follow-up attendances may

also contribute to the poor performance against the four-hour waiting time target at Prince Charles Hospital (paragraph 37).

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

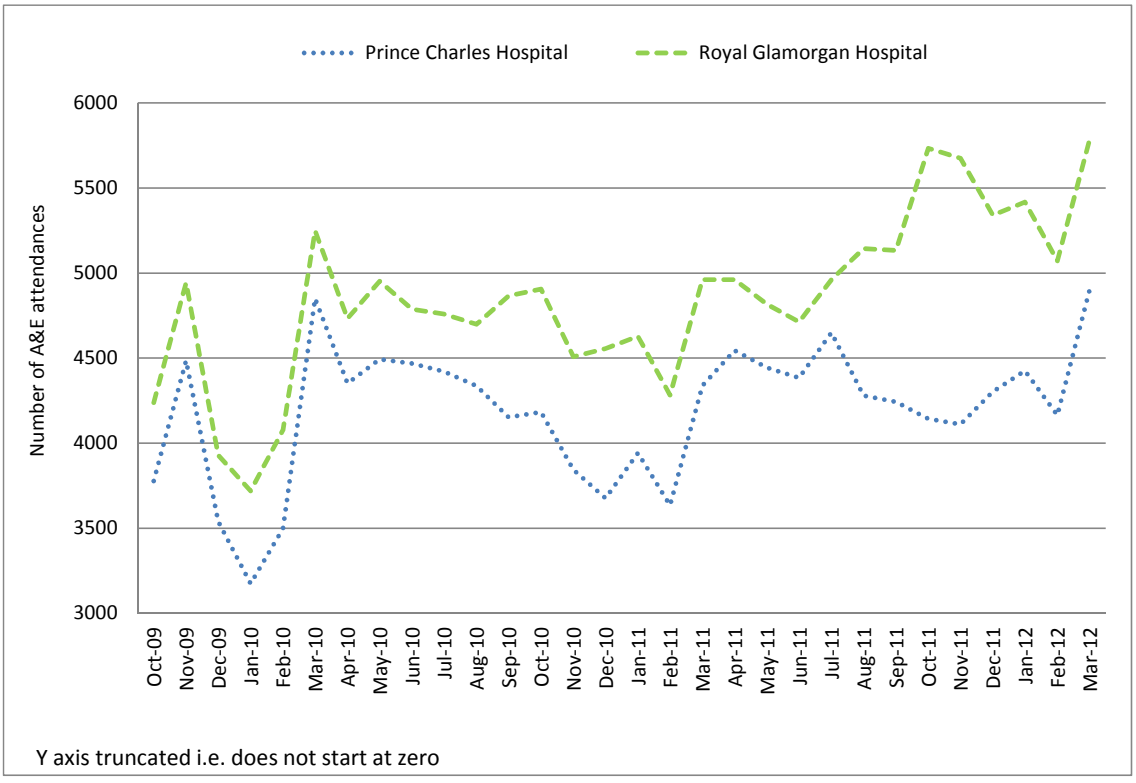
Hospital	Percentage unplanned follow-up attendances (%)
Prince Charles Hospital	18
Wrexham Maelor Hospital	6
Ysbyty Glan Clwyd	5
Nevill Hall Hospital	5
Royal Gwent Hospital	4
Ysbyty Gwynedd	2
Bronglais General Hospital	2
Glangwili General Hospital	2
Withybush General Hospital	2
Morriston Hospital	N/A
Princess of Wales Hospital	N/A
University Hospital of Wales	N/A
Royal Glamorgan Hospital	N/A
Wales average	**6**

N/A – Not available

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

16. The pattern of attendance at both A&E departments is broadly similar, although the number of A&E attendances each month at Prince Charles Hospital is, on average, 16 per cent lower than the number at the Royal Glamorgan Hospital (Exhibit 3). The pattern diverged after July 2011 when A&E attendances at Prince Charles Hospital started to fall while A&E attendances at the Royal Glamorgan Hospital continued to increase. The pattern diverges until October 2011, when there is a peak in attendances at the Royal Glamorgan Hospital. The pattern returns to a similar shape between January and March 2012, although the overall gap between the two departments is larger compared with the same period in 2011.

Exhibit 3: Trend in monthly attendances at major A&E departments at the Health Board, October 2009 to March 2012



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

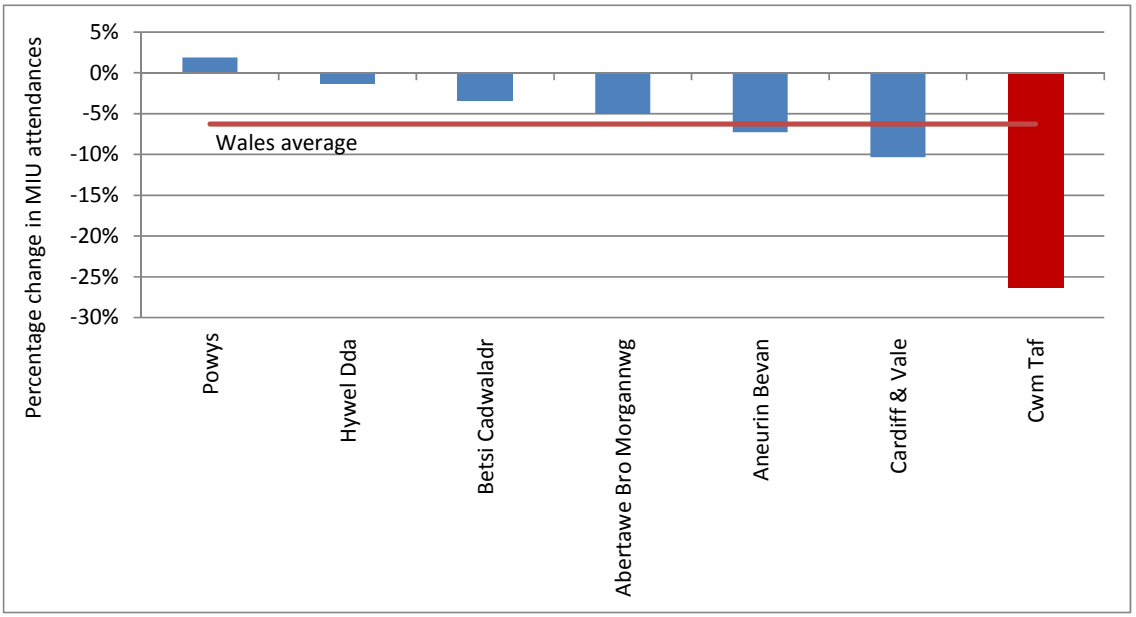
17. The Health Board has taken a number of actions to increase nursing capacity within its A&E departments because of ongoing difficulties recruiting medical staff. Since 2010, the minor injury units at Ysbyty Cwm Rhondda and Aberdare Hospital[4] were closed

[4] The minor injury unit at Aberdare hospital was relocated to Ysbyty Cwm Cynon in April 2012.

at weekends, thereby freeing up emergency nurse practitioners (ENPs) to support both A&E departments. The minor injury unit at Ysbyty Cwm Rhondda was closed temporarily between October 2011 and May 2012 in order to sustain the A&E department at the Royal Glamorgan Hospital by redeploying the ENPs. Apart from the peak in A&E attendances at the Royal Glamorgan Hospital in October 2011, the changes to the opening hours do not appear to have impacted on the pattern of monthly attendances at either department.

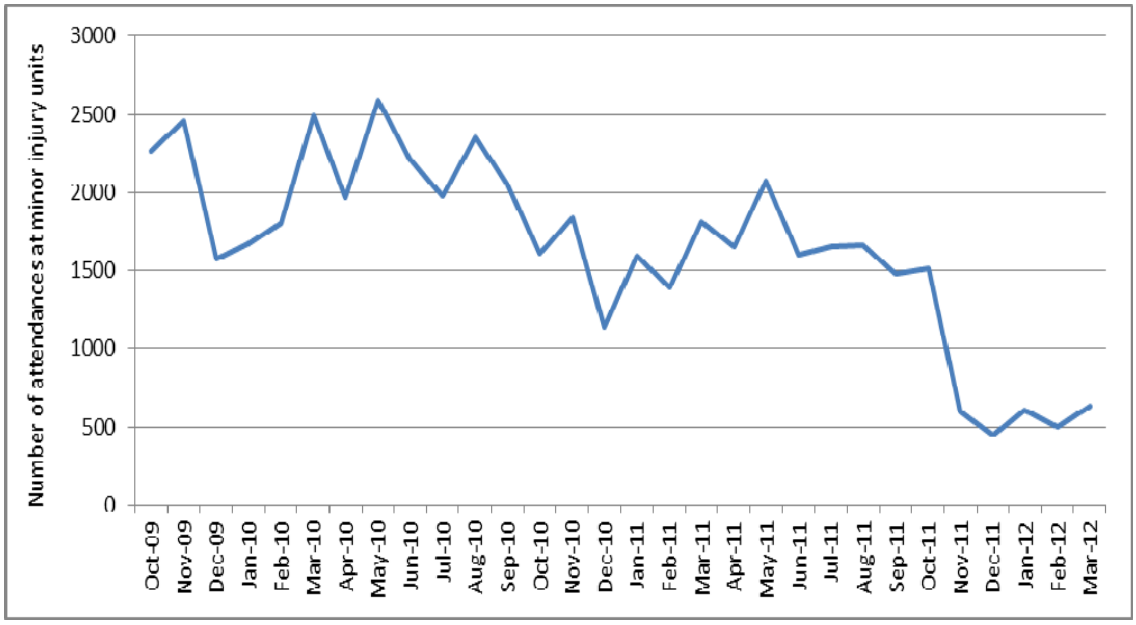
18. Between 2010 and 2011, the number of attendances at minor injury units across Wales reduced by six per cent (Exhibit 4). The Health Board experienced the biggest reduction with attendances falling by 26 per cent from 23,709 to 17,474. The fall in number of attendances is likely to be explained by the temporary closure of the unit at Ysbyty Cwm Rhondda when attendances plummeted (Exhibit 5), coupled with the changes to the opening hours.

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



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

Exhibit 5: Trend in monthly attendances at minor injury units at the Health Board, October 2009 to March 2012



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

19. Attendances at minor injury units are not always appropriate. A Health Board audit of attendances at the Ysbyty Cwm Rhondda minor injury unit showed that a small but growing number were not classified as 'minor' but were of a more serious nature, such as chest pain or stroke, and significant trauma, including head injury or hip fracture. In 2009-10, 130 attendances at the Ysbyty Cwm Rhondda minor injury unit were described by nursing staff as more serious than a minor injury. By 2010-11, this number had risen to 168 of whom just over half (87) had chest pain. Most of these patients needed an emergency ambulance to transfer them to the A&E department at the Royal Glamorgan Hospital. However, A&E staff told us that many of these patients waited too long to be transferred because the ambulance service (the Welsh Ambulance Services NHS Trust) did not categorise them as an emergency, believing the patients to be in a clinically safe place.

20. Staff at the Ysbyty Cwm Rhondda minor injury unit have also monitored the number of patients attending with 'problems best dealt with by their GP' instead of attending the unit. Between August 2010 and January 2011, 226 patients attended the unit but did not have a minor injury. After triage, approximately half these patients were redirected back to their GP practice. Working with the Local Medical Committee, the Health Board implemented a policy whereby patients can be referred back to their GP provided the triage score is low and physical parameters, like temperature and pulse, are normal. Emergency nurse practitioners working in the minor injury units are reportedly confident in referring patients back to their GP[5].

21. 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. Only one of the nine practices responding to our survey[6] reported undertaking any work to identify patients who repeatedly attended the emergency department or other unscheduled care service. Practice managers reported that practices used to be notified when their patients accessed the emergency department but that notification had ceased without explanation in early autumn 2011. Across Wales, a high proportion (84 per cent) of practices reported being notified. One of the Health Board's proposed priorities for managing demand in 2010-11 was to develop a feedback system to notify practices of A&E attendances and hospital admissions but this development was not underway at the time of our audit. Since our fieldwork, the Health Board has developed a feedback system, which it is ready to implement.

22. The College of Emergency Medicine now recommends that every A&E department should have at least 10 emergency medicine consultants to provide up to 16 hours 'on-site shop floor' cover seven days a week[7]. At the time of our fieldwork, the Health Board did not meet this recommendation from the college (Appendix 2).

[5] The Health Board anticipates the temporary redeployment of the ENPs from Ysbyty Cwm Rhondda to the Royal Glamorgan Hospital will help to redirect patients to primary care from the A&E department and that other nursing staff will learn from that.

[6] In November 2011, we e-mailed a questionnaire survey to general practice managers at 498 GP practices in Wales. Practice managers were asked to complete the survey on behalf of the practice. The overall response rate across Wales was poor with only 26 per cent of practices responding. At the Health Board, only nine of the 48 practices surveyed (19 per cent) responded, despite encouragement from the Health Board to do so. While unlikely to be representative of all Cwm Taf practices, we have used these responses to illustrate particular issues.

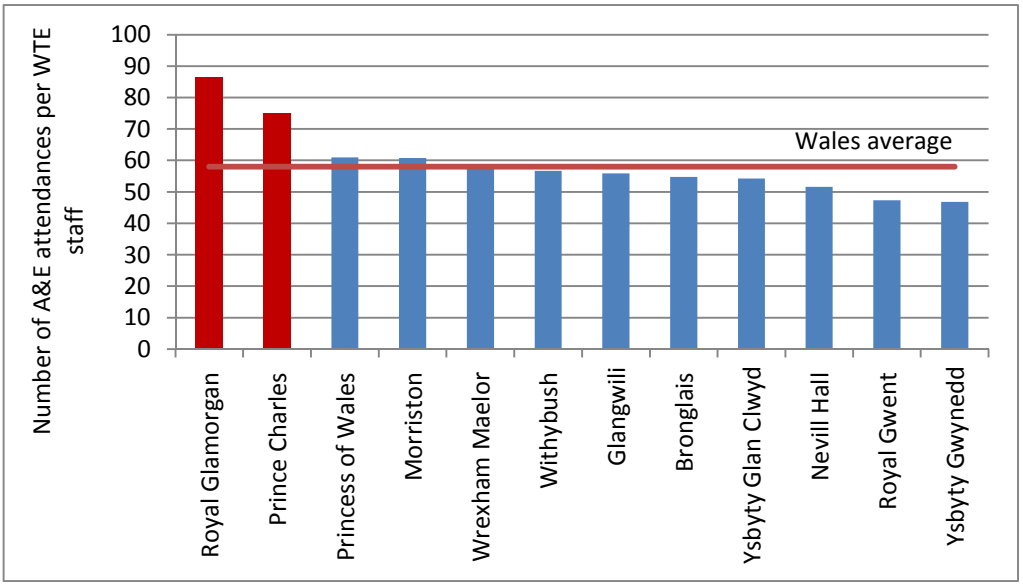
[7] College of Emergency Medicine, *Emergency Medicine Operational Handbook, The Way Ahead*, December 2011

23. The Health Board has been planning its A&E workforce on the assumption that five whole-time equivalent (WTE) consultants and nine WTE middle-grade doctors per site will provide 24-hour cover on site. However, like other health boards, Cwm Taf has had a shortfall in the number of consultants and middle-grade doctors working in A&E. In November 2011, there were 3.6 WTE consultant vacancies and eight WTE middle-grade vacancies (Appendix 3), due in part to recent retirement, long-term sick leave and recruitment difficulties. A recent campaign to attract A&E consultants failed to attract suitable candidates for appointment and plans to recruit from overseas have not been as beneficial as previously anticipated. The Health Board has indicated that three doctors from Dubai will take up post in 2012. In the meantime, the Health Board continues to rely on locums to cover any shortfall, which carries a level of risk in respect of reliability and sustainability.

24. The number of nursing staff deployed in both A&E departments increased by 50 per cent from 63 to 94 WTE between the end of March 2008, when we last collected data from emergency departments, and the end of November 2011 (Appendix 4). Part of the increase is due to the introduction of Band 3 healthcare support workers, as well as an increase in registered nursing staff. Although, the number of registered nursing staff increased, the overall number deployed as ENPs reduced over the same period, most noticeably at Prince Charles Hospital where the number of ENPs fell from 10.6 WTE in 2009 to 3.4 WTE in 2011. At the Royal Glamorgan Hospital, the number of ENPs increased from zero to 5.2 WTE. Both A&E departments have a small number of vacancies for nursing staff (Appendix 5). At the end of November 2011, the nursing vacancy rate for both A&E departments was nine per cent compared to four per cent across Wales.

25. In November 2011, workload pressure, measured as attendances per WTE staff, was considerably higher at both A&E departments, in spite of deploying locum medical staff to cover vacancies. Attendances per WTE staff at the Royal Glamorgan and Prince Charles hospitals were 86.4 and 74.9 respectively. The average for Wales was 58 attendances per WTE (Exhibit 6). Meanwhile, attendances at Aberdare minor injury unit were also higher at 1,198 per WTE staff compared with the Wales average (Exhibit 7).

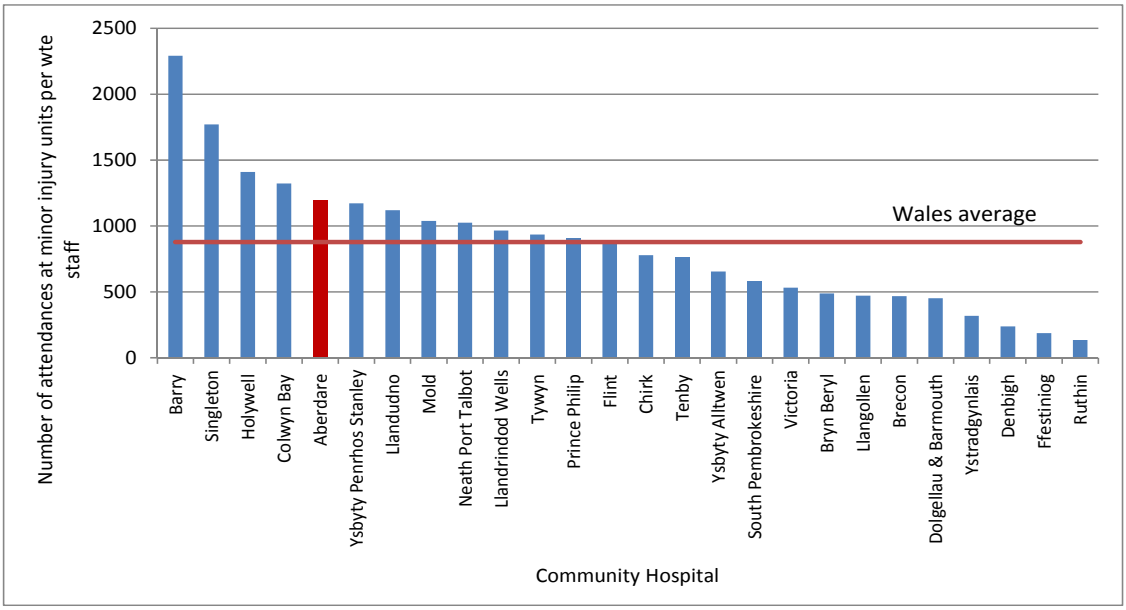
Exhibit 6: Number of attendances at major A&E departments in Wales per WTE A&E staff (including locum medical staff) in November 2011



Workforce data are not available for University Hospital of Wales.

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

Exhibit 7: Number of attendances in 2010-11 at minor injury units across Wales per WTE 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.

Despite a number of positive actions to manage pressure in the A&E departments, improvement against targets is not evident

26. The Health Board has taken a number of actions to address the pressures within its emergency services and improve patient flow through the department. These include: remodelling the way in which services are provided; increasing the skills of A&E staff; putting systems in place to manage acute pressures through alternatives to attendance or admissions; and by increasing numbers of staff and skills.

27. At the beginning of March 2011, the Health Board piloted a physician-led, front-door assessment service for acute medical referrals. As part of this service model, an acute physician, supported by other staff, works across the A&E department and the medical day unit to rapidly assess medical patients referred by GPs or those waiting in A&E. The pilot was judged successful. Full implementation of this model was dependent upon creating permanent space for clinical decisions units at both A&E departments.

28. Although the permanent space was found to create the two clinical decision units, full implementation of the model is dependent upon the capacity of the medical workforce to provide integrated and rapid assessment at the front door. Currently, acute physicians are available for a limited time each week on the clinical decision units at both A&E departments. At Royal Glamorgan Hospital, acute physicians are available all day on Mondays and Tuesdays with A&E staff indicating that the clinical decision unit works efficiently, turning patients around quickly. At Prince Charles Hospital, the acute physician is available all day on Wednesdays. At other times, both clinical decision units are reliant on the on-call rota with acute physicians reportedly attending after lunch. Any delay in reviewing patients on the clinical decision units has a knock on impact on the flow of patients through A&E. A&E staff indicated that patients themselves can sometimes wait more than eight hours on a trolley within the clinical decision unit and that currently these waits are not counted in relation to the A&E waiting times target.

29. The Health Board has also taken a number of actions to reduce demands on A&E and improve the flow of patients through the hospital. It has introduced a single point of referral for admission and assessment in secondary care, via the bed management team. The bed management team can offer an alternative to referral, such as a same-day appointment with a consultant in an outpatient department or on the medical day unit. At night, the single point of referral is via the Hospital at Night team.

30. In February 2012, the Health Board also implemented two policies, which were intended to help alleviate pressure in A&E at times of high demand. The first, the *Emergency Departments Policy for the Escalation of Resource*, formalises the process for redirecting on-call medical staff to areas of high pressure, usually A&E. The aim is to support the admission and assessment process, and ensure the hospital runs smoothly.

31. The second policy, the *Elastic Ward Policy*, is intended to manage patient flows at times of extreme pressures within A&E. This policy is based on similar policies successfully implemented in several UK hospitals. A patient awaiting admission following medical assessment in A&E is transferred to a ward where another patient is scheduled to be discharged within four hours but has yet to leave the ward. The policy, part of the Health Board's emergency pressures escalation plan, is intended to be activated only during the daytime when discharge activity is planned at ward level. Transferring patients in this way helps relieve overcrowding in A&E. A&E staff told us that the policy is rarely implemented and that when they need to activate the policy ward staff are reluctant to comply with the policy. A&E staff see the policy, in principle, as helping to manage risk more evenly rather than concentrating large numbers of sick people in one department. We were told that ward staff rarely come to the A&E departments to either get an appreciation of the pressure the department is under or to 'help out'. Since our fieldwork, the Health Board has plans to set up a system at Prince Charles Hospital whereby ward sisters visit A&E each morning to see for themselves the pressure the department is under. This system is intended to speed up the process for planned discharges, freeing up beds for those patients in A&E waiting to be

admitted, and identifying patients that can be safely cared for under the Elastic Ward policy.

32. Each A&E department operates as an integrated unit with nursing staff working across the main A&E and clinical decision units to improve skills and ensure that each nurse has a minimum skill set. Both departments have introduced a Band 3 healthcare support worker/emergency department assistant to carry out tasks like phlebotomy and ECGs and to apply simple dressings for patients attending for follow-up.
At Prince Charles Hospital, A&E care bundles have been introduced to help junior doctors assess, treat and make appropriate referrals for diagnostic tests and specialist assessment.

33. At Royal Glamorgan Hospital, a well-established Therapy Assessment Team is available weekdays to provide rapid physiotherapy or occupational therapy assessment for patients in A&E, including the clinical decision units. The team generally respond to referrals within 30 minutes. It aims to prevent avoidable admissions or facilitate early discharges. Based on the number of referrals that the team received between October 2010 and September 2011, we estimate that the team was seeing less than one per cent of A&E attendances at the Royal Glamorgan Hospital.

34. The Health Board has used the general medical services (GMS) contract to offer GP practices the opportunity to provide a minor injuries/wound care local enhanced service. At the time of our fieldwork, two-thirds of practices were accredited to provide the service to their patient population and another three practices were awaiting accreditation. If practices decide not to provide the service, a 'federated' approach is in place whereby patients can attend another practice to receive the service. The Health Board anticipates that fewer patients will attend A&E departments or minor injury units for wound care or minor injuries that are more appropriately treated in primary care.
At the time of our audit, A&E staff had mixed views about the impact of this local enhanced service but they did report that it was relatively easy to book an appointment at a practice for patients who showed up at A&E. The Health Board plans to audit the effectiveness of this local enhanced service.

35. In addition to temporarily redeploying ENPs (paragraph 17), the Health Board launched a successful campaign to recruit advanced emergency practitioners drawn from both nursing and paramedic professions. These staff will supplement the middle-grade medical staff within the A&E departments, managing a caseload of patients who present with undifferentiated and undiagnosed minor and major illnesses and injuries. This should help alleviate some of the pressure in A&E as patients are assessed and treated in a timely way.

Performance against the four-hour waiting time target for A&E department patients has been consistently poor

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

37. The Health Board's performance in relation to the four-hour emergency department target has been consistently below the 95 per cent target since October 2009 (Exhibit 8). Performance against target has been generally better than the Wales average, particularly at the Royal Glamorgan Hospital. Performance at Prince Charles Hospital improved considerably and exceeded that at the Royal Glamorgan Hospital between April and June 2011, which coincided with the opening of the new emergency care centre at Prince Charles Hospital at that time. Thereafter, performance deteriorated and by December 2010 only 80 per cent of patients had left the department within four hours. The Health Board has indicated that this poor performance was due to problems in transferring patients to wards. A small proportion of patients spend longer than eight hours in the A&E department at Prince Charles Hospital and performance against the eight-hour waiting time target has been generally worse than the Wales average (Appendix 6). A&E departments are not organised to care for patients over long periods and may pose a risk to patient care, such as pressure damage to the skin due to difficulties changing a patient's position on a trolley, the lack of routine medicine rounds to ensure patients get their routine medications or the inability to provide hot meals or the assistance to those patients who need help to eat or drink.

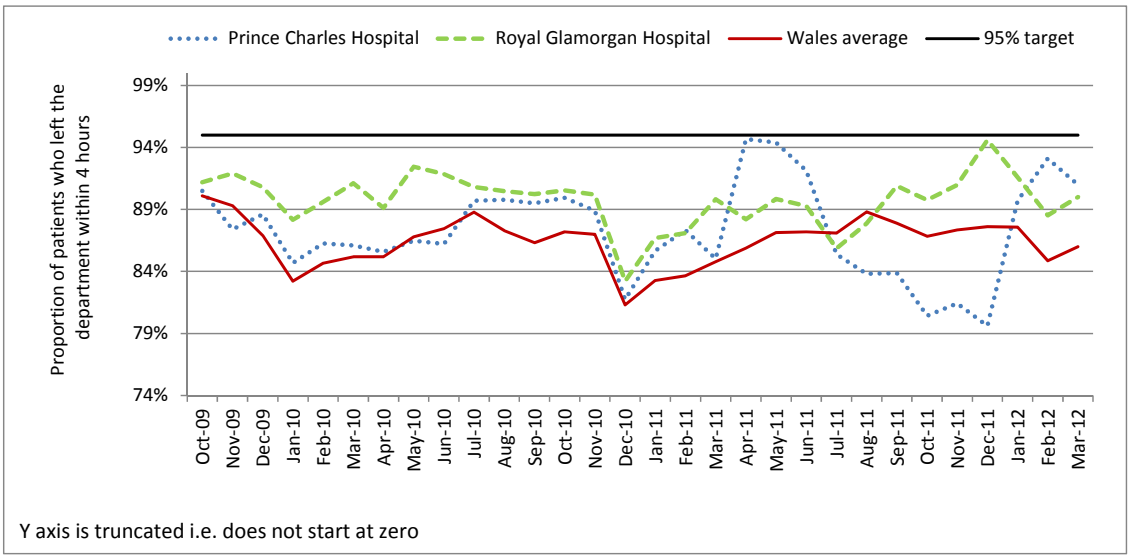
38. Nursing staff that we met cited possible reasons that prevent timely discharge from both A&E departments and a reliance on admission, which then impact on the whole hospital, including:

- the dilemma of sending frail, elderly people home during the evening without the support of a community service to look in on the individual that evening or first thing the next day; and
- a lack of non-emergency transport available out-of-hours to take patients home.

39. Meanwhile, performance at the Royal Glamorgan Hospital started to improve having fallen below the Wales average in July 2011. By December 2011, the department just about reached the target (94.6 per cent). The Health Board attributes this improvement in performance to the temporary redeployment of the ENPs from the minor injury unit at Ysbyty Cwm Rhondda to the A&E department where they work in the minors stream. This releases A&E medical staff to focus on patients in the majors stream. Staff indicated that this has helped to reduce the time from clinical assessment to onward referral to specialists, which ultimately improves patient care.

40. The most recent data for 2012 show that performance at both departments is better than the Wales average. At the Royal Glamorgan Hospital, performance is not that different to the trend in the previous year, while at Prince Charles Hospital, performance is better than the trend in the previous year.

Exhibit 8: Trend in proportion of patients who spend less than four hours in the emergency department from arrival until admission, transfer or discharge



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

41. From December 2011, the Welsh Government changed the way in which breaches to the waiting time targets are counted. 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 at both hospitals.

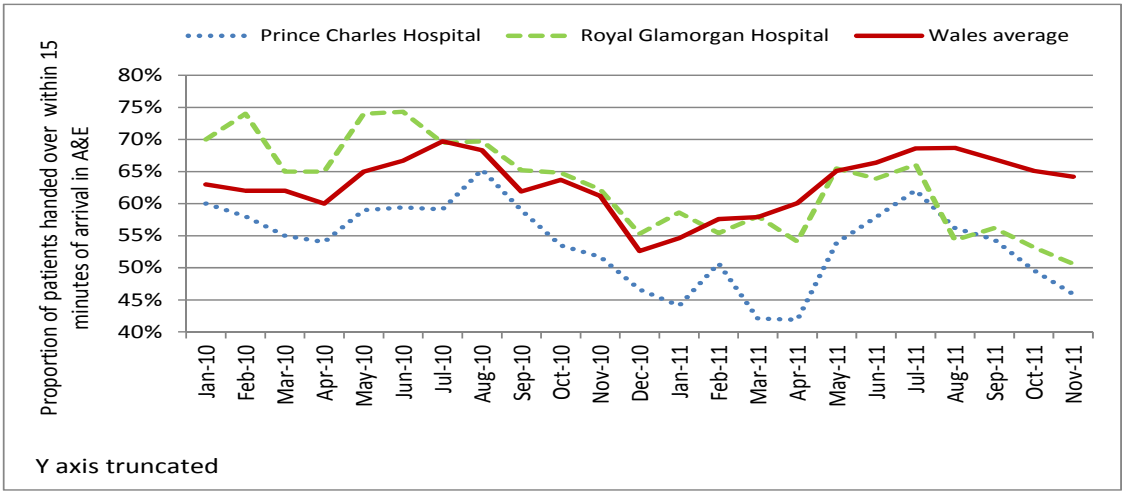
42. Patients attending the A&E department at Prince Charles Hospital are spending longer in the department. In 2007-08, patients attending A&E spent, on average, 136 minutes in the department (arrival to departure). In 2010-11, patients spent on average 171 minutes in the department, which is one of the longest lengths of stay recorded by A&E departments across Wales (Appendix 7). Comparable data for 2010-11 are not available for the Royal Glamorgan Hospital.

Many patients arriving at A&E departments by ambulance wait too long to be handed over to the care of hospital staff

43. Approximately one-quarter of patients attending A&E departments arrived by ambulance during 2010-11 (Appendix 8). 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.

44. The handover period starts when ambulance crews notify A&E staff they have arrived with a patient. The period ends when the crew transfer the patient's clinical care to the A&E staff. The percentage of patients handed over by ambulance crews to the Health Board's emergency departments within 15 minutes has been on a downward trend since January 2010 (Exhibit 9). At November 2011, only around half of these patients were handed over within 15 minutes. Performance at Prince Charles Hospital has been consistently worse than the Wales average. Performance at the Royal Glamorgan Hospital was noticeably better than the Wales average in the first half of 2010. But, since 2011, performance has been well below the Wales average.

Exhibit 9: 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.

45. In early 2011, the Health Board and ambulance service implemented a joint action plan to tackle the poor performance in relation to the handover target but without success given performance has deteriorated against the 15-minute handover target. Subsequently, the Health Board and ambulance service jointly audited the handover process over a 24-hour period in July 2011. The audit identified issues including a lack of spare equipment, such as spinal boards, to free up ambulance crews for their next call and a lack of clarity about who was responsible for the handover process and achieving the handover target. We did not see any evidence that the issues identified by the Health Board's audit had been actioned and A&E staff told us that an action plan had yet to be put in place.

46. Ambulance staff that we met during our fieldwork described the working relationship between themselves and the Health Board's A&E staff as good or very good. They had mixed views about the importance of recording patient handover times and did not believe there had been improvements to the patient handover process as a result of the previous action plan. Ambulance staff perceived that nursing staff were sometimes 'keen to hit the buttons' on the handover screens to show they were meeting targets, even when the handover process had not been completed.

47. A&E staff also raised concerns about a high number of patients referred by their GP for medical assessment, who arrive by ambulance all at the same time. They believe that 'stacking' these conveyances is another factor contributing to delays in patient handovers.

48. A snapshot audit undertaken by A&E staff in May 2011 found that 20 per cent of 999 conveyances could be treated in a way other than transfer to A&E because they did not need serious treatment or follow-up. Data collected at all health boards for 2010-11 found that on average, one in three (29 per cent) patients who arrived by ambulance were discharged without the need for any follow-up (Appendix 9). At Prince Charles Hospital, nearly half (48 per cent) the patients arriving by ambulance were discharged without the need for any follow-up while a small proportion did not require treatment. The Health Board and ambulance service have been working together to address alternatives to conveyance to A&E by analysing the main reasons for ambulance calls, where the demand is coming from, for example care homes or GP surgeries, and its subsequent impact on A&E. The ambulance service has been leading on the development of a number of emergency care pathways based on the volume of calls and main presenting conditions but progress in developing these pathways has been slow.

The Health Board is reducing its reliance on the acute sector to manage chronic conditions and positive action to tackle delayed transfers of care appears to be taking effect but multiple admission rates and lengths of stay for some chronic conditions remain above target

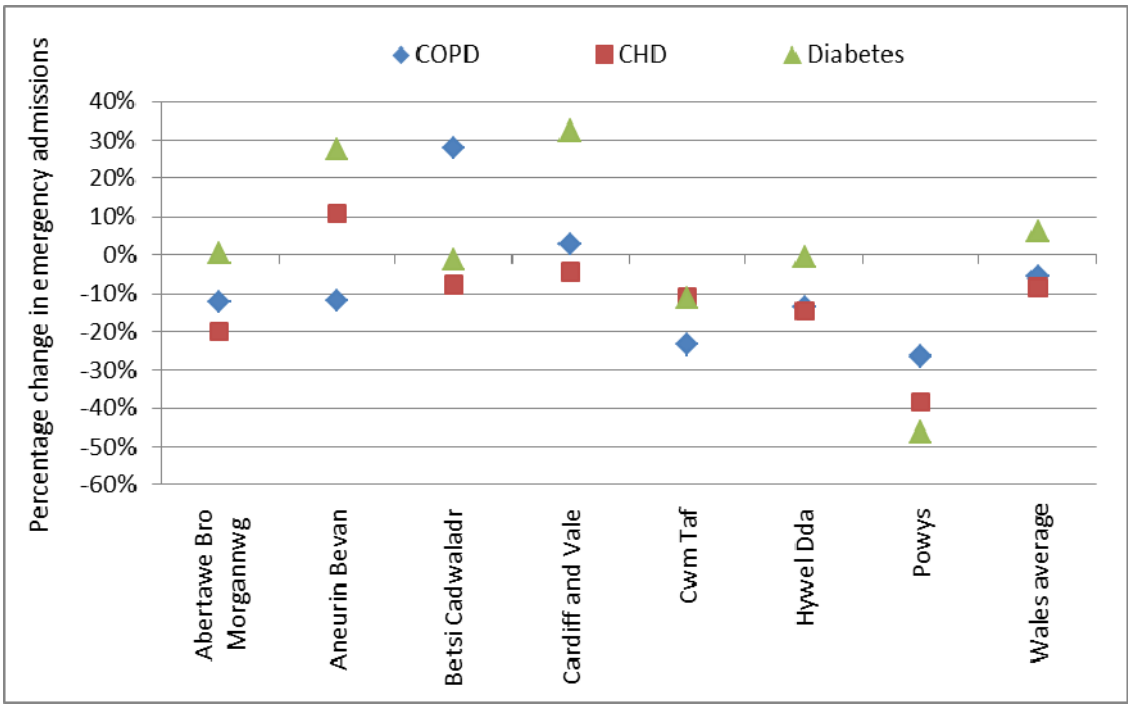
Reliance on the acute sector to manage chronic conditions is reducing with Cwm Taf having made more progress than most other health boards but multiple admission rates and lengths of stay for some chronic conditions remain above target

49. 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, particularly as a small proportion of patients spend longer than eight hours in the A&E department (paragraph 37).

50. Since the start of 2007-08, NHS bodies have been expected to achieve reductions in admissions for COPD, coronary heart disease (CHD) and diabetes. At the Health Board, these three conditions accounted for eight per cent of all emergency admissions to hospital that year, which was the same as the Wales average. In 2010-11, this proportion reduced to seven per cent at the Health Board while the Wales average was unchanged.

51. Over the last five years, the number of emergency admissions for COPD and CHD fell across the NHS in Wales by six per cent and nine per cent respectively. However, the number of emergency admissions for diabetes increased by six per cent (Exhibit 10). The Health Board's performance relative to other NHS bodies is very good; COPD emergency admissions reduced by 23 per cent, while those for CHD and diabetes both fell by 11 per cent.

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



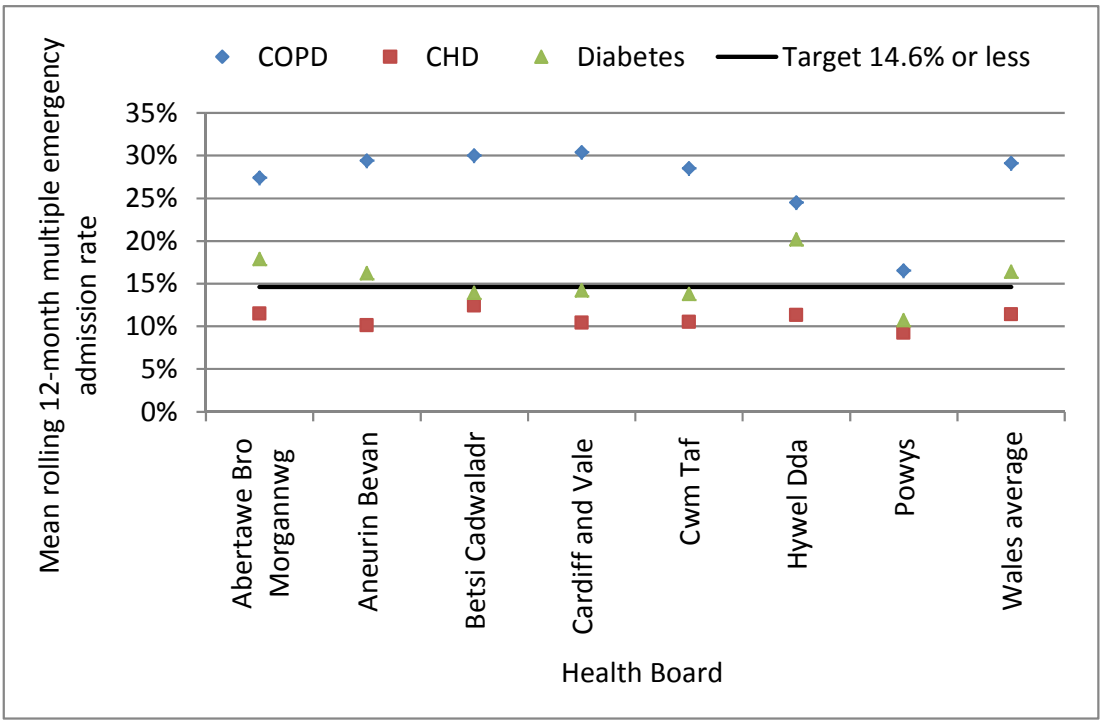
Source: Wales Audit Office analysis of data derived from the Patient Episode Database for Wales and provided by NHS Wales Informatics Service (NWIS).

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

53. In summary:

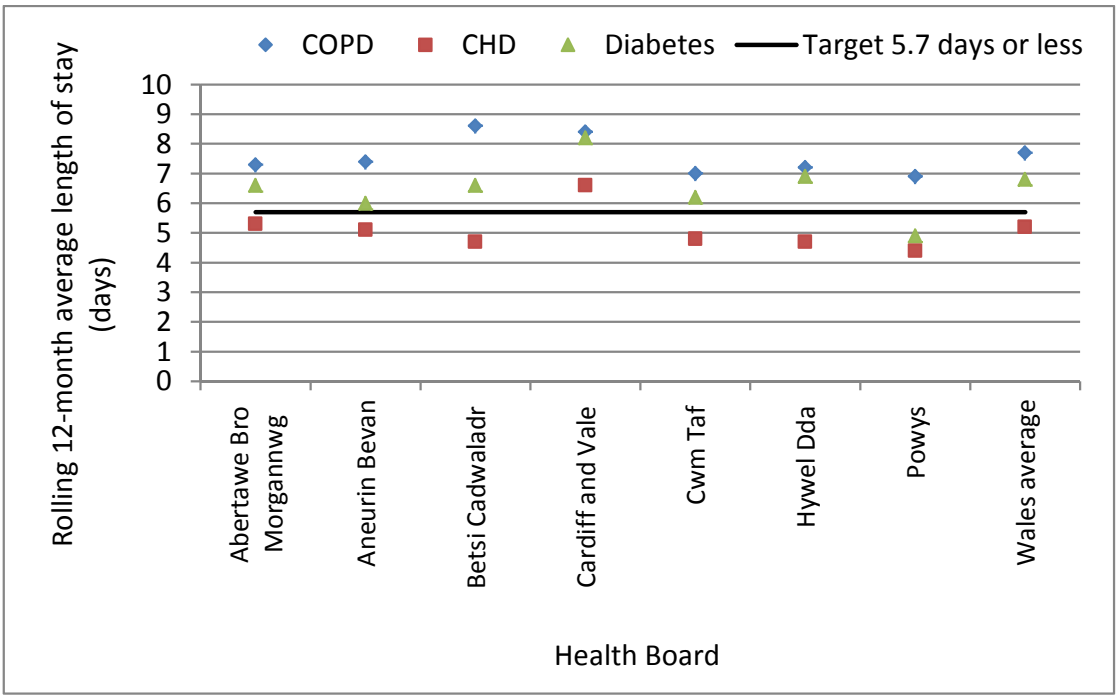
- The COPD multiple admission rate has been consistently and substantially above target throughout the last five years. The average length of stay reduced over time but remained above target (just over six days at July 2011).
- The CHD multiple admission rate has remained below the national target. While the average length of stay has reduced significantly (to just over three days at July 2011).
- The diabetes multiple admission rate has been both above and below target in different periods (16 per cent at July 2011). The average length of stay had remained relatively constant at around six days for much of the five-year period before falling below target between March and July 2011 (just under five days at July 2011).

Exhibit 11: Mean rolling multiple emergency admission rate between April 2006 and July 2011



Source: Wales Audit Office analysis of data extracted from the National Leadership and Innovation Agency for Healthcare's (NLIAH) report 'Progress Report on the CCM Service Improvement Plan as measured through the CCM Maturity Matrix', October 2011.

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



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

54. The Health Board's primary care support unit works with practices where admission rates for specific chronic conditions are high. This targeted work aims to up-skill practice staff to manage these patients more confidently in the community. 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. Cwm Taf practices could select three of five possible conditions (COPD, heart failure, falls, fever in children and end-of-life care) giving rise to emergency admissions. We asked practice managers for views on the quality of the data and whether it would make a difference. Just two practice managers reported using the emergency admissions data that the practice received from the Health Board as part of the QOF process. However, none thought the data were helpful, citing data inaccuracies as a reason.

Although there had been a rise in the overall number of patients experiencing a delayed transfer of care, positive action to tackle the problem appears to be taking effect

55. 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.

56. Between 2006-07 and 2010-11, the number of admissions, and associated bed days, at Cwm Taf decreased by 1.6 per cent and seven per cent respectively. However, the number of patients experiencing a delayed transfer of care at Cwm Taf has increased by 60 per cent from 393 in 2006-07 to 629 in 2010-11 with a similar rise in delayed bed days (Exhibit 13). Although, an increasing number of patients experience a delayed transfer of care, the average number of bed days lost per patient (the average length of time patients are delayed) has changed little over the last five years with the exception of 2008-09.

Exhibit 13: Number of patients experiencing a delayed transfer of care from acute and community facilities (excluding mental health facilities) at the Health Board (2006-07 to 2010-11)

	Number of patients experiencing a delayed transfer of care	Number of lost bed days	Average lost bed days per patient
2006-07	393	17,621	44.8
2007-08	479	19,710	41.1
2008-09	455	16,695	36.7
2009-10	549	26,673	48.6
2010-11	629	28,368	45.1

Source: Data provided by NHS Wales Informatics Service.

57. Recent action by the Health Board and its partners to tackle the problem of delayed transfers of care includes:

- Introducing fortnightly length of stay meetings for senior nurses to review delayed transfers of care where length of stay is protracted. The Health Board has indicated that during 2011-12, this has led to reductions in the overall number of patients with a delayed length of stay in excess of 40 days.
- Implementing the anticipated date of discharge system in autumn 2010 to improve the discharge planning process. The Health Board has indicated that this has increased the number of patients discharged before midday.
- Working in collaboration with the Rhondda Cynon Taf County Borough Council (RCT Council), to test a 'single point of access' whereby ward staff at the Royal Glamorgan Hospital and Ysbyty Cwm Rhondda make referrals direct to the Council's Intermediate Care and Reablement Service without the need for a social service assessment. By November 2011, the findings from the pilot indicated that this new direct pathway from hospital to the single point of access was supporting more timely discharge and saving bed days. The Health Board and Merthyr Tydfil County Borough Council (Merthyr Tydfil Council) have now rolled out this model on wards at Prince Charles Hospital.
- From 2012, the reablement service in the RCT Council area is expanding to provide reablement services to people with dementia. Again, ward staff at Royal Glamorgan Hospital and Ysbyty Cwm Rhondda will be able to refer direct to the reablement service the small number of patients with dementia, who are admitted each year as an emergency.

58. It is too early to judge the impact of these actions on overall numbers of patients delayed in 2011-12[8] but data from the delayed transfer of care census does show that the number of patients affected in any one month is reducing (Appendix 12). Data compiled by the Health Board at the end of March 2012 indicate that there has been a substantial reduction in the number of patients delayed.

[8] Data on overall numbers of patients delayed during 2011-12 will be aggregated by the Welsh Government in summer 2012.

The Health Board has made good progress in strengthening the way it seeks to support people in the community and prevent unnecessary use of hospitals

The Health Board is beginning to test new ways to identify individuals at risk of unplanned admissions and support them in the community

59. 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 identified four levels of care, ranging from primary prevention and health promotion through to complex case management, to ensure support is targeted and effectively co-ordinated, according to individuals' risk and care needs.

60. Delivery of the chronic conditions integrated model and framework relies on health boards identifying the needs of their communities and 'stratifying' practice populations according to levels of risk of unplanned hospital admissions. Individuals identified at greatest risk of unplanned hospital admissions should be actively managed to ensure they receive the right care in the most appropriate setting. An all-Wales risk stratification tool is unlikely to be available until at least 2013. In the meantime, the Health Board is preparing to test two methods for identifying those patients at most risk of repeated hospital admissions.

61. The first method aims to identify vulnerable patients using criteria developed by the locality clinical directors. These criteria include patients requiring either district nursing services, advanced care planning or social services assessment. The test involves identifying vulnerable patients using these criteria and comparing the information with retrospective admissions data to see if there is a match. Plans are in place for a cluster of practices in the Merthyr locality to test these criteria, as well as the ease with which practices can collect the information.

62. The second method aims to identify patients post-admission by scoring their readmission risk using a tool called LACE[9]. The higher the score the more intensive support needed on discharge. Testing involves comparing the LACE score for patients readmitted within 30 days with the LACE score on their previous admission. The Health Board proposes testing LACE on patients re-admitted to Prince Charles Hospital.

[9] Patients are scored based on **L**ength of stay, **A**cuity of admission, **C**o-morbidities and **E** number of A&E attendances in the last six months.

63. In future, patients identified as vulnerable or at high risk of hospital admission could be referred to one of two new intermediate care services. The first, the Community Integrated Assessment Service (CIAS), will provide a multidisciplinary assessment for people aged 50 or older who are at risk of admission to hospital, at risk of falling or starting to fail at home. The Health Board has identified that a significant proportion of older patients admitted to hospital during 2010-11 were admitted three or more times. A review of admissions to the Acute Medical Unit by two physicians between April and October 2010 had also found that a small proportion of admissions could have been avoided if intermediate care services had been available.

64. Following assessment, CIAS will forward a discharge plan back to the patient's referrer with a list of recommendations for ongoing care and treatment. At the time of our audit, the composition and costs of the CIAS team had been identified with staff in place with the exception of medical staff input. Until such time the service is not operational. Once medical staff input is secured, CIAS will provide a five-day service (Monday to Friday), which will be available across Cwm Taf. The CIAS team also plans to work with A&E staff at Royal Glamorgan Hospital to identify patients who could benefit from the service given the high proportion (68 per cent) of medical admissions coming via A&E departments.

65. The second intermediate care service being developed during 2011 is the Virtual Ward. The Virtual Ward will provide care for patients at high risk of unplanned admissions in their own homes. Patients will receive an initial assessment from the Virtual Ward team leader, who is likely to be a day hospital sister, in the first instance. The team leader will develop a plan of care and co-ordinate input from health and social care service or arrange diagnostic tests or make referrals as appropriate. The team leader will have support from a multidisciplinary team, including a pharmacist, the patient's GP, a district nurse, a physiotherapist or occupational therapist, a specialist nurse and social care staff. This multidisciplinary team will hold ward rounds, either face-to-face or by videoconference. At the time of our fieldwork, the Health Board had not tested the Virtual Ward but aimed to have it in place by March 2012.

66. Since our fieldwork, the Health Board has been successful securing pump-priming funding from the Welsh Government's Invest-to-Save fund to increase the breadth of support available through CIAS, the Virtual Ward and the reablement service for the frail and elderly. This expansion will provide robust alternatives to acute admission or alternatives to rehabilitation in hospital.

Service redesign and investment is helping to shift the location of care from hospital to community

67. 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 £1.14 million in transitional funding over the three years. This funding was used to help implement the chronic conditions integrated model and framework in a number of ways, for example by:

- reviewing the roles of specialist nurses to identify the level of community focus;
- assessing the skill-mix of community nursing services;
- helping to establish the locality model and locality manager roles;
- developing advanced nurse practitioner roles;
- supporting clinical champion sessions in primary care;
- establishing training and education models;
- exploring the feasibility of establishing a role for a generic support worker for individuals receiving both health and social care to minimise duplication and provide a seamless service; and
- pump-priming a multidisciplinary community-based pulmonary rehabilitation service.

68. Budgetary information provided by the Health Board (and distinct from the transitional funding) also indicates increased funding for intermediate care and chronic conditions services over the last five years. In 2005-06, the combined budget for intermediate care and chronic conditions services was estimated at £2.8 million. By 2011-12, the budget was £5.1 million for the 34 services (excluding district nursing services) either in place or planned at the time of our fieldwork (Appendix 13). Two-thirds of these services were funded from the Health Board's revenue allocation while the remainder were funded in collaboration with the Welsh Government, local authority partners or others, such as the Parkinson's disease society.

69. The NHS reforms in 2009 and the publication of *Setting the Direction*, have provided the impetus to reshape services, test new roles or move services, albeit in small ways, from the district general hospitals into the community, for example:

- Establishing a consultant-led multidisciplinary community diabetes team, providing joint clinics involving the Consultant Diabetologist and GPs; the multidisciplinary team enables improved community-based diabetes care through enhanced knowledge and joint service delivery for both patients and healthcare professionals; over the course of 12 months, the team received 372 referrals.

- Establishing a time-limited project to inform the development of an advanced nurse practitioner role in managing housebound patients with chronic conditions; the advanced nurse practitioner focused on providing medication reviews, identifying patients for referral to other health or social care professionals where appropriate and assessing the impact of the service on hospital admissions or GP visits; the project was discontinued in November 2011 and the findings from the evaluation will inform wider service planning in relation to the needs of housebound patients with chronic conditions.
- Reconfiguring district nursing services to release skilled team leaders to implement a community intravenous antibiotic service for medically stable patients with diabetes.
- Moving the chronic pain service from acute to community hospitals.

70. The Health Board has also worked to agree ways that GPs and other primary care staff can access advice from consultants within 24 to 48 hours to help manage requests for outpatient referrals. For example, GPs can ask questions about patients with cardiac problems by secure e-mail. A similar scheme is planned for paediatric services in 2012. However, practices responding to our survey perceived little support to help avoid referring patients to hospital. We found that:

- none of the practices perceived that it had good access to either telephone or e-mail advice from consultants (or other specialists) to help manage a patient's acute condition and avoid a visit to hospital, with practices citing difficulties in knowing which consultants they could ring, and the difficulties speaking to a consultant during surgery hours;
- only three practices responding to our survey perceived that they had good access to 'rapid access clinics', with the exception of the chest clinic, which was said to be excellent; and
- none of the practices responding believed there was a good range of community services to which they could refer patients to avoid an emergency admission or visit to hospital, and only one practice agreed that it had enough information about the range of community services available to prevent avoidable admissions.

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

72. The Health Board's vision for its locality model made it clear that not all services would be located within localities. Where there was a lack of critical mass or where services were of a more specialist nature, these would be provided across localities as part of a CRT. The CRT at Cwm Taf comprises six specialist nursing services (Box 1), of which three are well-established. Fewer than nine WTE staff make up the team, which provides specialist advice and support to clinicians, particularly those in primary care, as well as facilitating improvements in patient care across the primary and secondary care interface.

Box 1: Community Resource Team

The six specialist nursing teams that make up the CRT are:

1. The diabetes nurse facilitator has a small caseload of complex patients, who find it difficult to comply with treatment; the nurse facilitator carries out joint visits with district nurses and provides expert advice on insulin regimes and care plans.
2. The respiratory specialist nurses do not carry a caseload but provide expert advice; also work with practices with high COPD admissions rates to support practice nurses to audit case notes to review the quality of care and to see if admissions could have been avoided.
3. The primary care nurse facilitator delivers the Care Home local enhanced service (paragraph 90).
4. The Parkinson's disease specialist nurse provides support and specialist advice and education for all aspects of Parkinson's disease care for clinical staff, patients and their carers, and at times will carry a small caseload.
5. The tissue viability team provides specialist advice or expert consultation on prescribing or clinical treatments for patients with leg ulcers, pressure sores and complex wounds to district nursing teams and ward nurses; the team also provides some specialist clinics where it treats patients before transferring them back to mainstream services.
6. Non-cancer lymphoedema service is newly established and will provide specialist advice and support in relation to the clinical management of individuals presenting with non-cancer lymphoedema, including assessment and appropriate management strategies.

73. Over the last few years, there have been changes to the network of community hospitals as the Health Board continues to replace old and outdated facilities with new ones, like Ysbyty Cwm Rhondda, the Cynon Valley Community Hospital and Merthyr Health Park, an integrated health and social care centre supporting new models of care in the community. Increasingly, the Health Board is using community hospitals for the provision of new community services, such as the non-cancer lymphoedema service and the CIAS. It is also relocating services, such as the chronic non-malignant pain service, from district general hospitals to the community hospitals. The Health Board is also exploring the possibility of providing step down beds at Pontypridd and District Cottage Hospital for patients with ongoing complex needs, who are moving from acute to community care.

74. Data published by the Welsh Government[10] show that across Wales the average number of daily-staffed beds reduced by 5.5 per cent between 2009-10 and 2010-11. Across Cwm Taf hospitals, the reduction was 11 per cent with the biggest impact on community hospitals where bed numbers reduced from 665 to 549. The specialities hit hardest were those of general medicine and elderly care medicine. This means there will be greater reliance placed on community-based intermediate care services to prevent or divert acute admissions or to provide ongoing support on discharge from hospital.

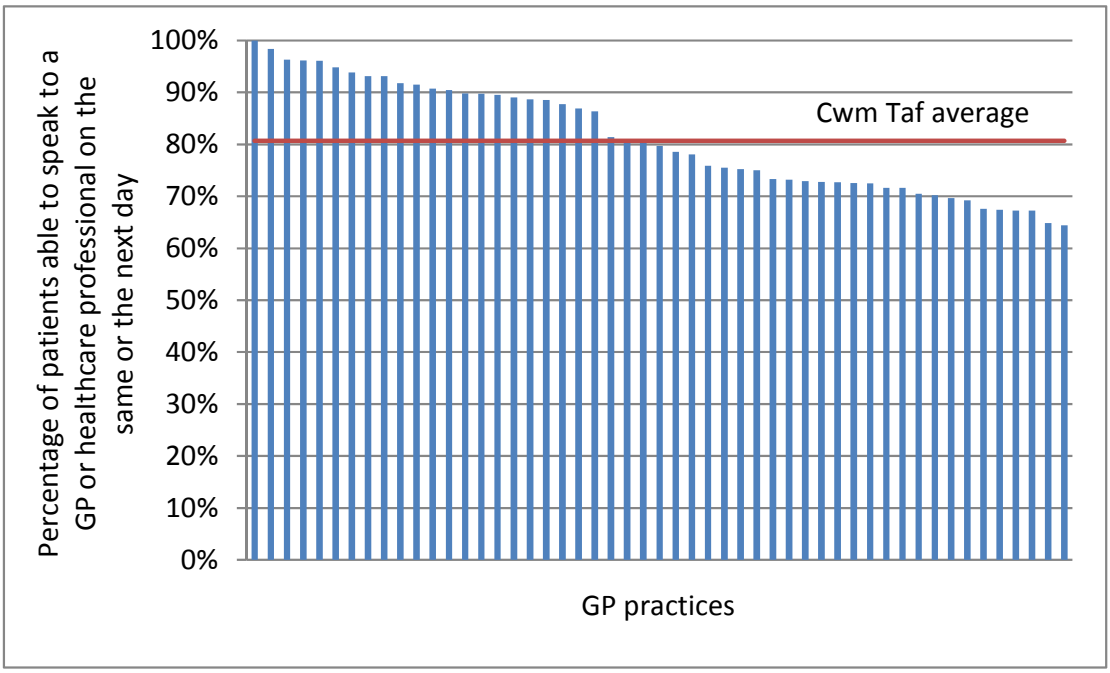
The Health Board and some GP practices are taking positive action to improve access for patients during core hours but demand for out-of-hours services is rising and the reasons are not yet clear

75. 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.

76. Findings from the 2011 Welsh GP Access Survey, which was conducted in February 2011, suggest that a relatively high proportion (81 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 but there were large variations across practices (Exhibit 14). 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 unable to get through by phone.

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

Exhibit 14: Percentage of patients registered with GP practices in Cwm Taf who reported being able to see or speak to a GP or healthcare professional, the same or next day



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

77. At the beginning of 2011, with the support of the Local Medical Committee, the Health Board asked just under half (23) of its GP practices to review opening times and to provide reasonable access during core hours (8.00am to 6.30pm) five days a week. Historically, the 23 practices were closed for a half day each week. By October 2011, three of the 23 practices were open all week. Meanwhile discussions over the timescales to achieve core opening hours were ongoing with the remaining practices. As well as reviewing opening times during practice development visits, the Health Board intends carrying out 'secret shopper' exercises to check that practices are adhering to the core opening hours.

78. Five practices currently participate in the extended opening hours directed enhanced service. The Health Board has indicated that following a review, this directed enhanced service has not had the intended impact of improving access outside normal opening hours with too few patients taking advantage relative to the cost of the service. It is now considering how to use the funding more effectively given the relatively high cost of the service compared with other enhanced services.

79. Three of the nine practices responding to our survey reported that they had analysed the number and pattern of telephone calls to the practice. For those practices that did analyse the number and pattern of telephone calls, additional staff had been deployed to answer calls during peak periods, namely 8:00am to 9:00am and 2:30pm to 3:30pm, improved staff training for handling calls and reduced the number of times patients were asked to ring back. Six practices told us that they had formal protocols in place to deal with requests for appointments. Practice receptionists in six of the practices received training to identify callers who needed an urgent or emergency appointment.

80. Practices themselves were also looking to improve access. Seven practice managers from Cwm Taf responding to our survey told us that they used the GP Access Survey to review issues around access and to implement changes where appropriate. The types of changes cited by practice managers included:

- providing more same-day appointments, particularly on Mondays and Fridays;
- keeping a one-hour session free of appointments in the morning and afternoon for patients requesting an urgent or emergency appointment;
- making appointments available from 8:30 am;
- developing decision support templates to prioritise urgent and emergency appointments;
- identifying a GP within the practice to provide an 'on-call' service in the morning and afternoon for those patients with an acute illness or needing advice;
- providing GP telephone advice appointments;
- offering patients appointments at branch surgeries; and
- increasing the availability of nurse practitioner clinics.

81. In spite of these reported changes, the availability of same-day appointments varied across the nine practices responding to the survey. The percentage of same-day appointments ranged from 25 per cent to 84 per cent. In addition to reviewing appointment systems, eight of the nine practices were also tackling the problem of patients who do not attend their scheduled appointments by telephoning or writing to patients who fail to show up, as well as displaying information prominently in the surgery about the number who fail to attend and what this means for other patients.

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

- confusion amongst patients about what defines an emergency and what services are the most appropriate to use;
- a small number of patients seeking repeat appointments to get a second opinion; and
- increasing patient expectations not matched by increasing responsibility for one's own health.

83. The Health Board can also deploy its primary care resource team to support practices. For example, the Health Board can, if necessary, deploy salaried GPs to provide general medical services where there is no incumbent GP in a practice. The primary care resource team can help cover for long-term sick absence or backfill for practice nurses to undertake continuing professional development.

84. Individuals with urgent primary care needs can access GP services out-of-hours between 6:30pm and 8:00am on weekdays, and all day at weekends, bank holidays and public holidays. In 2010-11, there were just over 41,000 attendances at the Health Board's four GP out-of-hours centres, 5,200 more than in 2007-08. As well as seeing patients at the out-of-hours centres, patients can also receive a home visit if they are too sick to travel to the centres or receive advice over the telephone to self-care. The cost of out-of-hours services is also rising. It totalled £3.17 million in 2010-11, the equivalent of £10.47 per registered patient. However, expenditure has shown much bigger variations over the last five years (Appendix 14). The Health Board attributes the rise in expenditure to an overspend against budget for medical, administrative and clerical staff.

85. Health Board staff told us that demand for GP out-of-hours services is often high just after practice closing time at 6:30pm and that requests for appointments peak in the early evening and Saturday mornings, particularly for children. Higher levels of activity out of hours is reportedly associated with demand from patients registered with a few individual practices. Since our fieldwork, the Health Board has been actively engaging with GP practices and the public to understand the reasons in order to manage this demand more effectively. Early indications suggest a number of factors may be driving the increase, such as increasing numbers of elderly people being cared for in the community or an individual's inclination to contact the service due to its responsive nature. Work is ongoing to try and substantiate some of the hypotheses.

86. Few practice managers responding to our survey perceived that out-of-hours services were good at meeting the needs of patients with several reporting that patients were simply advised to visit their own GP the next working day. Those practices who thought the out-of-hours service was good told us that patients spoke highly of the service.

87. At times, the Health Board has found it challenging to recruit GPs to provide adequate cover at the four primary care centres, and in October 2011, it took steps to inform the public that it might have to operate out-of-hours services at Royal Glamorgan and Prince Charles hospitals at weekends in order to provide clinically robust services. As part of the Health Board's cost savings programme, it is looking for opportunities to make the current out-of-hours service more efficient and cost-effective for example by:

- reviewing the skill-mix of the out-of-hours service;
- considering deploying advanced nurse practitioners to work alongside GPs out-of-hours to treat minor illnesses;

- reviewing the demand and capacity of primary care centres and the feasibility of reducing the number of centres; and
- reviewing rates of pay and benchmarking costs with other health boards.

88. At the meeting of the Board in March 2012, the Chief Executive indicated that, following a review of the process to secure shift cover, it should be possible for the four out-of-hours centres to remain open.

The Health Board is now making more use of primary care contracts to support patients with chronic conditions and unscheduled care needs

89. Historically, the use of primary care contracts in creating capacity to care and support patients in the right place has been limited. In 2006-07, the Health Board's predecessors spent £2.9 million on GMS enhanced services with 36 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 or unscheduled needs. By 2010-11, expenditure had increased to more than £3.7 million. In addition to the minor injuries/wound care service (paragraph 34) and the extended opening hours service (paragraph 78), services for chronic conditions, such as COPD and diabetes, were also in place.

90. In 2010, the Health Board also used some of the GMS allocation to establish a Care Home local enhanced service. A primary care nurse facilitator delivers the service to patients residing in both nursing and residential homes, where patients' GPs have selected not to provide this local enhanced service. The key requirements of the local enhanced service include:

- an initial comprehensive physical assessment and baseline mental health assessment, which covers screening, diagnosis, emotional support and counselling, referral and discharge, case management and care co-ordination;
- two medication reviews per year, liaising with community pharmacists to optimise treatment;
- monthly review of patients to address CCM issues;
- timely referral to secondary care services including liaison with care of elderly consultants; and
- promotion of the End of Life Care Pathway.

At the time of our audit, the Care Home local enhanced service was the subject of a formal evaluation. Ongoing monitoring of the local enhanced service had shown a positive impact on patient care with some patients being identified with health conditions that had not been previously picked up.

91. In addition to the GMS contract, the Health Board commissions a small number of enhanced services from local community pharmacies for a more modest level of expenditure (just over £80,000 in 2010-11) 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; 29 of the 77 community pharmacies currently participate in the scheme and between October 2010 and September 2011, these pharmacies received 1,356 referrals.
- Minor ailment services – since 2010-11, three community pharmacies have provided a minor ailment service; prior to this date, the community pharmacy contract was not used in this way at the Health Board or its predecessor bodies.
- A homecare medication administration service developed in conjunction with RCT Council in 2007 to enable homecare workers to support local residents in receipt of social care services to manage their medication. Forty-nine community pharmacies are commissioned to provide the medication administration record charts to enable homecare workers to record when they have administered the medication. Referrals come from health and social care professionals working in the community or from hospital staff when patients are discharged from the ward or A&E. The service received 100 referrals between October 2010 and September 2011. The scheme does not operate across the Merthyr Tydfil area although plans are in place to roll it out.

The Health Board has had limited success so far in changing the way that the public uses services, and the uptake and completion of dedicated self-care programmes is still too low

The Health Board continues to promote 'Choose Well' but the campaign appears to have had little impact so far on the way the public uses services

92. 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.

93. The 2009 report recommended that a national communications strategy should be developed to improve public understanding about how to most appropriately access care. In response to this recommendation, in March 2011 the Welsh Government launched the national 'Choose Well' campaign. Choose Well aims 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'.

94. In advance of the all-Wales campaign, the Health Board launched its own local 'Choose Well' campaign in March 2010. In the short-term, there seems to be little change in behaviour. The Health Board is keeping alive the 'Choose Well' message with written materials, like leaflets in the A&E departments, minor injury units and GP practices. A press release in October 2011 publicised the role that community pharmacists play in helping people to manage their own health instead of ringing the out-of-hours service or attending A&E. The Health Board acknowledges that it may take several years before the full impact is seen, in terms of changes in public behaviour.

95. The Health Board believes that the public has good knowledge about the availability of services in and out-of-hours but a limited understanding about which are the most appropriate to use. For example, staff cited longstanding cultural issues in the way A&E services are used, with the local population seeing it as an extension of primary care. As we noted in paragraph 20, staff at the minor injury units will redirect patients to primary care where appropriate. Meanwhile reception staff at the accident emergency department at Prince Charles Hospital will make appointments with the out-of-hours service for patients with primary care needs who attend the department out-of-hours. In addition to redirecting patients and promoting the 'Choose Well' message, the Health Board needs to build public confidence in scheduled services as an appropriate and effective alternative to emergency services.

96. In 2012-13, the Health Board will work with health boards in the South East Wales region to ensure that the campaign has the maximum impact possible. The collaboration aims to deliver consistent messages across the region, exploit social media and make more use of in-house newsletters and magazines to disseminate Choose Well messages to staff and the public. This collaborative approach also aims to develop Choose Well ambassadors amongst each health boards' workforce.

Plans for the communications hub to signpost people to the right services are still in their infancy

97. 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.

98. The Health Board's plans for a single point of access via the communications hub have not really progressed since the position we reported previously in 2011. Currently, the communications hub comprises four distinct call-handling services, namely the primary care out-of-hours call handling service, the patient-focused booking team, who organise outpatient appointments, the non-emergency patient transport service and the district nursing messaging service. The communications hub operates across 24 hours, 365 days a year. Services are delivered between 8.30am-6pm weekdays with the exception being the GP out-of-hours service which operates 6.30pm-8am on weekdays and from 6.30pm Friday until 8am Monday morning. Due to a number of operational and technical issues all services currently have unique telephone numbers. Healthcare professionals do, however, have a dedicated telephone number to bypass the call queuing system, where calls can be passed to the appropriate service. Currently, there is no single contact number for information and advice or signposting. An electronic directory of services, developed in collaboration with local authority and third sector partners, is due to be launched during in autumn 2012. As the communications hub is co-located with RCT Council's customer contact centre at Ty Elai, integrated call handling is an area which the Health Board and the Council are looking to develop.

99. In September 2011, the Health Board appointed a manager to take forward its vision for a single point of access via the communications hub. Initial priorities concentrated on the repatriation of the Cardiff GP Out-of-Hours service. This was followed by a full review of systems and processes across the remaining constituent services to ensure delivery of the best possible services. The review identified three main themes to guide service improvement those being building capacity within the workforce; improved performance management; and improved communication to drive greater efficiency. As a result of this work the communications hub is now in a position to explore expansion opportunities in order to develop the vision for the single point of access.

100. The Health Board continues to crystallise its vision for a communications hub in relation to its role and the model for delivery. It has been able to exploit RCT Council's expertise in providing a customer contact centre, including knowledge of IT and telephony infrastructures, to help shape its vision. While there is no clear development plan setting out the purpose and function of the communications hub, the Health Board has taken steps to put in place the infrastructure needed. RCT Council is supporting the Health Board to ensure that call-handling services for healthcare services can be provided from a single communications hub. The Health Board has worked incrementally to start to move the organisational arrangements for some community services, like district nursing, to the communications hub. Meanwhile, the Health Board continues to participate in the national working group, along with RCT Council, to identify the physical infrastructure needed to achieve the most cost-effective means of linking communications hubs across Wales 24/7.

101. Paragraphs 19 and 20 noted the challenge the Health Board faces in ensuring the right patients attend minor injury units. The Health Board has launched a new system of telephone triage – 'Phone First' – for patients who sustain a minor injury. When patients call 'Phone First', they will receive one of the following: self-care advice; advice to phone NHS Direct Wales; signposting to a GP if it is a minor illness; directed to a GP offering the minor injury enhanced service; given an appointment to attend the minor injury unit; or advised to go to A&E. When publicising these new arrangements, the Health Board will need to be mindful of the limited impact that 'Choose Well' has had to date on helping the public to choose the right service. Furthermore, the public meetings about the temporary closure of the minor injury unit at Ysbyty Cwm Rhondda have also highlighted the lack of understanding about what minor injury units can and cannot treat. As well as publicising the new arrangements, the Health Board needs to consider how 'Phone First' fits with the development of the local communications hub.

102. The Health Board has indicated that it has worked hard to publicise the 'Phone First' system with the local public, GP practices and its own healthcare staff. Early indications are that 'Phone First' is having the desired effect. Individuals are telephoning 'Phone First' to schedule appointments at the minor injury unit. It is also reported to be drawing away demand from A&E at the Royal Glamorgan Hospital. The Health Board plans to assess the impact of Phone First at three months. If the system is working and having a positive impact, it will be rolled out to the minor injury unit at Ysbyty Cwm Cynon.

Support for patient education and self-care has improved but the uptake and completion of dedicated self-care programmes is still too low

103. 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 and assistive technologies, such as telehealth and telecare.

[11] The self-care continuum starts with actions that individuals take to stay fit and healthy, self-care of minor ailments, with or without the support of professionals like GPs or pharmacists, to more formal help in managing complex health problems.

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

104. Our previous audit of CCM at the Health Board's predecessor bodies in 2006 found that fewer than half of the community services for people 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 for CCM included patient education and support for self-care.

105. The Health Board's predecessor bodies also supported a number of disease-specific patient support programmes, such as those for diabetes, which it continues to support. X-PERT and DAFNE are two such education programmes for people with Type II and Type 1 diabetes respectively. Plans are in place to offer all newly diagnosed patients access to X-PERT once the Health Board assesses the capacity required. The service is currently available 2.5 days over one week per month with patients waiting approximately one month to start the programme. DAFNE is available 4.5 days over one week per month. The programme can support 96 patients per year but patients can wait between 6 to 12 months to begin the programme.

106. The Health Board funded the COPD forecast alert service provided by the Met Office. The Met Office monitored environmental conditions and warned people when their health was likely to be affected, giving them the opportunity to take action to stay well. Around 1,000 patients used the service but the Health Board has recently discontinued the service having undertaken a cost benefit analysis exercise.

107. Since our previous audit of CCM in 2006, the Health Board has rolled out 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 the confidence to look after their own health needs. In a ministerial letter to chief executives in 2009, the Minister for Health indicated that health boards should aim to get one per cent of the chronic condition population through EPP courses over the following three to four years.

108. Although 19 EPP courses were provided across the Health Board between April 2010 and December 2011, the number of people registered for an EPP course varied each quarter (Exhibit 15). Nearly half (48 per cent) the individuals registered to attend a course, took up a place and completed it while the other half did not attend or dropped out once the course was underway. The completion rate (that is the number of individuals registering for a course and completing it) was the lowest amongst the health boards; the Wales average was 63 per cent (Appendix 15). In order to achieve the expectations set out in the ministerial letter, the Health Board will need to ensure that five times as many individuals complete a course. Since our fieldwork, the Health Board has indicated that it brought the EPP back in house to strengthen the management of the programme.

Exhibit 15: Quarterly trends in the provision of EPPs* at the 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	2	22	8	1	13
Q2 – 2010-11	3	40	11	11	18
Q3 – 2010-11	3	37	14	2	21
Q4 – 2010-11	1	20	6	5	9
Q1 – 2011-12	3	46	12	12	22
Q2 – 2011-12	2	20	1	3	16
Q3 – 2011-12	5	45	2	18	25
Overall total	**19**	**230**	**54**	**52**	**124**

**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 EPP Cymru.

109. Expenditure on the EPP programme was collected for the period October 2010 and September 2011. The relatively poor completion rate means that the cost per EPP course completed was £735. This cost is approximately double the cost at Betsi Cadwaladr and Hywel Dda (Exhibit 16).

Exhibit 16: 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.

110. Completion rates for other education programmes provided by the Health Board show a mixed picture. In 2010-11, only 38 per cent of individuals invited to take part in the X-PERT programme took up a place and completed it. The cost per X-PERT course completed was approximately £162 and its costs would reduce if the completion rate improved. Meanwhile, two-thirds of individuals registered to take part in the pulmonary rehabilitation programme took up a place and completed it.

111. In addition to these more structured education programmes, the Health Board has had limited success in implementing telehealth to test whether this could be used to manage patients with COPD, heart failure and hypertension more effectively at home. GP practices showed little interest in signing up for telehealth; only one practice took part in the pilot. The pilot ceased in 2011 with mixed outcomes. Working with the heart failure team at Prince Charles Hospital, the Health Board will pilot telehealth with a small number of patients with heart failure. Meanwhile, the Health Board's local authority partners are actively promoting telecare to help people maintain independence in their own homes. To this end, RCT Council trialled the provision of six weeks free telecare for people accessing the reablement services with positive results, namely the continued use of telecare once the reablement service withdrew.

112. A number of other community-based services that the Health Board supports incorporate a large element of patient education and support for self-care, as well as promoting healthy lifestyles, such as healthy eating, weight management, exercise and smoking cessation. These services include:

- the cardiac rehabilitation service;
- the pulmonary rehabilitation service;
- stroke education;
- minor ailment services provided by community pharmacists; and
- exercise referral schemes.

113. Since 2009, the Health Board has supported 'Pathways to Health' within Merthyr Tydfil and 'STEPS' within RCT. Both schemes are part of the Welsh Government-funded national exercise referral schemes with contributions from the Health Board and its local authority partners. The budgets for both schemes totalled £349,000 in 2011-12.

114. Referrals to the schemes can come from many routes, but most importantly from GP practices. The Pathways to Health scheme receives roughly 80 referrals per month while the STEPS scheme receives roughly 110 per month. Between October 2010 and September 2011, Pathways to Health and STEPS received 698 and 1,273 referrals respectively. The number of referrals to the Pathways to Health scheme is significantly less than its potential capacity. Information from RCT Council shows that the Council aimed to increase throughput by 23 per cent during 2011-12 but at the end of December 2011, the number of people referred was 10 per cent behind target. RCT Council is working with the Health Board to actively market the service to encourage GP referrals.

The Health Board has a clear vision for the future management of chronic conditions and unscheduled care, supported by revised governance arrangements and a clear commitment to partnership working

115. 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.

While the Health Board has a clear vision for the management of chronic conditions and unscheduled care, it needs to be supported by robust workforce plans

The Health Board has a clear and consistent approach to the delivery of services for chronic conditions and unscheduled care but successful delivery will depend upon effective public engagement and clarity on service planning

116. The Health Board's vision for CCM has been set out in successive documents since 2008. In 2008, the Health Board's predecessor bodies, in collaboration with representatives from the local authorities, voluntary sector, ambulance service, community health councils and the NLIAH, produced a chronic conditions strategy. This strategy set out the vision that individuals would have access to services in the community for the treatment and management of chronic conditions, as well as support for self-care and advice on health promotion. The strategy was predicated on the all-Wales chronic conditions integrated model and framework, including the need to move resources into the community and reduce demand for unscheduled care in relation to chronic conditions. The chronic conditions strategy has been underpinned by a series of action plans, which have set out a number of annual priorities. The chronic conditions strategy was scheduled for review at the end of March 2012. Since our fieldwork, the Health Board has taken the decision to integrate the chronic condition strategy with its strategies for intermediate care and primary care and localities.

117. In 2010, the Health Board published a five-year Strategic Workforce and Financial Framework (SWaFF), which set out the key actions for securing the transformation required to deliver sustainable service improvements and financial balance between 2010 and 2015. The SWaFF reflects the direction of travel articulated in the national primary and community services strategy, *Setting the Direction*, namely an integrated approach between health and social care in the provision and delivery of services.

118. The SWaFF set out a number of priorities in relation to CCM and unscheduled care with clear outcomes identified over the short and medium term. For example, the Health Board aims to have structured education programmes in place for major diseases by 2013 with patients referred on diagnosis and structured education programmes in all disease areas with access for all patients who require such support by 2015. Clear goals for unscheduled care services included developing the communications hub as a 'vehicle for harnessing the multiagency resources to provide health and social care services'.

119. The Health Board has not developed its own local strategy for unscheduled care. Instead, it developed a number of action plans to deliver improvements in relation to unscheduled care, such as bed management and discharge planning.

120. The Health Board's vision for an integrated approach to the provision and delivery of services is reflected in the Health, Social Care and Well-being strategies and both Councils' improvement plans. These strategies and plans set out a range of actions that will also support the delivery of SWaFF priorities in relation to chronic conditions and unscheduled care.

121. In autumn 2011, the Health Board undertook a wide-ranging series of acute service reviews to inform its long-term approach for transforming and sustaining services. At the time of our fieldwork, the Health Board had yet to agree how it would take forward the review findings, particularly those which might impact on neighbouring health boards. The reviews' key findings have now been incorporated into service and speciality plans, which underpin the Health Board's overarching operational plan for 2012-13.

122. National and regional discussions about the network of hospitals that will exist in future are vital to ensuring patients across Wales have appropriate access to services, such as those at A&E departments. Until decisions are taken on this network, the Health Board intends working to reshape services within its own boundaries.

123. Changes to the pattern of hospital services is a highly emotive and controversial issue. Effective involvement and engagement with the public and other stakeholders will be a critical success factor in implementing these plans. The Health Board has been actively working with the Stakeholder Reference Group and other public fora to trail the case for changing the way in which acute and community services are provided. At this stage, the Health Board has not formally consulted with the public about service changes but anticipates working closely with the local Community Health Council. Recently, the Health Board successfully engaged with the public and local politicians over the need to temporarily close the minor injury unit at Ysbyty Cwm Rhondda. The Health Board will need to build on this approach and develop similar strategies to engage communities about the changes necessary to transform local services.

Service evaluations are more common and are helping to shape service developments

124. Our previous audit of CCM at the Health Board's predecessor bodies in 2006 found that few services had been evaluated in terms of clinical outcome, patient experience,

admissions avoided or cost-effectiveness. Where service evaluations had been carried out, these were predominantly about patient satisfaction. By 2011, the picture had changed with most services evaluated or audited in relation to patient outcomes, cost-effectiveness, admissions avoided and the impact on other health and social care professionals, as well as patient satisfaction. Even where formal evaluation or service audit had not been carried out, a number of positive service outcomes were cited, such as:

- a reduction in calls to the District Nursing Service;
- an increase in the number of healthcare professionals and healthcare support workers receiving education and training;
- an increase in the number of practice nurses able to facilitate nurse-led clinics for COPD or asthma;
- standardisation of blood glucose monitoring across the care home sector; and
- standardisation of documentation, policies and procedures.

125. As the Health Board develops new services, it is building in an appropriate range of measures against which to review the impact of the service. It is also using service evaluation to reshape services and target resources more effectively. For example, the specialist respiratory nursing service historically helped facilitate early discharge for patients admitted to hospital with COPD and provide post-discharge education and pulmonary rehabilitation. Following a review of COPD admission and readmission rates in early 2011, the focus of the team's work is changing to provide an integrated approach for managing respiratory conditions across primary and secondary care.

The Health Board has plans in place to increase workforce capacity in A&E departments, and similar plans need to be developed to address the shift required for community services and expected retirements in primary care

126. 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. This is something that the Health Board acknowledged in the SWAFF.

127. The Health Board acknowledges the challenges to sustaining A&E services across two sites given the difficulties recruiting appropriate medical staff. To sustain the current provision of A&E services and minor injury units, the Health Board will depend upon the following:

- an appropriate number of consultants in A&E and general medicine to provide an integrated 'front door';
- an appropriate number of middle-grade doctors to provide 24/7 cover across both hospital sites;
- the success of the new workforce model of advanced emergency practitioners; and
- directing patients to the right service at the right time.

In the future, the current model of A&E services and minor injury units may be largely dependent upon changes to service models in neighbouring health boards.

128. We reported earlier (paragraphs 23 and 24) that a high number of vacancies for medical and nursing staff is contributing to the pressure in both A&E departments. Issues around A&E capacity are not new and over the last two years, the Health Board has had to implement short-term solutions to increase capacity, namely reducing the opening hours of the minor injury units and temporarily closing the Ysbyty Cwm Rhondda minor injury unit. This has enabled the Health Board to redeploy ENPs from the minor injury units to both A&E departments.

129. Now that the advanced emergency practitioners are in post, the Health Board plans to evaluate the introduction of the role at three and six months to see whether the balance of staffing can be further shifted towards more advanced emergency practitioners in A&E. The Health Board acknowledges that it needs to work hard to retain these staff, as other health boards in Wales consider implementing a similar model. In order to sustain A&E services going forward, the Health Board is working with the University of Glamorgan to develop a framework for professional development 'to grow' more advanced emergency practitioners from within its current workforce.

130. 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 its workforce plans do not reflect the potential service changes expected in relation to the shift from secondary to primary and community care, in particular, the 10 per cent increase in the proportion of staff providing services in the community between 2010 and 2013[13]. The Workforce Plan for 2011-2017 shows a forecast reduction of 1.5 per cent in the number of full-time equivalent (FTE) staff in the primary, community and mental health sector by 2017. However, no real change in FTE numbers is forecast over the same period for the acute sector. Since our fieldwork, the Health Board has carried out an exercise to reconcile the numbers of

[13] Welsh Government, NHS Wales Annual Operating Framework, 2010/2011

staff working in the community with information held by budget holders for acute and community services. The Health Board acknowledges that one of the challenges to compiling a robust workforce plan is the need to reconcile workforce numbers with the necessary skills and competencies to deliver different models of care in primary and community care settings.

131. Whilst GPs 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. As part of the workforce planning, the Health Board identified that 26 per cent of GPs and 15 per cent of practice nurses could potentially retire by 2016-17. This suggests some services may not be sustainable without considering the impact of primary care workforce planning.

132. We would expect current service and workforce planning to identify and help take forward new thinking in terms of role redesign. There are already positive examples in place, such as the review of specialist nurse roles to identify the level of community focus and the development of advanced nurse practitioner roles to operate in care homes or support local authority day services and reablement teams to identify individuals who need healthcare input. District nursing teams were also restructured to release capacity to facilitate a shift in service provision from secondary to community care, such as providing the community intravenous antibiotic service. In future, relevant workforce information for social care, independent and voluntary care will need to be included in plans.

The Health Board has revised its governance arrangements for chronic conditions management and unscheduled care, and is now better placed to deliver planned service changes

133. 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.

134. The Health Board established the Setting the Direction Assurance Collaborative (the Collaborative), a multi-agency forum to oversee the implementation of the organisations' plans to improve primary and community-based services. The Collaborative is scheduled to meet quarterly and met for the first time in September 2011. Although not a formal committee of the Board, the Collaborative will provide assurance to the Board, through the Chair of the group and the minutes of meetings, that plans are being progressed.

135. The Collaborative includes representatives from the third sector, directors of social services for both local authorities and a selection of Health Board staff. The Health Board's staff are drawn from across the organisation and include four executive directors including those with responsibility for primary and community services, planning, public health and operational delivery, as well as finance and HR managers, and clinical directors for localities and a number of acute services. The Collaborative brings together groups progressing work in relation to unscheduled care and chronic conditions, as well local work in response to *Setting the Direction*, such as the primary care localities group and the communications hub group. By bringing these groups together, the Collaborative can align respective work programmes more effectively given the interrelation between unscheduled care and chronic conditions and improve the arrangements for monitoring delivery against work programmes.

136. At the time of our fieldwork, the terms of reference for the Collaborative were being finalised while those for each of the subgroups was also subject to review. Both the unscheduled care and chronic conditions groups are multidisciplinary and multi-agency fora, each chaired by a different member of the Collaborative. Until recently, a hospital consultant chaired the unscheduled care steering group but the Chair has passed to the Assistant Medical Director for Primary Care, in anticipation that it will focus attention on the role primary care plays in managing demand for unscheduled care. Under the auspices of the new Chair, membership of the group was under review.

137. Discussions about shifting resources from the acute to community sector were not really underway. The Collaborative is expected to agree a strategy for transferring resources and develop a formula to calculate the impact of new service developments. To that end, the subgroups were being asked to review timescales, financial implications and outcomes in relation to their respective work plans.

138. In addition to prioritising the use of resources, the Collaborative plans to agree a set of performance measures to monitor the implementation of the programmes of work of each subgroup. Currently, performance reports to the Board in relation to chronic conditions and unscheduled care have tended to focus on national Tier 1 targets, such as average lengths of stay and waiting times in A&E departments.

139. Building on the work of the chronic conditions subgroup, the Collaborative plans to adapt the matrix used to monitor the implementation of the chronic conditions integrated model and framework. This will include a number of process and outcome indicators to monitor direction of travel, such as measuring the shift in resources from secondary to community and primary care. A simple traffic light system, similar to that used for performance reports to the Board, is proposed as possibly one way in which to monitor progress against work plans. Since our fieldwork, the Collaborative has agreed the framework for monitoring progress against *Setting the Direction,* including a locality dashboard with key indicators, such as the uptake of patient education programmes and people supported in the community by social services.

The Health Board is committed to building strong partnerships with key stakeholders but efforts to engage clinicians in primary care have not been wholly effective

The Health Board is committed to engaging clinicians and placing them at the centre of service redesign but efforts to engage clinicians in primary care have not been wholly effective

140. 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.

141. The Health Board has worked hard to ensure clinical engagement is effective. In 2010, senior managers and senior clinicians took part in a baseline assessment to assess the organisation's level of clinical engagement as a basis for planning future improvements. Although senior managers and senior clinicians had a shared understanding of what constituted good clinical engagement, the level of clinical engagement was perceived to be relatively low. A number of suggestions were made to improve clinical engagement, including increasing clinical input at the Board and ensuring clinicians could influence decision making.

142. Since the baseline assessment, membership of the Executive Board has expanded to include representatives from the medical staffing committees and roughly half of the Board members have a clinical background. The Health Board has also embarked on an organisational development (OD) programme to engage senior managers and clinicians, and a number of senior events have taken place. OD support is available for directorates to ensure that staff are engaged and committed to the direction of travel. The OD team is assessing training needs and training is available through the clinical leadership programme.

143. At the time of our fieldwork, clinicians told us that contact between themselves and senior and middle managers had increased as their involvement was sought in delivering strategic and financial savings plans. The need to involve clinicians in transforming services will only grow given the challenges faced by the Health Board. Under the direction of the Chief Executive, clinicians from all areas of the Health Board were invited to participate in the process of acute service reviews undertaken in autumn 2011. Although clinicians that we met told us they felt able to contribute to these reviews, a couple of service review meetings were postponed while clinical directors secured involvement from colleagues, suggesting that not all clinicians are engaged.

144. Senior management staff indicated that the Chief Executive is looking for commitment and not simply 'engagement' from all staff across the organisation. The process of the acute service reviews is said to have contributed to clinicians' understanding of the need for change and their role in the change. Clinicians told us that they felt engaged in their service reviews and development of plans to modernise services. However, both managers and clinicians raised concerns that difficult decisions about service transformation could be put off for political reasons leading to a slow pace of change and disillusionment. Transformation will only happen if the local community understands and supports the case for change. Difficult public meetings about the temporary closure of the Ysbyty Cwm Rhondda minor injury unit have highlighted to clinicians the challenges in 'selling' the need to change the way in which services are provided.

145. In late autumn 2011, the Health Board changed the organisational structure following the appointment of a Chief Operating Officer, who is tasked with driving improvements in service delivery. The divisional management tier, between the Board and the clinical directorates, was removed, bringing directorates closer to the executive team. The changes are intended to deliver improved performance with clinical directors directly accountable to the Chief Operating Officer on operational matters. Positive views were expressed during our interviews with clinicians about the efforts the Health Board was making to strengthen their involvement in their clinical leadership role.

146. The Health Board successfully re-invigorated the clinical director's forum in early 2011. Clinical directors, including the four locality clinical directors, meet monthly under the leadership of the Medical Director. One of its key aims is to enhance dialogue between clinical leaders and clinical staff to influence the Health Board's agenda. Clinicians told us that as attendance improved, so did the dialogue between primary and secondary care colleagues. The forum has been used to take forward CCM developments and to highlight key documents like *High Impact Changes for Community and Primary Care Services*.

147. 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. Locality-based structures should make it easier for primary care to take an active part in planning processes with locality clinical directors providing clinical leadership on the medical implications of service reconfiguration, clinical performance and conduct across clusters of practices. There are mixed views about the extent to which primary care practitioners are involved in the planning and redesign of services for chronic conditions and unscheduled care. Locality clinical directors were actively involved in the acute service reviews providing hospital colleagues with valuable insight into how and what services could be managed in primary care. However, the wider GP community was not directly involved in these acute service reviews. The Health Board recognises it needs to consider how best to inform GPs linked more generally to a desire for better communication between primary and secondary care.

148. Few practices responding to our survey were actively involved in the planning and redesign of services for chronic conditions and unscheduled care. Three of the nine practices responding agreed that they were actively involved in the planning and redesign of services for chronic conditions but only one practice agreed that it was actively involved in the planning and redesign of the unscheduled care system. Moreover, none felt adequately informed of the Health Board's plans for unscheduled care and only one practice felt that the Health Board provided sufficient support to become involved in the planning and redesign of unscheduled care.

The Health Board has developed strong relationships with its local authority partners, which is supporting service integration

149. 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.

150. Partnership working is seen by the Health Board as a major driver of change and essential to improve and sustain the quality and reach of its services. Local authority partners have expressed confidence in the Health Board's commitment to partnership working and service integration. There is regular dialogue at a senior management level and there have been moves to look afresh at the governance structures that support joint working in these areas. The directors of social services regularly attend either the executive team meeting or Board meetings and meet monthly with the executive lead for primary, community and mental health services.

151. We noted earlier the Health Board's commitment to working in partnership with local authorities, as well as joint working is respect of single points of access, the electronic service directory and the communications hub. A number of actions to support service integration have also been implemented and these include:

- Transferring the operational management of the Council's reablement teams to the Health Board's occupational therapy service.
- Merthyr Tydfil Council has moved to a locality model to build on the opportunities provided by the new Health Park.
- RCT Council is leading on work to establish an integrated locality-based team of health and social care professionals to integrate more fully the work already underway to meet the principles of *Setting the Direction.*
- Considered the feasibility of introducing a generic health and social care worker to support long-term independence and to this end, the Health Board and RCT local authority conducted an audit to look at whether there was duplication across a range of tasks undertaken for a group of patients who received visits from district nursing services and homecare services provided by the local authority. The audit did not identify any clear duplication for clients with chronic conditions. Instead, the scope for generic worker role is being considered as part

of the development of specific integrated teams such as the Virtual Ward and CIAS.

- Pooled resources with both local authorities to support the management and delivery of a joint equipment service, the Integrated Community Equipment Service.
- Worked jointly with both local authorities to address issues in relation to public transport to enable better access to services.

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 to Dec 10	Jan 11 to 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

Hours when a consultant in emergency medicine is available within major A&E 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	9am-5pm	9am-4pm
	Princess of Wales Hospital	9am-9pm	9am-9pm
Aneurin Bevan LHB	Nevill Hall Hospital	9am-11pm	Up to 6 hours
	Royal Gwent Hospital	8am-8pm	9am-4pm
Betsi Cadwaladr University LHB	Wrexham Maelor	8am-10pm	9am-midnight
	Ysbyty Glan Clwyd	9am-9pm	9am-5pm
	Ysbyty Gwynedd	9am-8pm	12pm-3pm*
Cwm Taf LHB	Prince Charles Hospital	9am-5pm	N/A
	Royal Glamorgan Hospital	9am-5pm	N/A
Hywel Dda LHB	Bronglais General Hospital	9am-5pm	On-call plus Hospital at Night team
	Glangwili General Hospital	9am-5pm 9am-7:30pm (Mon & Wed)	9am-3pm
	Withybush Hospital	9am-10pm	1pm-9pm

**Actual hours reported to be longer in practice*

N/A –Not available

Data for University Hospital of Wales are not available.

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

Appendix 3

Number of medical staff at major A&E departments

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

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

Change in the profile of pay bands of nursing staff deployed in A&E departments at Cwm Taf Health Board

Hospital	Pay bands	WTE number of nursing staff	
		At March 2008	At November 2011
Prince Charles Hospital	1 to 4	0	5.6
	5 to 9	34.6	35.9
Royal Glamorgan Hospital	1 to 4	0	7.91
	5 to 9	28.3	44.76
Total		**62.9**	**94.17**

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

Appendix 5

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

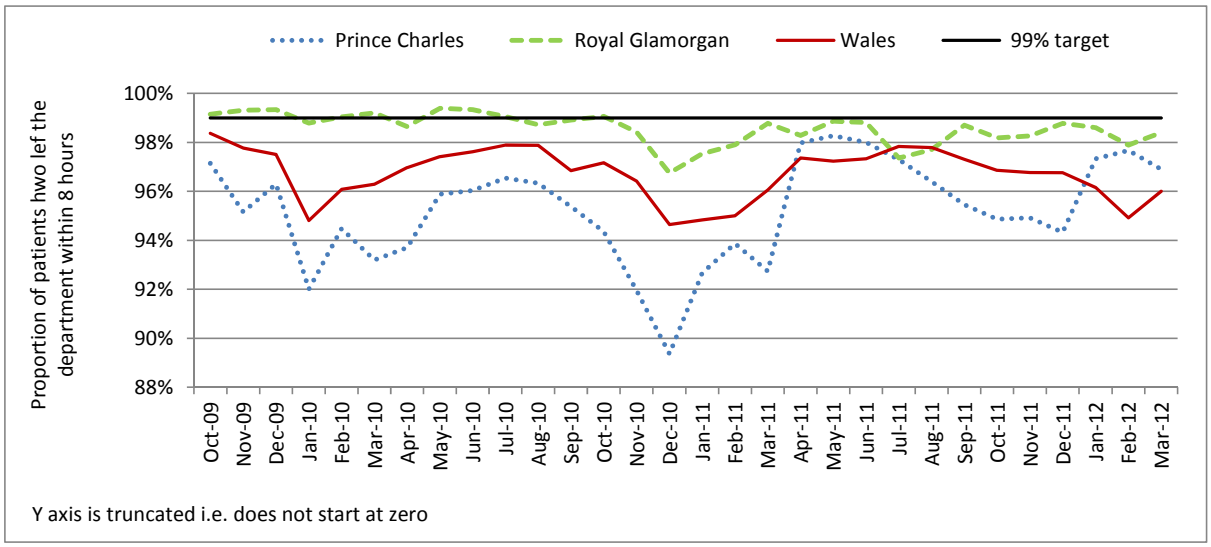
Hospital	WTE number of nursing staff				Vacancy rate (%)
	Bands 1 to 4		Bands 5 to 9		
	Filled posts	Vacant posts	Filled posts	Vacant posts	
Morriston Hospital	9.05	0	67.05	6	7
Princess of Wales Hospital	9.2	0	44.4	0	0
Nevill Hall Hospital	9.87	0.53	42.93	0.56	2
Royal Gwent Hospital	24.26	0.46	89.3	2.51	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 University Hospital of Wales are not available.

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

Appendix 6

Trend in performance against the eight-hour waiting time target, October 2009 to March 2012



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

Appendix 7

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
Ysbyty Glan 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 8

Change in the proportion of major A&E department attendances that arrived by ambulance in 2007-08 and 2010-11

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

N/A – Data not available

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

Appendix 9

Proportion of major A&E department attendances that arrived by ambulance in 2010-11 and were discharged without follow-up

Hospital	Percentage of patients arriving by ambulance and discharged without follow-up (%)
Prince Charles	48
Princess of Wales	45
Withybush	36
Glangwili	36
Bronglais	33
Royal Gwent	32
Nevill Hall	27
Ysbyty Glan Clwyd	27
Wrexham Maelor	26
Morriston	15
Ysbyty Gwynedd	6
Royal Glamorgan	N/A
University Hospital of Wales	N/A
Wales average	**29**

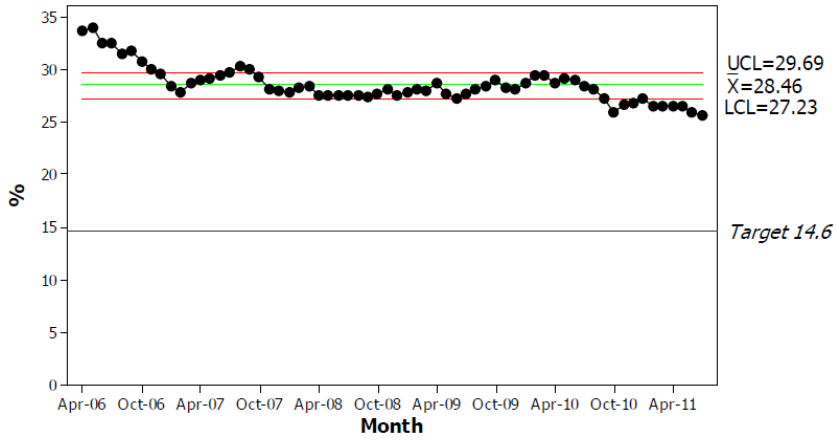
N/A – Data not available

Source: Wales Audit Office analysis of data collected from health boards in November 2011.

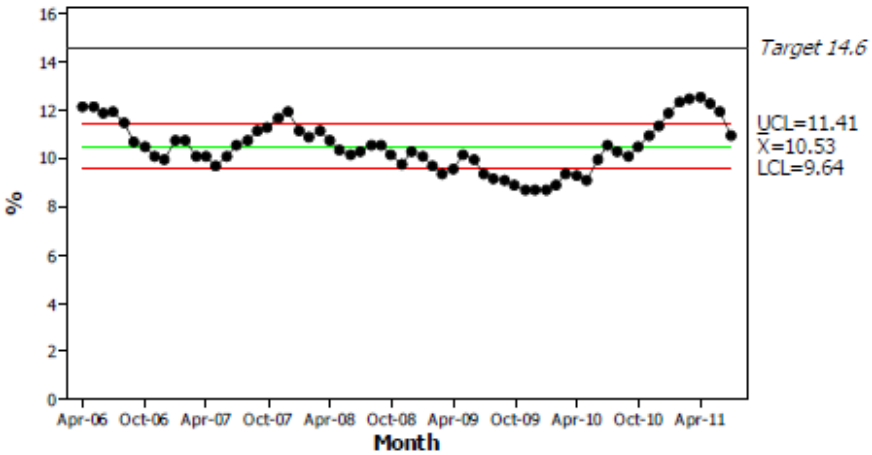
Appendix 10

Rolling 12-month multiple admission rates at Cwm Taf Health Board for COPD, CHD and diabetes

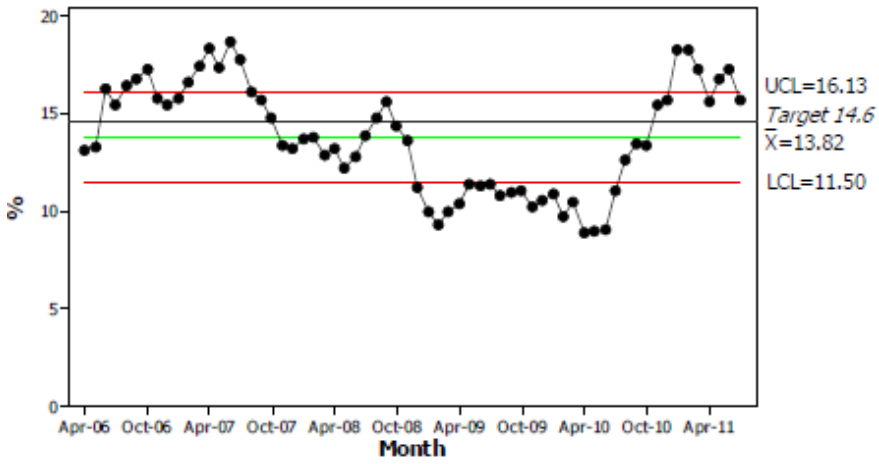
Rolling 12-month multiple admission rate for COPD emergency admissions



Rolling 12-month multiple admission rate for CHD emergency admissions



Rolling 12-month multiple admission rate for diabetes emergency admissions

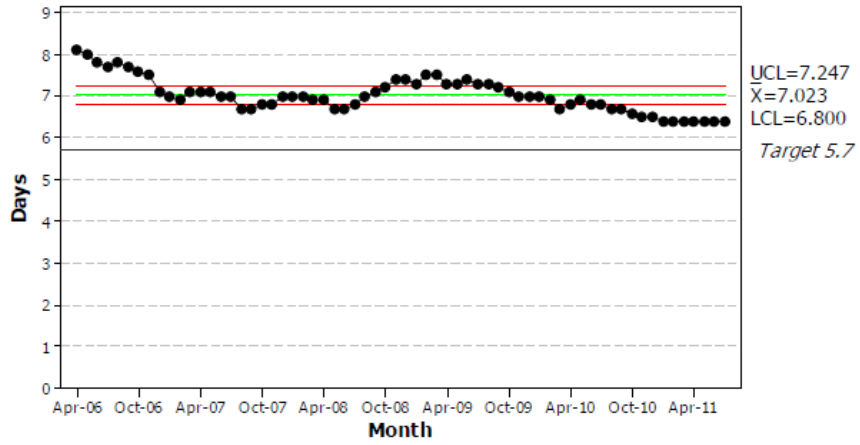


Source: NLIAH, Progress Report on the CCM Service Improvement Plan as measured through the CCM Maturity Matrix, Appendix 4, October 2011.

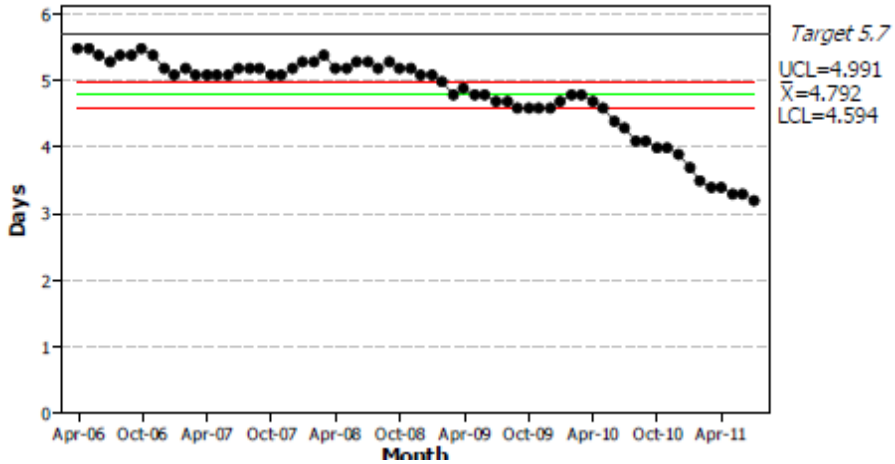
Appendix 11

Rolling 12-month average lengths of stay at Cwm Taf Health Board for COPD, CHD and diabetes

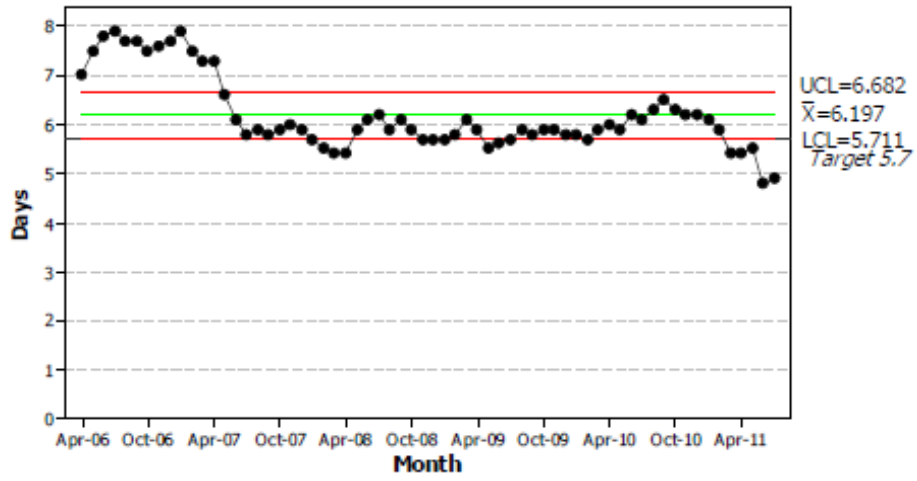
Rolling 12-month average length of stay for COPD emergency admissions



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



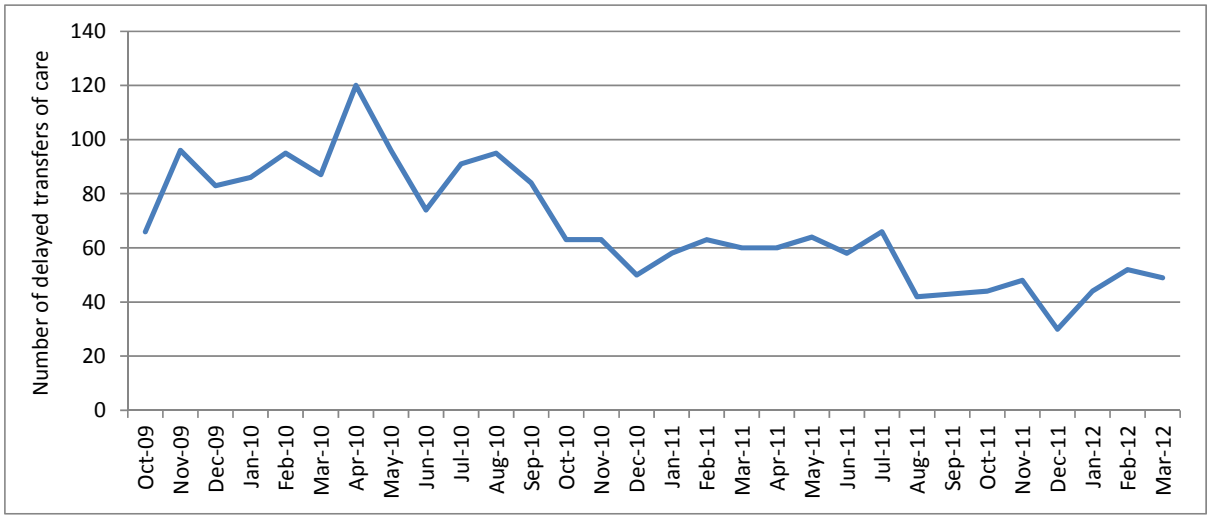
Rolling 12-month average length of stay for diabetes emergency admissions



Source: NLIAH, Progress Report on the CCM Service Improvement Plan as measured through the CCM Maturity Matrix, Appendix 4, October 2011.

Appendix 12

Trend in the number of delayed transfers of care from Cwm Taf's acute and community facilities*, October 2009 and March 2012



**These data exclude delayed transfers of care from mental health facilities.*

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

Appendix 13

Community services

Types of community services provided or commissioned by the Health Board at the end of November 2011 to support individuals with chronic conditions, as well as services to maintain independence and prevent unplanned admissions.

Types of community services	Provider
Patient education	
Education Programme for Patients	Health Board with volunteer tutors
DAFNE	Health Board
X-PERT	Health Board
Pulmonary Rehabilitation	Health Board
Cardiac Rehabilitation Service	Health Board with support from voluntary sector
Lifestyle	
Merthyr national exercise referral scheme	Local authority
RCT national exercise referral scheme, STEPS	Local authority
Community Pharmacy Stop Smoking Service	Community pharmacies
Maintaining independence	
Reablement services	Local authorities and Health Board
Telehealth monitoring	Local authority and Health Board
Homecare Medication Administration Scheme	Local authority
Age Concern primary care service	Voluntary sector
Community Resource Team	
Local enhanced service for care homes	Health Board
Non-cancer lymphoedema service	Health Board
Parkinson's disease clinical nurse specialist service	Health Board
Diabetes nurse facilitator service	Health Board
Tissue Viability Service	Health Board
Respiratory nurse facilitator service	Health Board

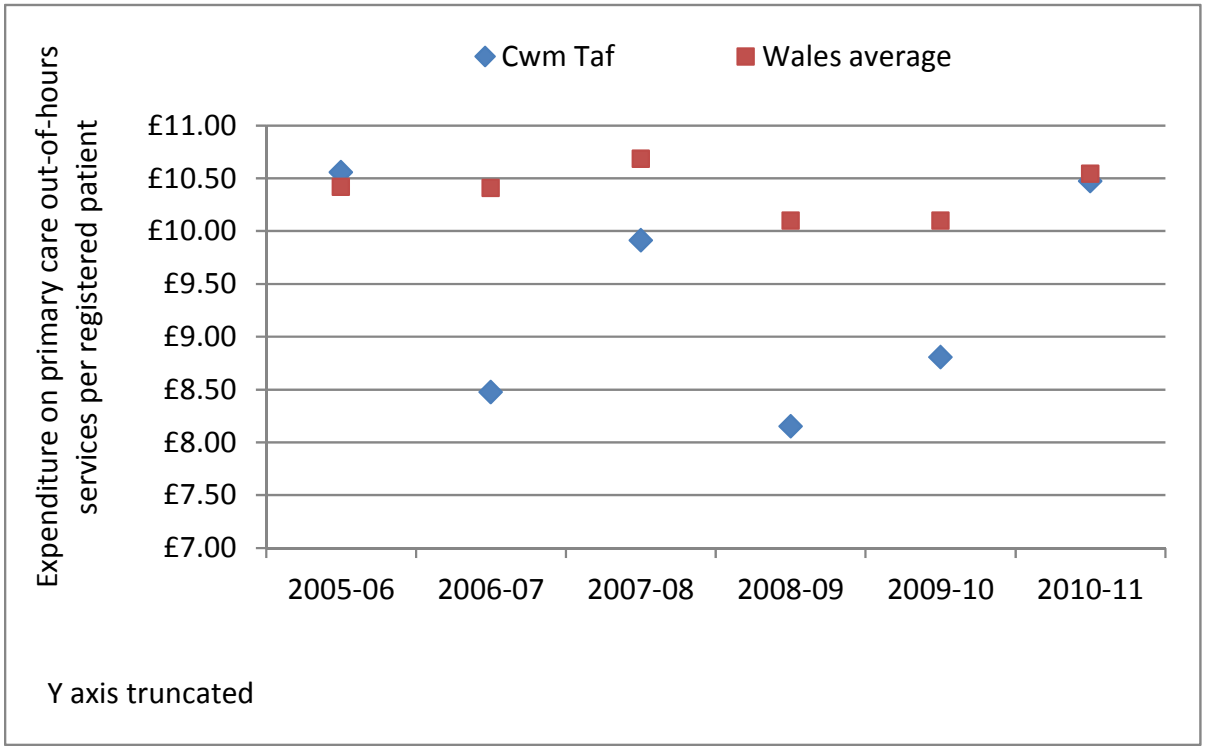
Types of community services	Provider
Preventing admission or facilitating/supporting hospital discharge	
Therapy Assessment Team	Health Board
Age Concern Morgannwg Hospital Discharge Service	Voluntary sector
Community Integrated Assessment Service (CIAS)	Health Board
Disease specific community services	
Community chronic non-malignant pain service	Health Board
Diabetes community team	Health Board
Heart failure nursing service	Health Board
Respiratory Specialist Nursing Service	Health Board
Stroke care nursing team	Voluntary sector
Stroke Day Service	Voluntary sector
Stroke 'Keep in Touch'	Voluntary sector
Stroke Association's Communication Support Service	Voluntary sector
Other community services	
District Nursing Service	Health Board
Home oxygen assessment service	Health Board

Source: Information provided by the Health Board.

Appendix 14

Expenditure on primary care out-of-hours services

Expenditure on primary care out-of-hours services per registered patient in the Health Board and the average for all health boards between 2005-06 and 2010-11



Source: Wales Audit Office analysis of audited accounts.

Appendix 15

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

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

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

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