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Unscheduled Care An Update on Progress



Unscheduled Care – An Update on Progress

I have prepared this report for presentation to the National Assembly under the Government of Wales Act 1998 and 2006.

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**Report presented by the Auditor General for Wales to the
National Assembly for Wales on 12 September 2013**



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Summary

- 1 Unscheduled care is a term used to describe any unplanned contact with the NHS or social care by a person requiring or seeking treatment or advice urgently or in an emergency situation. The term, however, is not consistently understood across public services and as a result, the Welsh Government is now moving away from using the term unscheduled care and is instead using the phrase ‘emergency and urgent care’.
- 2 Figure 1 shows some of the key services that provide unscheduled care. The large number of services shown in the diagram highlights how difficult it can be for people to choose a service when they need unscheduled care. The large number of organisations involved in providing these services, including health bodies, local authorities, the voluntary sector and others, highlights how complicated it can be to plan, coordinate and deliver changes to the system.
- 3 Wales has a population of around 3.1 million¹ and in 2011-12, we estimate that there were at least 8.8 million contacts with unscheduled care services². Many of these people went to unscheduled care services for help when they were at their most vulnerable and when they needed urgent assistance.
- 4 It is widely recognised that unscheduled care services are under considerable pressure and that wholesale change is necessary. In 2008, the Welsh Government’s strategy for unscheduled care, *Delivering Emergency Care Services*,³ stated that unscheduled care services were facing ever-increasing demand and there was public confusion about which services were available. *Delivering Emergency Care Services* also said that the strategy provided a real opportunity for Wales to have a service that was the envy of many developed countries.
- 5 The Wales Audit Office has previously published a large body of work on unscheduled care, culminating in the December 2009 report, *Unscheduled care: developing a whole systems approach*^{4,5,6}. The report highlighted a range of problems resulting in the system of unscheduled care operating in a disjointed way for people who need help. The report concluded that against the backdrop of the severe pressures on public funding, radically new ways of delivering unscheduled care needed to be introduced.

1 Office for National Statistics, *2011 Census: Key Statistics for Unitary Authorities in Wales*, 11 December 2012

2 The full calculation can be found at Appendix 2.

3 Welsh Government, *Delivering Emergency Care Services*, February 2008

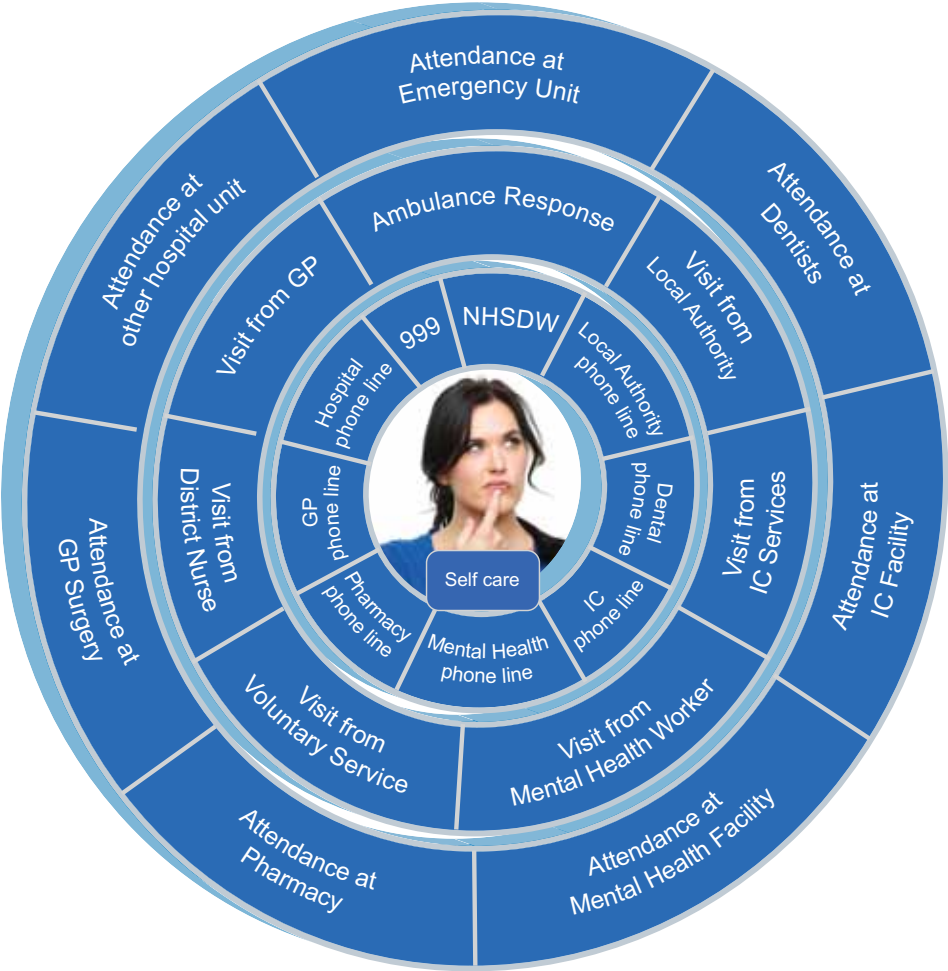
4 Wales Audit Office, *Unscheduled care: developing a whole systems approach*, December 2009

5 Wales Audit Office, *NHS Direct Wales*, September 2009

6 Wales Audit Office, *Unscheduled Care: Patient handovers at hospital emergency departments*, April 2009



Figure 1 - Unscheduled care is a broad term and includes the work of many services and organisations



Note
In the figure above 'IC' is short for intermediate care.

Source: Wales Audit Office

6 In June 2011, the National Unscheduled Care Programme Board produced a document entitled *Ten High Impact Steps to Transform Unscheduled Care (USC)*⁷. That document described 10 steps (as shown in **Figure 2**) that the programme board, in consultation with clinicians across Wales, considered to be essential for improving the system of unscheduled care.

7 *Ten High Impact Steps to Transform Unscheduled Care (USC)* argues there is a need to rebalance the system of care away from acute hospital settings towards community and primary care provision. This echoes the messages given in previous analyses of the healthcare sector in Wales by Sir Derek Wanless⁸ and Dr Chris Jones⁹.

Such a change would reduce demand on acute hospitals but importantly, it would benefit patients. Currently, too many patients have their scheduled or unscheduled care in hospital when care in the community would be more appropriate.

8 In the three years since the publication of our work on unscheduled care, NHS Wales has been attempting to improve unscheduled care services within a particularly challenging environment. **Figure 3** summarises the key challenges and constraints that are impacting upon NHS Wales as it attempts to drive improvement in the unscheduled care system.

Figure 2 - The 10 high impact steps to transform unscheduled care

- 1 Agree a shared vision for unscheduled care services
- 2 Define how improvement is to be measured across the whole system
- 3 Improve telephony and care coordination
- 4 Improve urgent primary care access
- 5 Expand and integrate out of hours services
- 6 Get the right message out to service users/health and social care workers
- 7 Target frequent user groups
- 8 Improve the flow through the emergency department
- 9 Improve discharge planning
- 10 Target the most important pathways

Source: *Ten High Impact Steps to Transform Unscheduled Care (USC)*, Unscheduled Care Programme Board

7 National Unscheduled Care Board, *Ten High Impact Steps to Transform Unscheduled Care (USC)*, June 2011

8 Sir Derek Wanless, *Review of Health and Social Care Services in Wales*, 2003

9 Welsh Government, *Setting the Direction: Primary and Community Services Strategic Delivery Programme*, February 2010



Figure 3 - There is a range of key challenges and constraints that are impacting on efforts within Wales to drive improvements to the unscheduled care system



Unprecedented financial pressures

Our July 2013 report, Health Finances 2012-13 and beyond, said that NHS Wales has faced tougher financial settlements than its counterparts in other parts of the UK.

The report also said that NHS Wales is facing a growing challenge to deliver cost reductions without impacting on patient experiences, safety and quality. These challenges have complicated efforts to improve unscheduled care services. Despite the financial pressures, NHS Wales must continue to pursue large-scale transformational change in unscheduled care in order to achieve sustainable services for the future.



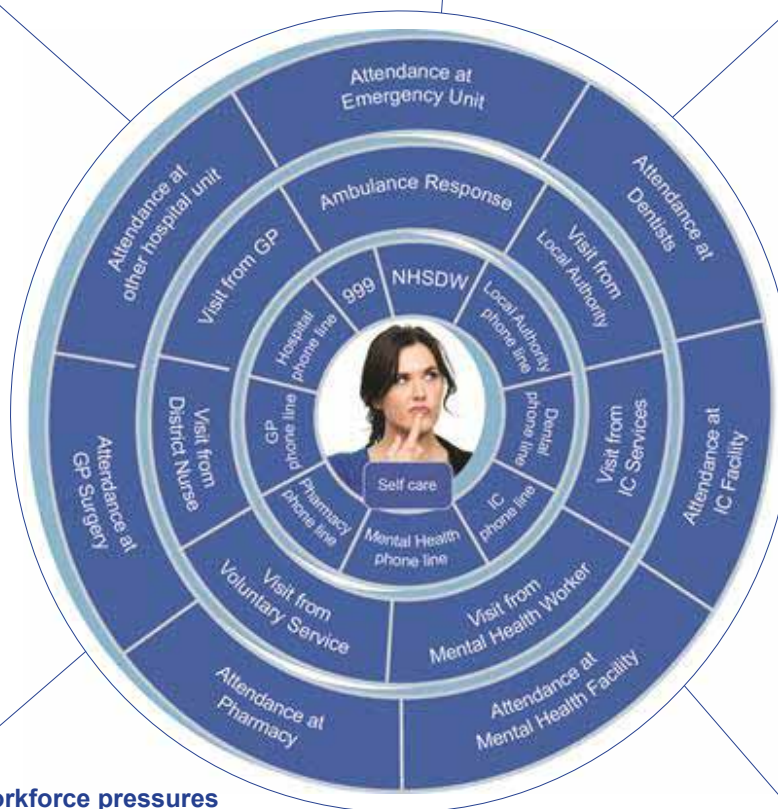
Wales is not alone

Many of the problems facing the unscheduled care system are not unique to Wales. Services in England, Scotland and Northern Ireland all appear to be facing challenges.



Demand is rising

Demand for unscheduled care appears to be increasing whilst the number of hospital beds has been reducing. The rate at which local authorities support older people in the community has also reduced. The reasons for rising demand are complicated but one factor is the ageing population and the increase in the number of frail, older people attending emergency departments. Such patients generally have more acute needs, which are more complicated to manage. This can affect patient flow. There has also been a general increase in the number of people using unscheduled care services, and an increase in the prevalence of chronic conditions.



Workforce pressures



Unscheduled care staff are working particularly hard to deal with workload pressures. This presents challenges around sustaining morale, staff engagement and support for change. There are also difficulties in recruiting and retaining staff to work within pressurised unscheduled care services.



Complex change takes time

In 2009 we identified many complex issues with the system of unscheduled care. We recognise that these issues are difficult to resolve and that complex changes take time to deliver. We also recognise that at the same time as trying to deliver complex changes to the system, NHS Wales is trying to address immediate operational issues.

Source: Wales Audit Office

- 9** Figure 3 mentions the issue of demand associated with the prevalence of chronic conditions. The areas of chronic conditions management and unscheduled care are crucially interrelated. People with chronic conditions tend to be frequent users of the unscheduled care system because when their conditions exacerbate, they often need to access services in an urgent and unplanned way. During 2011 and 2012 we carried out audit work at all health boards in Wales that took a broad look at efforts to improve chronic conditions management as well as unscheduled care. We have drawn heavily on those findings in producing this national report. The Auditor General plans to publish a separate national report later in 2013 that will summarise the key messages in relation to the management of chronic conditions in Wales.
- 10** This report aims to track progress made by public services in Wales to address the main issues we raised in December 2009. We also aim to highlight the key remaining challenges and opportunities for improvement.
- 11** Our review examined whether there has been progress in transforming unscheduled care services to address the issues previously identified in Wales Audit Office publications.
- 12** We have concluded that deteriorating performance since 2009 has prompted considerable focus on unscheduled care that is now securing early signs of improved performance. However, the transformational changes that are required for sustained improvement have not been fully implemented. Many factors, including rising demand, financial constraints, workforce challenges and problems with patient flow through the hospital, are continuing to place considerable pressure on unscheduled care services.
- 13** We came to this conclusion because:
- a** with rising demand some services are under severe pressure and performance against a number of key measures has deteriorated since 2009 although there have been signs of improvement in recent months;
 - b** whilst NHS Wales has made some progress on managing demand the work that is being done is not keeping pace with the increased pressures being placed on unscheduled care services and major challenges remain in relation to workforce, patient flow and ambulance services; and
 - c** national and local NHS leaders are clearly committed to improving unscheduled care but real transformation will require greater focus on the whole system, better care coordination, change in primary care and a sustainable configuration of hospital services.



With rising demand some services are under severe pressure and performance against a number of key measures has deteriorated since 2009 although there have been signs of improvement in recent months

Patients continue to face delays at various points in the unscheduled care system and waiting times are generally worse than in 2009 although there were improvements in spring 2013

- 14** The most basic requirement for an unscheduled care system is that it should provide care quickly to people with urgent or emergency needs. Our most recent work found that delays remain frequent at various times during a patient's episode of care and patients are now more likely to experience long delays that are clearly detrimental to the quality and experience of care.
- 15** Where primary care is easily accessible and effective in dealing with people's needs, this can have wide-ranging benefits for patients and for the system. A national survey¹⁰ shows that 69 per cent of people who had made an appointment with their General Practitioner (GP) in the past 12 months said it was easy to get an appointment at a convenient time. Whilst the majority of people said they were able to get a convenient appointment, a significant minority said they were not. Our analysis further suggests there are parts of Wales where people can face problems and delays in accessing urgent primary care.
- 16** With rising demand on the ambulance service, there have been ongoing difficulties in meeting key performance targets. Data showing responses to Category A calls and cardiac arrests, and for providing timely back-up responses to rapid response vehicles, show that too many patients face delays in receiving a response from the ambulance service.
- 17** Our report in April 2009¹¹ highlighted problems involving delayed handovers of patients between ambulance staff and hospital staff at emergency departments. These delays have a negative impact on patient experience and dignity as patients often await care in hospital corridors or in the back of an ambulance. They also have potential patient safety implications because patients can be delayed in getting the definitive assessment and care they require. Delayed handovers also impact on the ambulance service's ability to respond to fresh calls as crews are detained at emergency departments. The proportion of handovers completed within 15 minutes has decreased since 2009, although the position improved in spring 2013. A greater proportion of patients also now face long delays in handovers.
- 18** Four-hour waiting time performance at Welsh emergency departments remains below the national target although there have been month-on-month improvements in performance between February and June 2013. Eight-hour waiting time performance has deteriorated since 2009 although again there has been marked improvement in recent months. Despite this, some patients still experience waits in excess of 12 hours in emergency departments. The majority of people experiencing these long delays are older people which is concerning given the vulnerability of this patient group and potential complications that can arise as a result of long waits in an inappropriate care setting.

¹⁰ Welsh Government, *National Survey for Wales*, SDR 163/2012, 27 September 2012. The survey asked how easy or difficult it was for people to make a convenient appointment with a GP. It found that 67 per cent of people who had seen their GP in the past year, and made an appointment for themselves, said it was easy.

¹¹ Wales Audit Office, *Unscheduled Care – Patient handovers at hospital emergency departments*, April 2009

NHS Wales has processes in place to monitor risk levels but it does not yet collect sufficient information to know whether patient outcomes and experiences are improving

- 19** In 2009 we concluded that the way in which NHS Wales measured its performance in unscheduled care did not focus sufficiently on the quality of care or the outcomes people have from their treatment. Our follow-up work indicates that problems remain with the way in which performance is measured and monitored and that there is scope to improve the information systems that support the monitoring of unscheduled care services. One problem is that there is not enough measurement and focus on some vital parts of the system, such as services based in primary and community care and elements of patient flow in the acute hospital.
- 20** There have been actions taken to introduce measures of quality and outcome but some data sets are poorly completed and in common with the rest of the United Kingdom, there is a need to improve outcome measurement in unscheduled care. It is a positive step that NHS Wales is now monitoring mortality for certain unscheduled care conditions¹² and that data on hospital mortality is being made publically available. However, delays in clinical coding mean the data underpinning the mortality indicators have limitations. Whilst the monitoring of stroke services appears to be an example of good progress, there are limitations in the monitoring of outcomes from trauma and in the care provided by the ambulance service.
- 21** Whilst there are limitations in the data on unscheduled care outcomes, there are quality assurance and risk management processes that aim to ensure unscheduled care services are safe and of high quality. Arrangements include day-to-day monitoring of safety levels

and workload pressures through the use of live data and telephone conferences between the Welsh Government and the wider NHS Wales at periods of escalation. There is also central reporting and monitoring of quality information including serious incidents. Work is ongoing within NHS Wales to further strengthen the assurance on the quality and safety of unscheduled care services.

- 22** There is not yet a systematic approach to monitoring patient experience and the measurements which are undertaken are not frequent enough and tend to focus on people's experiences of individual aspects of the services rather than their experience of unscheduled care as a whole. In May 2013, the Welsh Government published a national framework for patient experience and a set of common questions for all health boards to use when monitoring patient experience. As unscheduled care is currently such a high-risk area, we would expect health boards and the ambulance trust to implement the framework rapidly and ensure patient experience in unscheduled care services is measured as a priority.

There remain gaps in the understanding of demand for unscheduled care but it is clear that some services are struggling to maintain quality and safety due to increased workload

- 23** In 2009 we stated that 'a fundamental weakness in the current system of unscheduled care is that there is no coherent understanding of demand'. The recent pressures being experienced within unscheduled care services have prompted specific analyses by the Welsh Government and NHS bodies aimed at explaining the reasons for increased demand on services. These analyses are important and they represent a step forward. However, gaps remain in the understanding of demand,

¹² Stroke, heart attack and hip fracture-major trauma.



particularly in routine analysis of demand carried out at a local level. There is only limited understanding of the actual needs and clinical conditions of people using the system and there is little joined-up information about how people move through the system from one service to another.

- 24** Our interviews with staff, together with the data that do exist, suggest that some unscheduled care services are now under greater pressure than in 2009. More people are using primary care out-of-hours services, emergency ambulance services and NHS Direct Wales. Whilst there is a long-term trend showing an increase in the number of people attending major emergency departments, this number decreased slightly in 2012-13. It is difficult to be certain about the causes of the decrease in emergency department attendances but the reduction in attendances is a positive development. Despite the decrease in 2012-13, our fieldwork suggests these departments are under high pressure and this pressure is affecting staff morale. A specific issue for health boards is the increase in the number of older patients attending emergency departments. Many of these patients are frail and have complex health needs which typically results in a hospital admission.
- 25** There is concern amongst some staff and stakeholders that because of the increased pressures in emergency departments some ways of working that can compromise the quality and safety of care are becoming the norm rather than the exception. Examples of these practices include the nursing of patients in corridors, overnight stays in the emergency department and long delays to patient handovers from the ambulance service to emergency department staff.

Whilst NHS Wales has made some progress on managing demand the work that is being done is not keeping pace with the increased pressures being placed on unscheduled care services and major challenges remain in relation to workforce, patient flow and ambulance services

Actions taken to manage demand for unscheduled care have not had sufficient impact

- 26** In 2009 we said that people can be uncertain of how and where to seek help. This can result in people using certain services when there may be better services available to address their needs. Despite there being only limited data on demand, we have been able to show that that some demand continues to be in the wrong place within the system. In other words, some people are not getting to the most appropriate service for their needs. The causes of misplaced demand are complex but, as currently configured, the system often pushes people towards the wrong service. This is often a fault of the system and not a fault of the patient.
- 27** NHS Direct Wales has a potentially important role to play in helping people access the right care they need. NHS Direct Wales is now succeeding in drawing a greater number of calls from the public. However, the service is experiencing a number of strategic and operational problems including high levels of staff sickness, poor performance in answering calls from the public and ongoing uncertainty about its future role in NHS Wales.

- 28** In February 2011, the Welsh Government launched a national campaign called *Choose Well*. The campaign aims to persuade the public to think carefully before going to the emergency department or dialling 999. There are some good aspects to the campaign and there is potential for the campaign to have benefits in future. However, the campaign has so far had minimal impact in helping people access the right service and does not fully comply with good practice principles for social marketing.
- 29** One of the main challenges we identified in 2009 was that there were not enough appropriate and effective community-based services to meet demand and act as genuine alternatives to acute care. Our new work recognises that implementing these complicated changes to service models takes time but despite some improvement, the pace of change needs to be accelerated and there has not yet been the necessary step change in drawing activity away from more traditional unscheduled care services.
- 30** We recommended in 2009 that health boards should improve and simplify the points of access to unscheduled care. Whilst work has begun to design single points of access, such as communications hubs and the 111 call service, this work remains in a relatively early stage and the target date for completing 111 implementation is in 2015. The public continues to face a complex and confusing range of options about where to go for help when they have an unscheduled care need or query.

Challenging workforce issues are potentially compromising the safety and sustainability of unscheduled care services

- 31** The staff that provide unscheduled care are a key strength in the system but the NHS in Wales has found it difficult to address a range of workforce issues. Emergency departments and primary care out-of-hours services are struggling to recruit and retain medical staff, partly because of the high workload pressures. These issues affect services across the United Kingdom but there are specific problems in Wales such as a perceived higher workload in Welsh emergency departments than in the rest of the United Kingdom and concerns about low levels of training and supervision of emergency department doctors¹³.
- 32** In addition, there has not been enough progress in developing staff with extended, specialist skills for unscheduled care. Such staff can work autonomously and take definitive decisions to address people's care needs quickly and efficiently. There is a need to make further progress in relation to extended nursing roles and in up-skilling ambulance staff so that they are more able to assess and refer patients rather than just transport them to hospital.

Despite a great deal of focus from health boards, problems with patient 'flow' through the hospital are continuing to place pressure on emergency departments

- 33** A major cause of pressure in the emergency department is slow flow of patients through the acute hospital and NHS bodies have been attempting to improve flow during a period of long-term reduction in bed numbers across the NHS. Emergency department patients continue to suffer delays in receiving reviews from the inpatient specialist teams and delays in being admitted to ward beds.

¹³ Welsh Institute for Health and Social Care, *The Best Configuration of Hospital Services in Wales, Summary, April 2012*



34 Efficient and effective discharge continues to be a problem with limited success in ensuring discharge is planned well in advance and that ward rounds happen earlier in the day or at weekends. Many patients who are ready to be discharged are staying in hospital beds because of issues around funding and assessments for the social care they need, or because spaces are not available in the care home facility of their choice. Health and social care agencies need to work together to resolve these difficulties. We found some positive examples of such joint working but these were patchy. The significant financial pressures across the public sector mean there are risks that health and local government bodies will draw away from one another, rather than integrate their approaches further. The forthcoming Social Services and Well-being (Wales) Bill represents a key opportunity to ensure much better, integrated care for citizens.

The Welsh Ambulance Services NHS Trust continues to face difficulties that impact on the whole system of unscheduled care but some of the key difficulties cannot be addressed by the trust in isolation

35 Ambulance services form a fundamental part of the unscheduled care system. Timely ambulance responses save lives but the ambulance service also plays a key role in managing demand because it is often the first port of call for people seeking help. Ambulance performance remains problematic and despite some positive steps that attempt to ensure patients receive the most appropriate ambulance response for their needs, there remains considerable scope for the ambulance service to avoid transporting patients to hospital unnecessarily. This could be achieved by the ambulance service

up-skilling its staff and further developing pathways and protocols that allow patients to be treated at the scene or taken to services other than emergency departments.

36 Difficulties experienced within the ambulance service can have negative impacts on the wider unscheduled care system. Equally problems elsewhere in the system can have major impacts on the ambulance service and its ability to provide timely responses to emergencies. Many of the solutions to the problems with ambulance services cannot therefore be addressed by the Welsh Ambulance Services NHS Trust in isolation.

37 In November 2012 the Minister for Health and Social Services announced plans for a strategic review of the ambulance service. The review's report was published in April 2013¹⁴ and proposed a number of options for strengthening the provision of ambulance services in Wales. The Minister provided his first response to the review in May 2013 and said a further update would be provided in July 2013. Our current report does not provide a detailed review of the Welsh Ambulance Services NHS Trust but our work has highlighted a range of issues pertinent to improvement in unscheduled care. We found that broader and sustained improvement in the ambulance service is threatened by remaining financial issues, difficulties matching supply and demand, high sickness levels, issues with morale and the need to strengthen partnership working between the ambulance service and health boards.

¹⁴ Professor Siobhan McClelland, *A Strategic Review of Welsh Ambulance Services*, April 2013

National and local NHS leaders are clearly committed to improving unscheduled care but real transformation will require greater focus on the whole system, better care coordination, change in primary care and a sustainable configuration of hospital services

- 38** We have identified some important opportunities that the Welsh public sector must now grasp. The Welsh Government has committed to launch a 111 phone number for urgent, non-emergency care in Wales. This call service has the potential to produce a step change improvement in the understanding and management of demand. However, if implemented poorly, the service could add to public confusion and cause further problems with demand management. The Welsh Government has pragmatically delayed the implementation of 111 to ensure lessons are learnt from pilots in England. There remains disquiet in some quarters about the introduction of 111 and the emerging evidence from England has identified a number of risks that would need to be managed.
- 39** General practitioners are already playing a vitally important role in delivering unscheduled care and therefore, optimising the capacity for unscheduled care that already exists in GP services could have major benefits for patients and for those delivering services. We recognise that GPs are independent contractors and as such, there can be complications when the health boards and the Welsh Government want to change the way GPs work. However, our report suggests there is scope to implement common-
- sense solutions as well as more innovative approaches to deliver better access to urgent primary care.
- 40** Plans to reconfigure acute hospital services are controversial and at the time of drafting our report, health and social care communities were making difficult choices about the future pattern of services in their area. However, there are strong arguments in favour of change and if the right choices are made, this represents a rare opportunity to ensure the safety and sustainability of services.
- 41** The national arrangements for driving change in unscheduled care, including the national board, have until now had only a limited impact. Despite heavy scrutiny of health boards from the Welsh Government, there has not been the necessary scale of transformation in unscheduled care services. At the time of drafting our report, the local and national focus on unscheduled care has increased significantly and much work is now ongoing to understand and ease the problems in the system. A new approach from the Welsh Government aims to give health boards greater flexibility and autonomy to decide the improvement actions they wish to take, in return for greater local accountability for delivering improvements. The Welsh Government has also now developed a new work programme for unscheduled care with an emerging set of objectives for improvement. The renewed focus on unscheduled care is positive and whilst the new programme arrangements are yet to be tested, they have potential to drive improvement in the way that previous arrangements did not. This is because the new programme would appear to have additional resources available to it, will provide a higher-profile platform for driving change and will be supported by a more comprehensive structure of groups and boards.



Recommendations

Addressing the current safety issues within hospital emergency departments

- 1 There is a risk that increased workload pressures on emergency departments are resulting in ways of working that may compromise the quality and safety of care for patients. Pressures on the unscheduled care system are resulting in practices such as treating patients in corridors, patients spending entire nights on emergency department trolleys, and long delays in handover between ambulance staff and emergency department staff becoming increasingly frequent:
 - a To supplement existing quality assurance and risk management practices, health board medical directors and directors of nursing should carry out joint, urgent reviews to make sure they fully understand the safety implications for patients in their emergency departments. The reviews should identify the extent of safety issues, and produce specific action plans that seek to reinforce what is acceptable and what is not acceptable practice.

Driving delivery of the unscheduled care vision

- 2 Despite much effort from NHS bodies and heavy scrutiny from the Welsh Government, there has not been the necessary scale of transformation in unscheduled care services and health boards have differed in the extent to which they have used *Ten High Impact Steps to Transform Unscheduled Care (USC)*. At the time of drafting, health boards were preparing new unscheduled care plans for submission to the Welsh Government:

- a health boards' progress in delivering their unscheduled care plans should be reported robustly and regularly to their board meetings, to the Welsh Government and within the new national programme; and
- b those charged with developing the new unscheduled care programme should ensure the programme specifically addresses the issues presented in this report and in the *Ten High Impact Steps to Transform Unscheduled Care (USC)*.

Improving understanding of demand, performance, patient experience and outcomes

- 3 Gaps remain in the understanding of demand and continued problems with performance monitoring mean that NHS Wales does not have enough of the right information to know whether patient outcomes and experiences are improving:
 - a As a matter of urgency, health boards and the ambulance service should implement the new national framework for patient experience and ensure that they are routinely asking patients about their experiences of unscheduled care, across the whole system and not just in the emergency department.
 - b Unscheduled care indicators used by each health board and reported to their Board members should include a much wider suite of measures that cover, as a minimum, patient experience and outcomes, primary care access, performance of out-of-hours primary care, ambulance service and local NHS Direct Wales performance, 4-hour and 12-hour waiting time performance in emergency departments, instances of corridor nursing and overnight stays in

the emergency department, performance of community-based unscheduled care services and measures related to patient flow, including responsiveness of inpatient specialist teams in responding to referrals and requests to review patients from the emergency department.

- c** The Welsh Government should work with health boards to ensure the national Emergency Department Data Set (EDDS) is completed consistently and comparably across all units and that the data are used effectively to understand demand.
- d** In line with new standards issued by the Welsh Government, health boards should make it a priority to significantly improve their clinical coding performance.
- e** Public Health Wales should build on its recent analysis of unscheduled care demand by providing health boards and the ambulance trust with support to strengthen local demand analysis. This support should aim to strengthen local organisations' abilities to predict and pre-empt peaks in demand, across all unscheduled care services and not just the emergency department.

Communicating with the public and improving understanding of the need for change

- 4** The system of unscheduled care remains confusing for the public and there is continued evidence of patients accessing the 'wrong' service for their needs. With new reconfiguration plans being consulted upon, and the 111 call service due to be launched, it is essential that NHS Wales improves the way it communicates with the public to reduce confusion and to secure greater recognition of the significant problems in the current system:

- a** If the Welsh Government decides to continue with the *Choose Well* campaign, it should:
 - Ensure the campaign complies with the National Social Marketing Centre's good practice principles. In particular, the campaign should set clear, measurable targets and should be robustly evaluated.
 - Consider whether *Choose Well* would benefit from using the *MindSpace*¹⁵ methodology to optimise the approach of changing public behaviours.
- b** The Welsh Government should take the following actions in relation to the 111 service:
 - as part of the decision-making process about the future of the 111 call service, come to a clear decision about the strategic direction of NHS Direct Wales;
 - develop a model for 111 that avoids all of the issues experienced in the English 111 service pilots;
 - produce a detailed timeline setting out clear milestones that must be achieved before the final implementation of 111 in 2015;
 - ensure that the 111 service has supporting electronic systems to gather information on call casemix and volume to help contribute to a better understanding of unscheduled care demand and patients' urgent care needs; and
 - use the public communication campaign that will be needed to launch the new 111 service as an opportunity to communicate clearly and widely to

¹⁵ *MindSpace* is a checklist developed by the United Kingdom Government's Cabinet Office that aims to provide low-cost ways of changing people's behaviours, www.instituteforgovernment.org.uk/publications/mindspace



the public about how best to access unscheduled care services.

- c** The Welsh Government should use the opportunity of the hospital network reconfiguration to develop national definitions of unscheduled care services and facilities, to improve public understanding of what these services provide.

Addressing critical issues with unscheduled care skills and workforce

- 5** More progress needs to be made in ensuring the system contains sufficient staff with extended clinical decision-making skills so that patients can receive decisions much earlier in their episode of care:

- a** The Welsh Government should facilitate a Wales-wide exercise to share good practice, from Wales and further afield, in the use of Emergency Nurse Practitioners (ENPs).
- b** Health boards should monitor their use of ENPs to ensure they are not routinely drawn into core nursing roles and they should ensure that ENP roles are fully considered in their workforce plans for unscheduled care.
- c** The Welsh Ambulance Services NHS Trust should, as a matter of urgency, deliver transformation in the skill base of its staff so they have significantly stronger skills in assessing and referring patients.
- d** The Welsh Government should work with representative bodies and its counterparts across the United Kingdom to identify and address the root causes of recruitment and retention problems in the emergency department and primary care out-of-hours services.

- e** Based on local circumstances, health boards should consider revising their staffing models for unscheduled care services to include paramedics and nurses with extended decision-making skills. Health boards should also consider whether physicians and GPs can be used effectively in emergency departments to ease the recruitment and retention problems relating to middle-grade and consultant emergency medicine staff.

- f** Given the increase in emergency department attendances from older patients, health boards should reassess the skill base of their staff for meeting the needs of older people.

- g** Health boards should assess the levels and causes of stress within emergency department staff, with a view to protecting and supporting the workforce.

Optimising the capacity for unscheduled care that exists within general practice

- 6** A range of actions can be undertaken to optimise unscheduled care capacity in GP services. In particular, health boards should:

- a** Work with GPs to agree local standards for access to urgent primary care; and once agreed the extent to which these standards are achieved should be routinely monitored.
- b** Strongly encourage general practices to implement access arrangements that reflect good practice. In doing so, health boards should highlight the benefits that these good practices can bring to patients as well as to those working in general practice.

- c** Strengthen the support, guidance and information they give to GPs in order to avoid inappropriate emergency admissions.
- d** Request that GPs provide them with data on their capacity and demand for seeing patients within the practice. Health boards should work with primary care providers to ensure these data are analysed and used to improve services.

Unblocking problems with flow in the acute hospital and improving integrated working between health and social care

- 7** Problems with patient flow continue to be a major problem for emergency departments and throughout the acute hospital. To address these issues, much better joint working is required between the emergency department and the rest of the hospital, as well as between health bodies and social services:
 - a** Health boards should facilitate improved teamwork and mutual support between key staff groups involved in unscheduled care. This work should focus, in particular, on generating more shared ownership of the pressures and patient flow issues that exist in emergency departments by improving the links between staff in emergency departments, Clinical Decision Units (CDUs) and inpatient ward teams.
 - b** The Welsh Government's Department of Health and Social Services should lead a specific programme of work to support better integration of health and social care with the aim of ensuring the timely discharge of patients that are ready to be discharged from hospital. This programme should use the forthcoming Social Services and Well-being (Wales) Bill as a key driver for change but it should not wait for the bill to be enacted.



Part 1 - With rising demand some services are under severe pressure and performance against a number of key measures has deteriorated since 2009 although there have been signs of improvement in recent months

- 1.1** Part 1 of this report considers the levels of demand experienced by unscheduled care services and examines progress since 2009 in improving performance, patient outcomes and experience.

Patients continue to face delays at various points in the unscheduled care system and waiting times are generally worse than in 2009 although there were improvements in spring 2013

A significant minority of people face delays in accessing urgent care from their GP and problems are worse for adults of working age

- 1.2** Getting access to primary care right is a major enabler of an effective unscheduled care system. Where primary care is easily accessible and effective in dealing with people's needs, this can have wide-ranging benefits for patients. In such cases, people receive the care they need close to their homes and this also prevents people using other, sometimes more pressurised, unscheduled care services.
- 1.3** The most recent all-Wales data¹⁶ on patient satisfaction with access to primary care shows that 69 per cent of people who had made an appointment for themselves and seen their GP in the last year said that it was easy to

get an appointment at a time convenient to them. Whilst the majority of people said they were able to get a convenient appointment, a significant minority (31 per cent) said they were not. Adults of working age (aged 16 to 64) were more likely to find it difficult to get an appointment at a convenient time compared with those aged 65 and over.

- 1.4** Previous all-Wales data¹⁷ on patient satisfaction with urgent access to primary care is not directly comparable to that discussed above but showed that 84 per cent of people who tried to access such care were able to do so the same day or the next day. This compares with 83 per cent at the time of our 2009 report. When these data are analysed further, they reveal low performance levels at some practices and highlight particular scope for improvement in some health boards. For example, Aneurin Bevan Health Board had the lowest performance in Wales at 76 per cent and within that health board approximately a fifth of practices scored less than 70 per cent.
- 1.5** We have not been able to find any standard or comprehensive data in Wales regarding access to out-of-hours primary care. However, our fieldwork has revealed the following issues regarding access to primary care out of normal working hours:
- a** In our survey of health boards, there was clear disagreement with the statement that 'it is difficult for members of the public to access primary care services out of normal

¹⁶ Welsh Government, *National Survey for Wales*, SDR 163/2012, 27 September 2012. The survey asked how easy or difficult it was for people to make a convenient appointment with a GP. It found that 67 per cent of people who had seen their GP in the past year, and made an appointment for themselves, said it was easy.

¹⁷ Statistics for Wales, *Welsh GP Patient Survey*, SDR 103/2011, June 2011

working hours'¹⁸. Health boards' responses tended to suggest that access to primary care in normal working hours was more problematic than access during the out-of-hours period.

- b** The Primary Care Out-of-Hours Review carried out by the national Out-of-Hours Subgroup highlighted variations in access to out-of-hours services across Wales, and commented that Saturday mornings and bank holidays are challenging.¹⁹
- c** Our survey of GP practices showed some positive views on the effectiveness of out-of-hours services. In response to the question 'how good is your local primary care out-of-hours service in meeting the needs of patients out of hours?' 76 per cent of responders said 'very good' or 'good', 22 per cent responded 'neither poor nor good', and two per cent responded 'poor' or 'very poor'.

With rising demand on the ambulance service there have been ongoing difficulties in meeting key performance targets

- 1.6** Quick ambulance responses to 999 calls are vital for a functioning unscheduled care system. The vast majority of patients calling 999 are experiencing a genuine emergency and if ambulances are delayed in responding, lives can be lost unnecessarily.
- 1.7** **Figure 4** shows that since 2006-07 there has been a general, positive trend in the most-used measure of ambulance performance, the percentage of emergency calls (Category A) responded to within eight minutes. However, performance has deteriorated in 2012-13 and has fallen below the 65 per cent target.

Whilst performance, in percentage terms, has deteriorated between 2011-12 and 2012-13 the actual number of people who received a response within eight minutes increased from 97,924 to 101,258. This shows that the ambulance service has been able to respond, to an extent, to rising demand. These issues are discussed further at **paragraph 1.44** and in **Part 2** of this report.

- 1.8** Benchmarking ambulance service performance in different countries is complicated because of different performance measurement arrangements, funding arrangements and models of services. A basic comparison shows that the percentage of emergency calls (Category A) responded to within eight minutes in 2012-13 in Wales was 61.4 per cent whilst in England, the average performance was 75.5 per cent²⁰.
- 1.9** Whilst the eight-minute target has tended to be the most prominent ambulance performance indicator in Wales, the strategic review of ambulance services in Wales noted in April 2013 that it is a 'very limited way of judging and incentivising the performance of ambulance services'²¹. The bullet points below show that ambulance performance in Wales has remained below expected levels in a range of other measures:
 - a** If a rapid response vehicle is dispatched to an incident and requests back-up from a fully-equipped ambulance, the ambulance service has set a target that the back-up response should arrive within 19 minutes in 95 per cent of cases. Performance deteriorated between December 2011 and November 2012 and performance has remained consistently below the 95 per cent target.

¹⁸ All health boards disagreed or strongly disagreed with the statement, except in Hywel Dda Health Board where a particular issue was highlighted in the Carmarthenshire area. Cardiff and Vale Health Board did not submit a response to the survey.

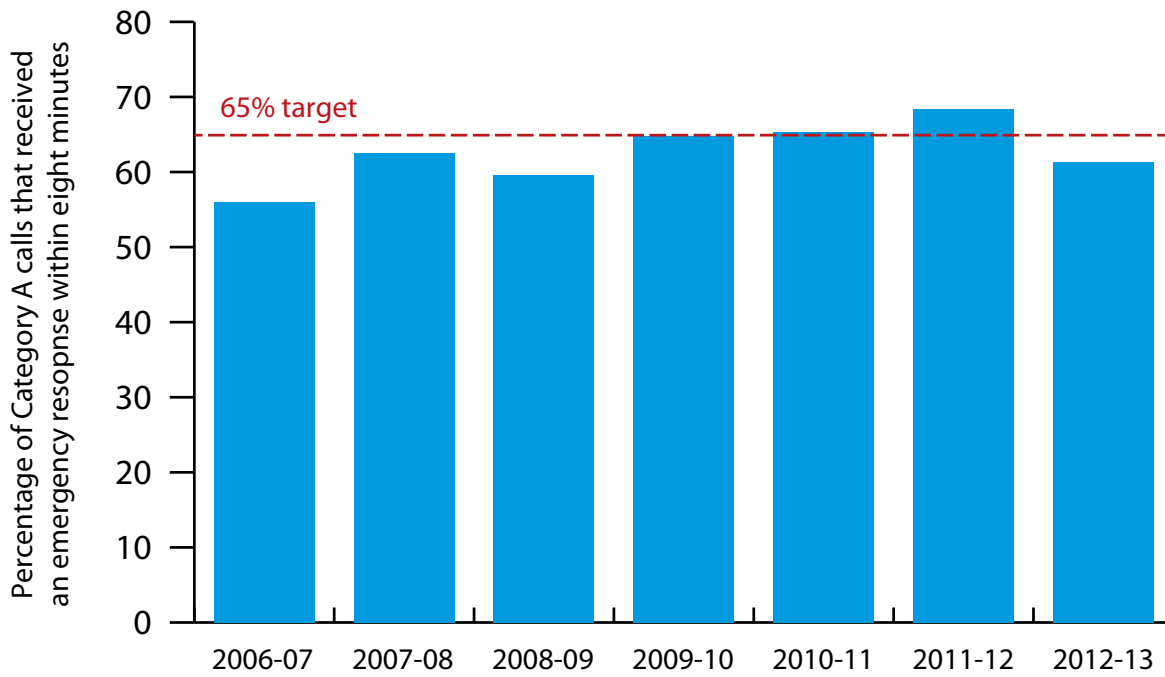
¹⁹ *Out-of-Hours Review: Interim Report for Out-of-Hours Sub Group*, Dr Chris Jones, April 2012

²⁰ The data for England were sourced from NHS England and consider the total number of Red 1 and Red 2 calls responded to within eight minutes.

²¹ Professor Siobhan McClelland, *A Strategic Review of Welsh Ambulance Services*, April 2013



Figure 4 - Emergency response times have improved in the long term but deteriorated in 2012-13



Note

Recording of ambulance response time performance changed in December 2011. A full explanation of the changes can be found at the following link: www.statswales1.wales.gov.uk/TableViewer/document.aspx?ReportId=37356

Source: Stats Wales

- b** For calls classified²² as Green 1 and 2, the ambulance service must ensure that a paramedic arrives at the scene within 30 minutes in 95 per cent of cases. Between April 2012 and February 2013 performance was typically around 80 per cent.
- c** Calls classified as Green 3 do not always receive a mobile response and instead, the call is transferred to NHS Direct Wales for clinical telephone assessment. The ambulance service has set a target that the patient should receive this assessment within 10 minutes in 90 per cent of cases. Performance deteriorated from a high of 93.3 per cent in August 2011 to 86.5 per cent in November 2012. The 90 per cent target has not been met since March 2012.
- d** Urgent calls from GPs are the most common call received by the ambulance service in Wales. In such calls, the ambulance service uses a protocol known as Card 35 which aims to ensure calls from GPs are treated with an appropriate degree of urgency. The ambulance call taker runs through a set of questions with the GP and together they decide upon an appropriate response time. The target is to comply with this agreed response time in 95 per cent of cases. Between December 2011 and February 2013, the ambulance service's best monthly performance was 69.7 per cent.
- e** The trust has set itself a target of reaching 52 per cent of cardiac arrest patients²³ with a defibrillator response within four minutes. Between 2008-09 and 2011-12 the trust has never met this target and the best annual performance was 35.6 per cent in

2011-12. In November 2012 performance deteriorated to 25.8 per cent. There are no outcome data available in Wales to show whether the patients that do not receive a defibrillator response within four minutes suffer negative outcomes as a result. This lack of outcomes data is discussed further at paragraphs 1.20 to 1.34.

Delays for patients being handed over from an ambulance to the emergency department have increased since 2009 but eased slightly in spring 2013

- 1.10** Our report in April 2009²⁴ showed that ambulance patients were too often experiencing a delay in being handed over to the care of hospital staff at emergency departments. These delays have a negative impact on patient experience and dignity as patients often await care in hospital corridors or in the back of an ambulance. They also have potential patient safety implications because patients can be delayed in getting the definitive assessment and care they require²⁵. Delayed handovers also have a significant impact on the ambulance service's ability to respond to fresh calls as many vehicles and crews are left waiting outside emergency departments unable to handover their patients.
- 1.11** The Welsh Government target is that all patients should be handed over from the ambulance service to the care of emergency department staff within 15 minutes of arrival at the department. **Figure 5** shows that since April 2009 there has been a decrease in the proportion of handovers completed within 15 minutes, although performance improved during spring 2013.

²² Full details on the classification of ambulance calls can be found in Part 2 of this report.

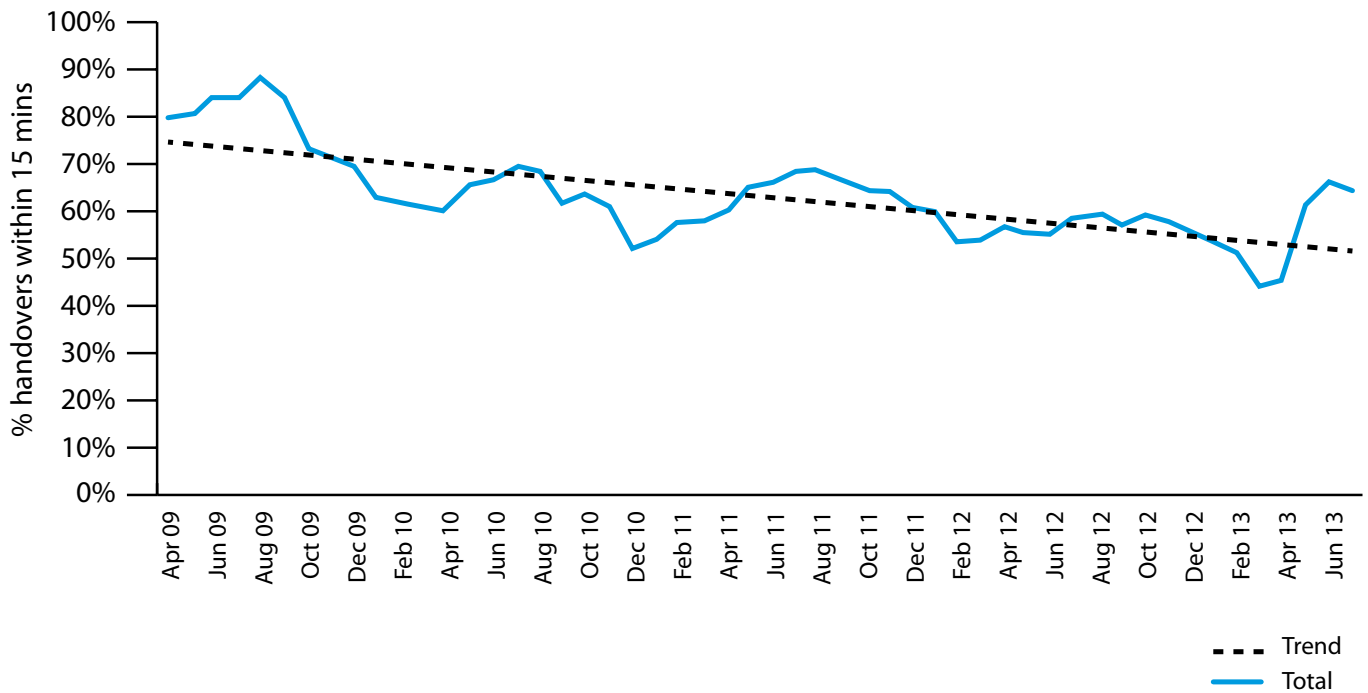
²³ These data consider incidents where the initial 999 calls gives ground to suspect the patient has suffered cardiac arrest. In some of these cases it will be discovered, upon arrival of the ambulance crew, that the patient did not suffer cardiac arrest.

²⁴ Wales Audit Office, *Unscheduled Care – Patient handovers at hospital emergency departments*, April 2009

²⁵ The NHS Confederation's report *Zero Tolerance: Making ambulance handover delays a thing of the past*, December 2012, draws attention to the clinical risks of delayed patient handovers and calls for a zero-tolerance approach to eliminate such delays.



Figure 5 - Since April 2009 there has been deterioration in the proportion of patient handovers completed within 15 minutes although there were improvements in spring 2013

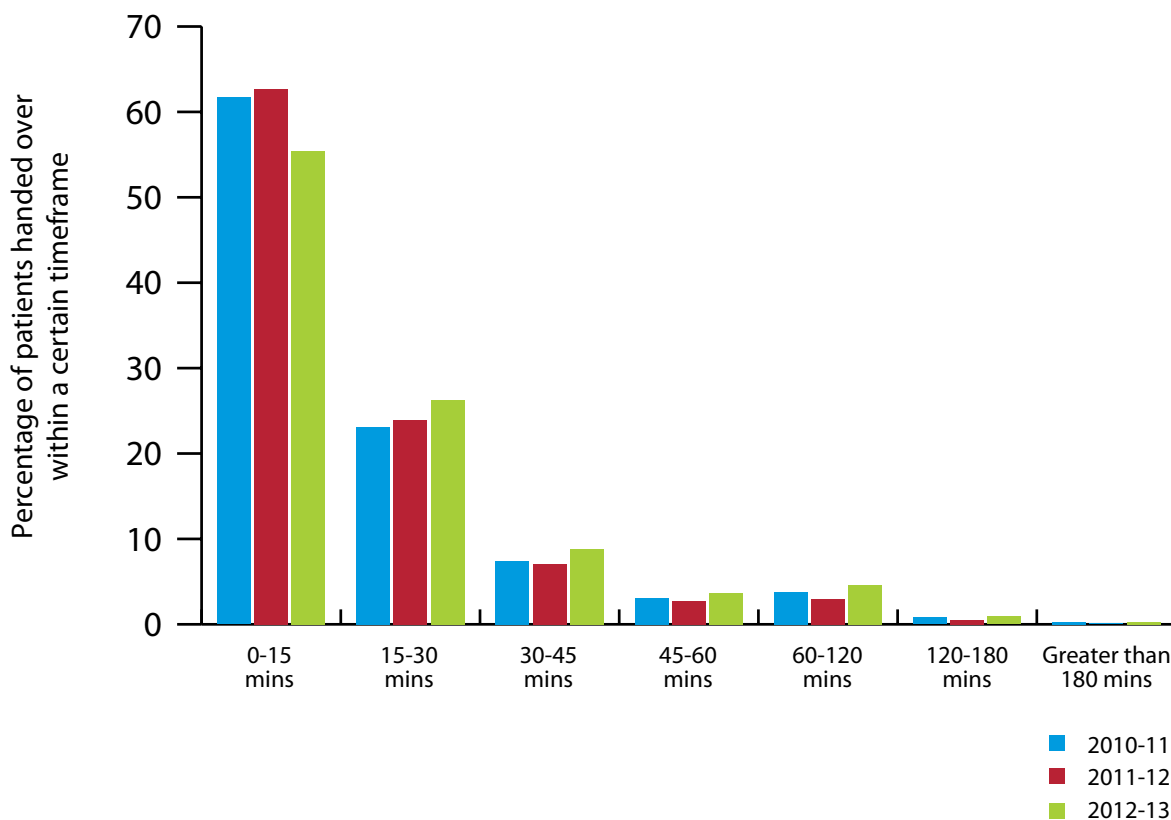


Source: Wales Audit Office analysis of data from the Welsh Government

1.12 A report²⁶ from the NHS Confederation in England in December 2012 recommended that handover delays of over an hour should be considered unacceptable. Figure 6 shows that between 2010-11 and 2012-13, there has been a small increase in the proportion of handovers taking longer than an hour at Welsh emergency departments.

²⁶ NHS Confederation, *Zero Tolerance: Making ambulance handover delays a thing of the past*, 6 December 2012

Figure 6 - Fewer handovers are completed within 15 minutes and the proportion of handovers taking an hour or more has increased



Source: Wales Audit Office analysis of data from the Welsh Government

In general patients are waiting longer in emergency departments with too many people spending in excess of 12 hours in these departments although there have been recent improvements

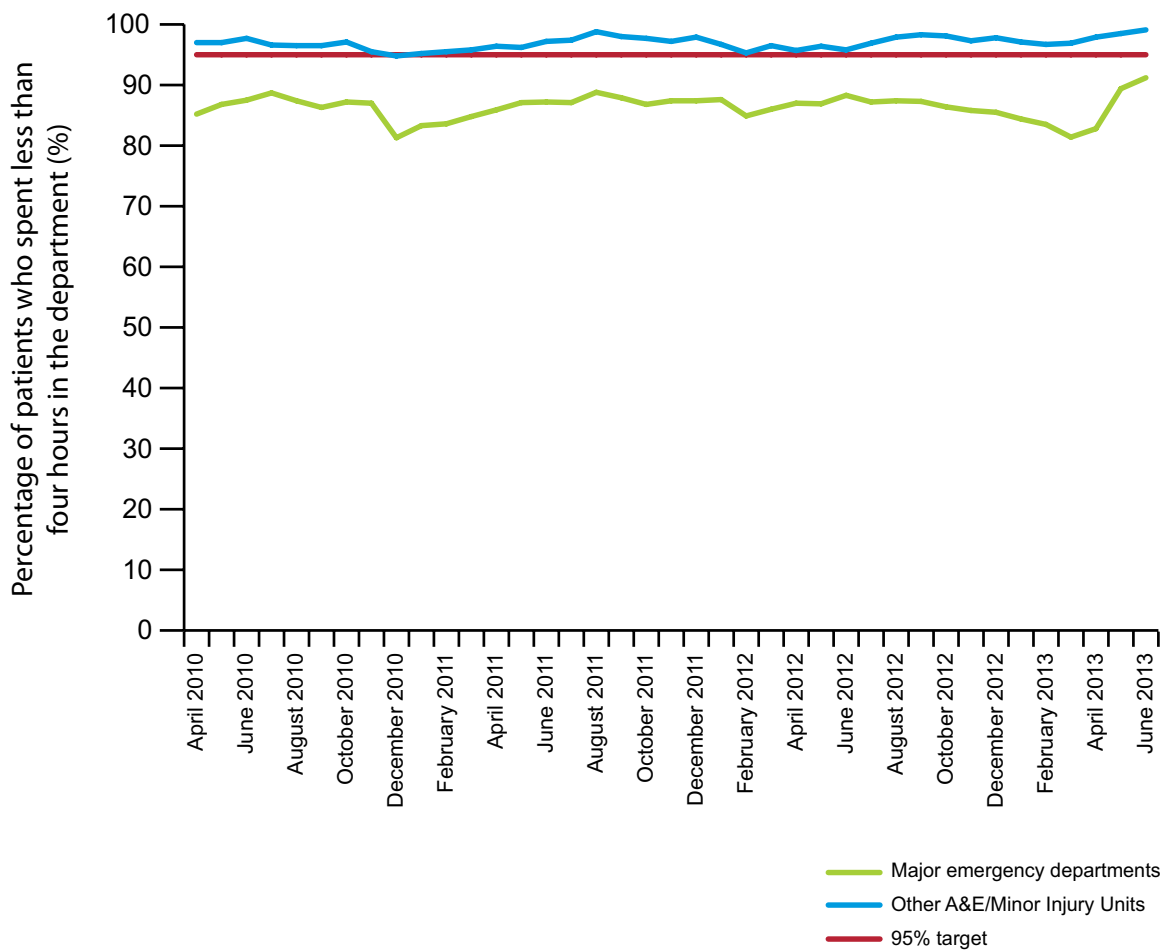
1.13 The four-hour waiting time target at emergency departments aims to ensure that patients are cared for quickly²⁷. Figure 7 shows that four-hour waiting time performance has been changeable since 2010. Average

performance against the four-hour target in major emergency departments has remained consistently below the 95 per cent target and deteriorated between summer 2012 and the early part of 2013. However, there have been month-on-month improvements in this performance measure between February 2013 and June 2013.

²⁷ The target states that 95 per cent of all new patients in emergency departments should spend no longer than four hours from arrival until admission, transfer or discharge.



Figure 7 - Four-hour waiting time performance in major emergency departments remains below target although there were signs of improvement in spring 2013



Source: Welsh Government

- 1.14** Comparisons between different countries can be complicated by differences in data definitions and recording processes but the data suggest Welsh emergency department waiting time performance is worse than in England but better than Northern Ireland. In major emergency departments during 2012-13, the Welsh performance against the four-hour target was 86.0 per cent, in England it was 93.8 per cent and in Northern Ireland it was 78.5 per cent. Comparisons to Scotland have not been made due to differences in the way that the four-hour waits are recorded²⁸.
- 1.15** One of the dangers of focusing on the four-hour target is that the total time waited by people who breach the target can be ignored. For example, a health body could ensure 95 per cent of its patients wait less than four hours but the other five per cent of patients could experience severe delays in their care. For this reason we analysed the average waiting time of patients in emergency departments. Where data were available, between 2007-08 and 2010-11, Wrexham Maelor Hospital was the only emergency department where the average waiting time did not increase. There was a similar pattern between 2011-12 and 2012-13 where the University Hospital of Wales and Ysbyty Gwynedd were the only units where the average waiting time did not increase²⁹.
- 1.16** Figure 8 shows performance relating to the target that 99 per cent of patients should wait no longer than eight hours in the emergency department.³⁰ The figure shows that performance in major emergency departments has seen long-term deterioration since 2006 although there was a marked improvement in spring 2013.
- 1.17** There are potentially serious implications for patients who experience long waits in emergency departments. Older people in particular are at higher risk of complications including pressure sores and dehydration. Upon releasing central funding for unscheduled care in July 2012, the Welsh Government stated its expectation that 12-hour waits would be eradicated. The data suggest that between 2011 and early 2013 there was a fairly consistent increase in the number of patients who spent more than 12 hours in major emergency departments. Figure 9 shows this trend and also highlights a marked improvement during spring 2013.
- 1.18** Figure 10 shows that the majority of patients that experienced long delays in emergency departments between January and June 2013 were older people. The figure shows a particular issue with people over 75 experiencing these long delays. These findings are not unexpected because of the demographics of the patients attending emergency departments, and because older people are more likely to have complex conditions and comorbidities that take longer to assess and treat within the emergency department. The figure also shows that older people attending emergency departments are more likely to require admission to a ward bed and once admitted they are more likely to have longer lengths of stay. Twelve-hour waits are unacceptable for patients of all ages but there are specific risks for older patients. Older people are also more susceptible to the hazards of hospitalisation, including falls, infections, impaired nutrition, hydration and general deterioration in physical condition^{31, 32, 33}. Long delays in emergency departments

28 Emergency department waiting times in Scotland measured up to the decision to admit a patient, whereas the period between decision to admit and admission is included for the other three nations.

29 Data between 2007-08 and 2010-11 were taken from Wales Audit Office data requests to health boards. The more recent data were provided by the Welsh Government.

30 Ninety-nine per cent of new patients should spend no longer than eight hours in all emergency care facilities, from arrival until admission, transfer or discharge.

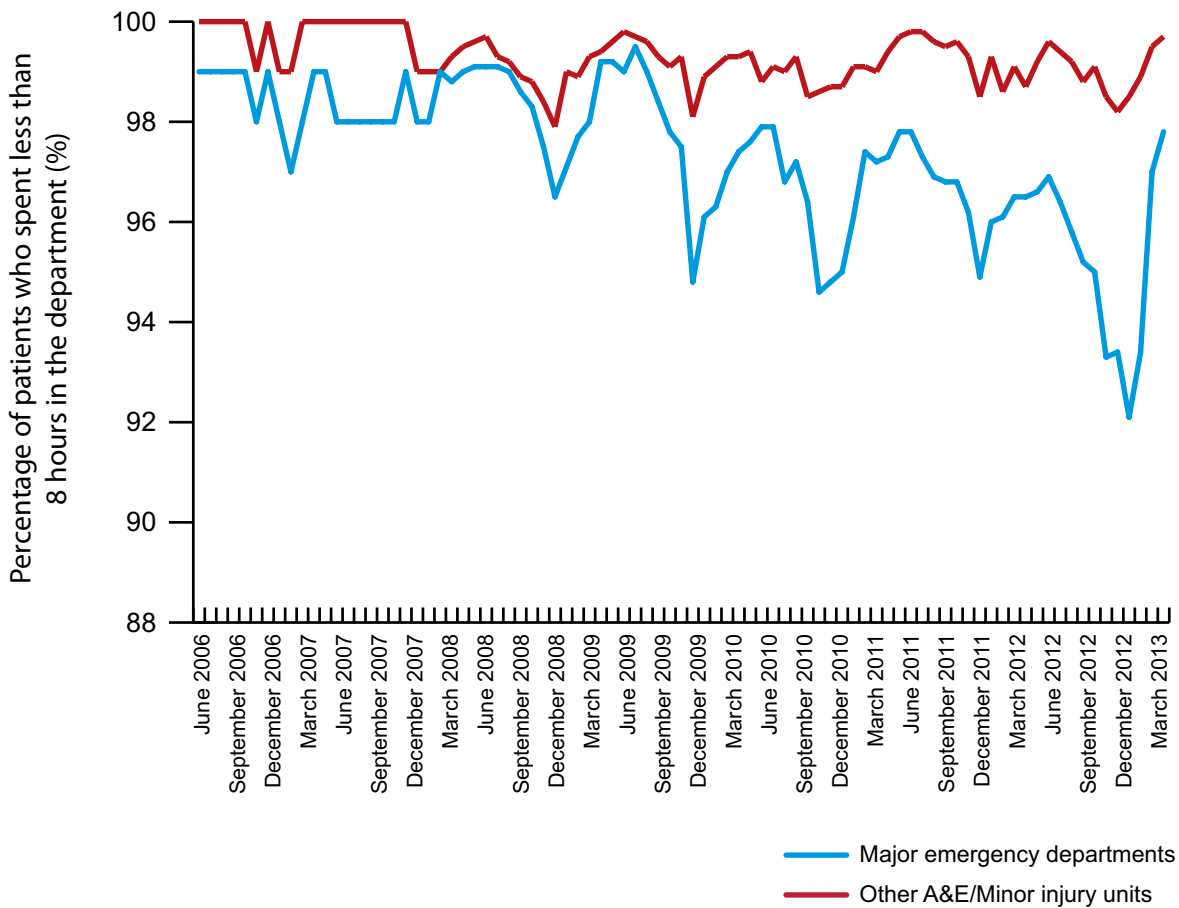
31 Welsh Government, *National Service Framework for Older People in Wales*, 2006

32 Department of Health, *Avoiding and diverting admissions to hospital – a good practice guide*, January 2004

33 *Oxford Handbook of Geriatric Medicine*, Oxford University Press, 2012



Figure 8 - Eight-hour waiting time performance has deteriorated in the long term but there has been recent improvement

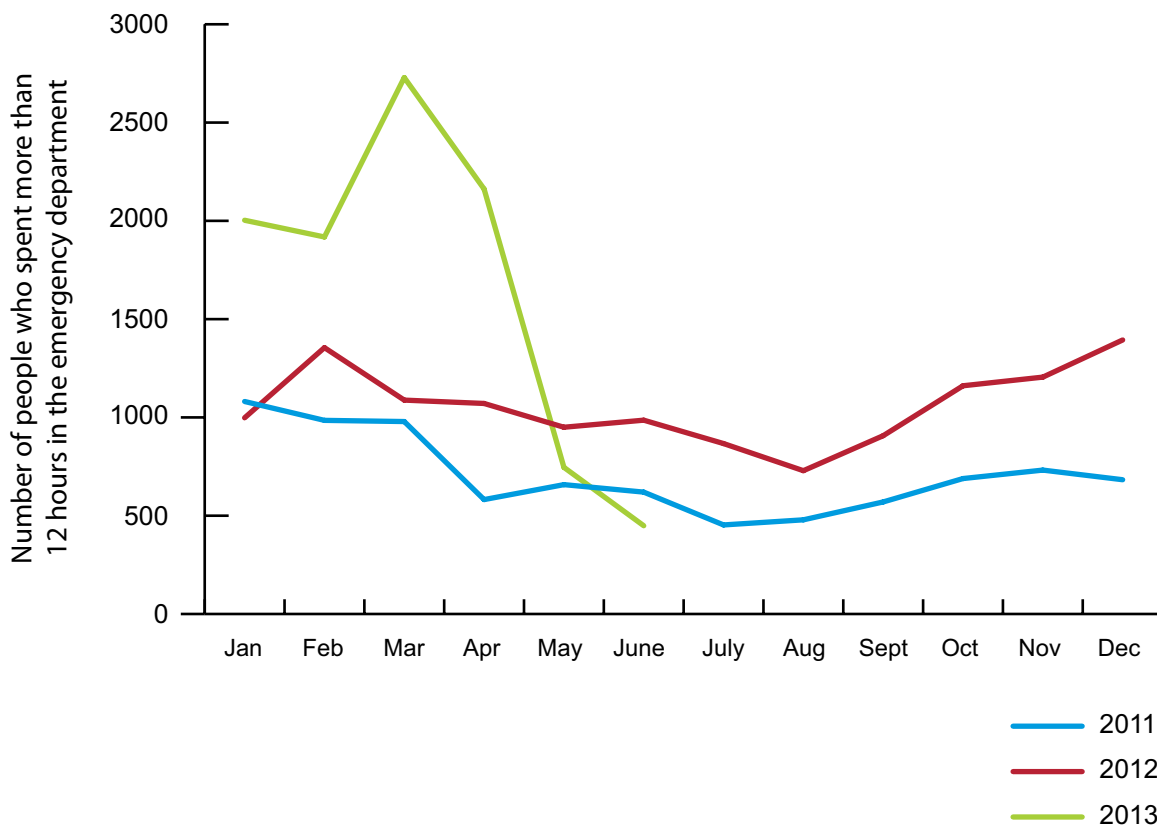


Note
For presentational purposes we have chosen not to begin the Y axis at zero.
Source: Welsh Government

can pose particular risks to older people who may find the environment cold, uncomfortable, disorientating, and lacking in privacy and dignity. Older people are at particular risk of developing pressure sores during delays in emergency departments because of the long time spent on trolleys.

1.19 Data from EDDS shows that between January 2012 and October 2012, an average of four patients per day waited more than 24 hours in major emergency departments in Wales. The equivalent figure between January 2011 and October 2011 was three patients per day. Waits of 24 hours or more were most frequent in the University Hospital of Wales, Prince Charles Hospital, the Royal Glamorgan Hospital and the Royal Gwent Hospital.

Figure 9 - The number of patients spending more than 12 hours in emergency departments increased between 2011 and early 2013 but there have been recent improvements

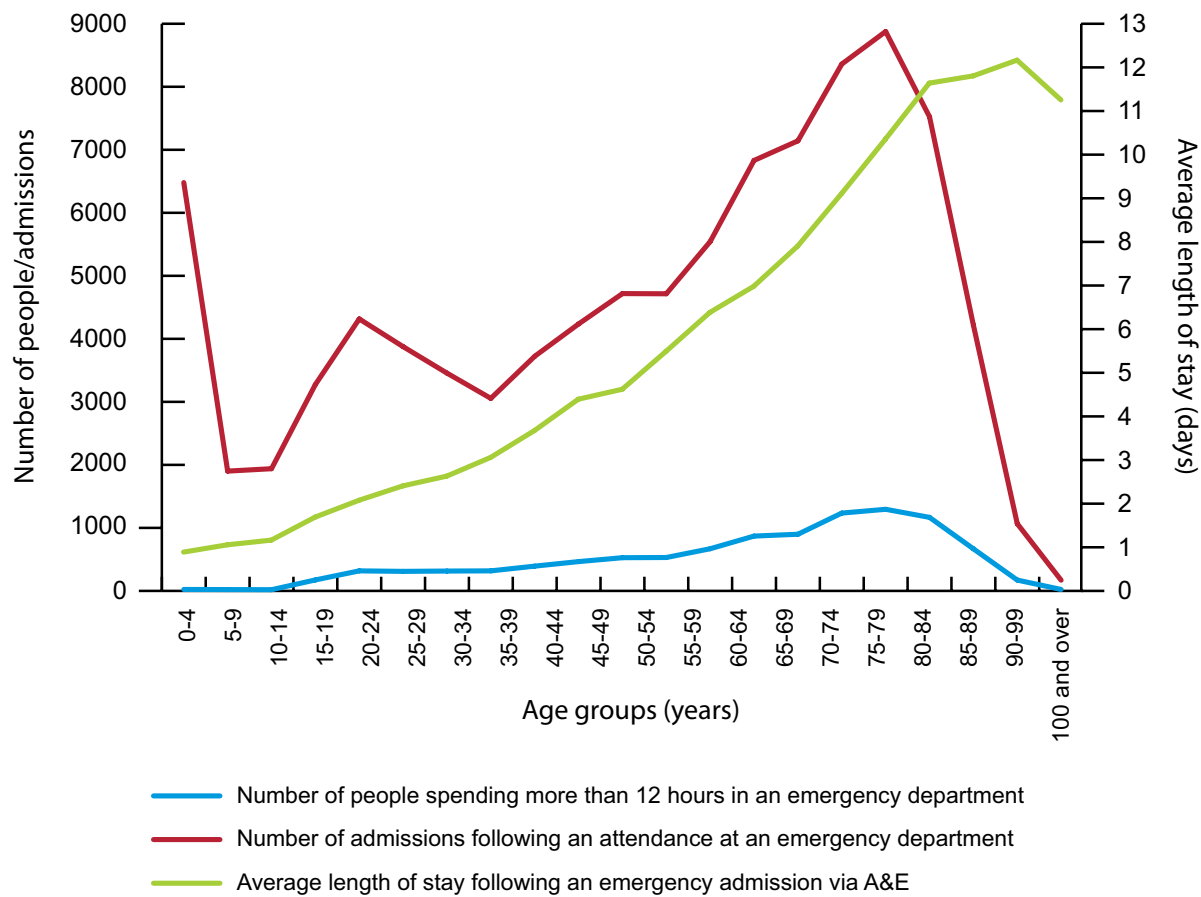


Note
Patients waiting over 24 hours have been included from January 2013 to be consistent with the changes to the national methodology for measuring emergency department waiting times.

Source: Wales Audit Office analysis of data from the Welsh Government's Emergency Department Data Set



Figure 10 - Most people who spend 12 or more hours in the emergency department are older people who are more susceptible to complications



Note
 The waiting time considers the difference between the 'admin arrival date' and 'treatment end date'. Where 'treatment end date' was not recorded, waiting time was calculated as the difference between the 'admin arrival date' and 'admin end date'.

Source: Welsh Government. The data cover January to June 2013.

NHS Wales has processes in place to monitor risk levels but it does not yet collect sufficient information to know whether patient outcomes and experiences are improving

Unscheduled care performance measures remain focused on emergency department waiting times and there is a need for better information to improve understanding of outcomes and patient experience

1.20 A basic requirement for unscheduled care services is that they should be able to monitor whether they are succeeding in providing safe and high-quality care. In our December 2009 report we drew attention to limitations in the monitoring and measurement of performance, quality and safety. Step two from the *Ten High Impact Steps to Transform Unscheduled Care (USC)* states that there should be agreement across the health community about what data/information is required to measure success. The document states ‘if we are serious about transforming USC, there is an expectation that USC targets evolve to reflect the pursuit of excellence in clinical care’.

1.21 We were told a number of times in our interviews across Wales that ‘what gets measured, gets done’, meaning that health bodies tend to focus their improvement efforts on the aspects of services that are subject to internal and external targets and performance monitoring. Our fieldwork found that the focus of performance measurement and management in unscheduled care remains on waiting times for services and primarily focuses on the emergency department. The suite of performance

measures in Wales remains quite narrow, focusing little on primary and community services³⁴ providing unscheduled care and on the factors affecting patient flow through the acute hospital. Despite our interviews highlighting key problems such as a delays in specialist doctors coming to the emergency department to review a patient, and delays in finding ward beds for emergency department patients, these aspects are not widely and comprehensively measured. Similarly, despite being told about difficulties in the operating practices of CDUs, and other short-stay units, including them being used as overflow units for the emergency department, we saw little evidence of these units being properly performance monitored and measured.

1.22 There have been some actions taken to introduce measures of quality and outcome but overall progress has been disappointing. It is a positive step that NHS Wales is now monitoring mortality for certain common unscheduled care conditions and **Figure 11** shows the Welsh Government’s main mortality data. We also consider it a positive step that in March 2013 the Welsh health boards made their hospital mortality rates publically available for the first time. However, the indicators of hospital mortality are based on data that have limitations because of poor clinical coding performance. Our fieldwork suggested that delays in clinical coding, a lack of detail in the coding information and potential variation in the way certain deaths are excluded from the data, mean there is scope to increase the robustness of these mortality analyses. Guidance issued by the Welsh Government in January 2013 has set out greater expectations in relation to the completeness of coding data in all health boards and the Welsh Government has carried out detailed analysis of available

³⁴ Since delivering our fieldwork, we have been made aware of new work by health boards to develop primary care dashboards for performance management purposes. This work was at a relatively early stage in its development at the time of publication of this report.



Figure 11 - The national mortality data suggest a mixed picture but there are limitations in the data

	2010-11	2011-12	2012-13
Death in hospital within 30 days of emergency admission for heart attack	4.4%	4.4%	3.5%
Death in hospital within 30 days of emergency admission for stroke	16.1%	17.2%	16.9%
Death in hospital within 30 days of emergency admission for hip fracture-major trauma	6.6%	5.8%	6.3%

Note
 These indicators rely on clinically coded data. Therefore as clinical coding improves, the mortality rates will change, especially for the most recent period of data.
 Source: Welsh Government/CHKS

mortality data. Health boards and trusts have also carried out local analyses of mortality and undertake case note reviews in an attempt to better understand the safety and quality of their services.

- 1.23** A report from the Welsh Institute for Health and Social Care³⁵ has indicated that emergency patients admitted to hospital at weekends are less likely to be treated by a senior clinician and are consequently more likely to have poorer outcomes. The report concluded that ‘we can be reasonably sure that several of our service models (notably in major trauma, general emergency care, aspects of stroke care, some specialised surgery) are clearly well short of world class, and it would be reasonable to conclude that people are therefore suffering unnecessary disability and even death as a result’.
- 1.24** Our 2009 report on the whole system of unscheduled care drew attention to problems with the monitoring of out-of-hours primary care services. The report said the current standards for out-of-hours services measure processes and procedures, rather than the quality of services provided to patients. A report³⁶ to the national Out-of-Hours Steering Group in April 2012 highlighted that there has been no change in these matters and concludes that the standards for out-of-hours services, and therefore the Welsh Government’s monitoring of these services, ‘are not outcome focused’.
- 1.25** An example of progress is in the monitoring of stroke services. Seventeen stroke-related performance indicators were developed through the *Stroke Services Improvement Programme*. These indicators were subsequently included in the *NHS Annual Quality Framework* and health boards now submit data relating to these indicators every month to the Delivery and Support Unit (DSU).

³⁵ Welsh Institute for Health and Social Care, *The Best Configuration of Hospital Services for Wales: A Review of the Evidence*, April 2012
³⁶ *Out of Hours Review: Interim Report for Out of Hours Steering Group*, April 2012

Whilst these are process measures rather than outcome measures, the indicators relate to interventions that are evidence-based and accepted as being good for patient experience and outcome. Whilst we have not carried out a detailed review of stroke services, it appears that the introduction of such frequent, and intelligent measurements has been beneficial.

1.26 Only limited data are available relating to the outcomes of trauma. The Trauma Audit and Research Network (TARN) administers a national benchmarking initiative but participation by the Welsh health boards has been very low. The Welsh Risk Pool Services (WRPS) found³⁷ that whilst some health boards have in the past not participated in TARN, some have recently restarted their involvement. In a small number of health boards the WRPS raised concerns that clinical staff do not have sufficient time and administrative support to review cases, collect data and take part in the trauma audit. With such limited information, NHS Wales is not able to fully understand the outcomes of trauma.

1.27 The outcomes for patients who suffer heart attacks (myocardial infarction) in Wales are similar for patients in England. The annual report³⁸ of the *Myocardial Ischaemia National Audit Project* (MINAP) in 2012 showed that the 30-day mortality for patients with two forms of heart attack (STEMI and nSTEMI³⁹) are similar in the two countries. However, the report does raise concerns that some Welsh hospitals are not submitting data on the management they provide to patients with nSTEMI.

1.28 The reporting of outcomes for heart attack patients as well as trauma patients will hopefully improve as a result of a Welsh Government document that emphasises the importance of participating in national audits⁴⁰. The document sets out a requirement for health boards to participate in certain national audits including TARN and MINAP.

1.29 There are longstanding problems with the clinical information collected by the Welsh Ambulance Services NHS Trust. Whilst it is a positive step that the trust has recently developed a range of clinical performance indicators there are major limitations caused by the ongoing, paper-based collection of clinical information. For each patient, ambulance crews record clinical information on a paper form. The compilation of this information requires the forms to be collected from ambulance stations and manually entered into a computer system. There can be delays of several months in inputting the data. Another problem is that the necessary clinical information is not recorded on around 30 per cent of forms. The current arrangements therefore produce limited data that is significantly delayed. The trust is currently considering a business case to replace its paper-based process with an electrical clinical record system but there has been slow progress in addressing this issue given that our review of ambulance services in 2006 drew attention to problems associated with paper-based recording of clinical information⁴¹.

³⁷ *Welsh Risk Pool Services Assessment of Clinical Evidence Criteria in High Risk Clinical Areas*, report to chief executives, 2011-2012

³⁸ MINAP, *How the NHS cares for patients with heart attack*, Annual Public Report, April 2011 – March 2012

³⁹ STEMI is an acronym for 'ST segment elevated myocardial infarction', which is a particularly severe type of heart attack. Most cases of STEMI are treated with reperfusion therapy, where efforts are made to supply oxygen to the heart as quickly as possible to prevent further damage to the heart muscle. Examples of reperfusion therapy include percutaneous coronary intervention and thrombolysis. Non-ST elevation myocardial infarction (nSTEMI) may be managed with medication.

⁴⁰ Welsh Government, *NHS Wales National Clinical Audit and Outcomes Review Plan 2012/13*

⁴¹ Wales Audit Office, *Ambulance Services in Wales*, 4 December 2006



1.30 The outcome information that is monitored by the Welsh Ambulance Services NHS Trust suggests a mixed picture of performance. The bullet points below summarise the main messages regarding the ambulance service's main measures of outcomes:

- a** Compliance with key aspects of care for stroke patients has improved during 2012 and compliance with aspects of care for diabetic patients has remained at a fairly high level during 2012⁴².
- b** There was lower compliance with pre-hospital care bundles⁴³ for STEMI and hip fracture.
- c** Data reported to the trust's Board in June 2012 showed that complaints were typically around 30 per month for emergency medical services and there were between 197 and 298 adverse incidents reported per month. This is against a backdrop of the ambulance service receiving around 30,000 calls to 999 every month that require a response.

1.31 Whilst there are limitations in the data on unscheduled care outcomes, these issues are not isolated to Wales. A report from the College of Emergency Medicine (CEM) has highlighted the need, across the United Kingdom, to improve outcome measurement for specific clinical conditions⁴⁴. Within NHS Wales, there are quality assurance and risk management processes that aim to ensure unscheduled care services are safe and of high quality. Current arrangements include day-to-day monitoring of safety levels and workload pressures, by the Welsh Government and by the health boards and

ambulance trust, through the use of live data via the Launchpad information system (as discussed in [paragraph 1.36](#)). Daily monitoring of risk also includes telephone conferences between the Welsh Government and the wider NHS Wales. These conferences provide discussion and monitoring of risk levels within unscheduled care services. Other arrangements include central reporting and monitoring of serious incidents and concerns, as well as spot checks of emergency departments by Healthcare Inspectorate Wales.

1.32 However, there is not yet a systematic approach to monitoring patient experience of unscheduled care services. The main ways in which patient experience is currently measured is through ad hoc patient surveys, patient stories, and complaints forms in emergency departments. However, these measurements are not frequent enough and tend to focus on people's experiences of individual services rather than their experience of the unscheduled care system as a whole.

1.33 A national framework for patient experience was published by the Welsh Government in May 2013. This has the potential to support a more systematic approach through the identification of a set of common questions for all health boards to use when monitoring patient experience across all NHS services. As unscheduled care is currently such a high-risk area, we would expect health boards and the ambulance trust to implement the framework rapidly and ensure patient experience in unscheduled care services is measured as a priority.

⁴² The data regarding the clinical performance indicators were provided by the Welsh Ambulance Services NHS Trust.

⁴³ Care bundles are an amalgamation of several components of patient management to produce a single checklist that a clinician or care worker should use to improve the clinical outcome of patients with particular conditions.

⁴⁴ College of Emergency Medicine, *The Drive for Quality: How to achieve safe, sustainable care in our Emergency Departments?* May 2013

1.34 The *National Survey for Wales*⁴⁵ provides some basic patient satisfaction information about health services. The survey shows that the majority of people (84 per cent) were satisfied with the care they received when they last attended an emergency department as a patient. By way of comparison, 92 per cent of respondents were satisfied with the care they received from their GP, 97 per cent were satisfied with the care of their practice nurse and 92 per cent were satisfied with their last appointment at hospital.

There is scope to improve the information systems that are used to monitor the performance, quality and safety of unscheduled care services

1.35 Local audit work revealed some limitations in the information systems that support unscheduled care. These are summarised in the bullet points below:

- a** There are mixed views about the effectiveness of the emergency department module within the all-Wales Myrddin Patient Administration System. Whilst some staff were enthusiastic about the module, others told us about major problems and thought the module was not fit for purpose. We were told of one occasion when the Myrddin system was inaccurately reporting four-hour waiting time performance⁴⁶ and that the system was not delivering the quality of data required for health boards to be able to plan their services. We were also told that when clinicians submit data queries to Myrddin, in order to better understand patterns and trends in demand, the results can take weeks to be returned. Several

clinicians told us their concerns about the quality and accuracy of discharge letters automatically generated by Myrddin. It is understood that NHS Wales Informatics Services (NWIS) has now begun the process of procuring a new national IT system for emergency departments.

- b** The Unscheduled Care Dashboard system maintained by the Welsh Government holds valuable information about the pressure levels being experienced within acute hospitals, known as the SITREPS status. However, historic records of the SITREPS status are not retained, which prevents analysis of the SITREPS status at certain days of the week and times of the year.

1.36 Despite these problems, we recognise that some positive steps have been taken to improve the information systems supporting unscheduled care. The new Launchpad system developed by the Welsh Ambulance Services NHS Trust provides senior NHS Wales managers with live data regarding the pressures being experienced by ambulance services and within emergency departments. We also recognise the benefits of new alert processes where senior health board managers are sent emails automatically if patient handovers or patient waits for treatment at emergency departments are delayed by a certain amount. Further details of how this information is used can be found at **Box 9 on page 86**.

⁴⁵ Welsh Government, *National Survey for Wales*, SDR 163/2012, 27 September 2012

⁴⁶ In this instance, Myrddin was reporting that four-hour waiting time performance was worse than in reality. This was because the Myrddin system was ignoring patients classed as 'clinical exceptions' and therefore should not have counted as breaches to the four-hour target.



There remain gaps in the understanding of demand for unscheduled care but it is clear that some services are struggling to maintain quality and safety due to increased workload

There remains considerable scope for NHS Wales to improve its understanding of demand for unscheduled care

1.37 In 2009 we stated that ‘a fundamental weakness in the current system of unscheduled care is that there is no coherent understanding of demand’. Gaps remain in the understanding of demand, particularly in the routine analysis of demand at a local level. There is only limited information on the actual needs and clinical conditions of people using the system and there is little joined-up information about how people move through the system from one service to another. In April 2013, the strategic review of ambulance services commented that there was a clear lack of integrated data across the patient journey. Without better data regarding people’s actual needs and regarding how and why they access certain services during their journey through the system, NHS Wales cannot properly understand the challenges it is facing.

1.38 The EDDS provides considerable scope to record information about the conditions that people present with and the outcomes of their care. However, our analysis of EDDS shows that much of the clinical information is poorly completed within emergency departments. Typically, the main diagnoses of patients attending emergency departments are not recorded which significantly limits the ability to undertake important analyses of demand

and workload. Some 58 per cent of the patient attendances on EDDS have a diagnosis that was either ‘unknown, not recorded, or not otherwise specified’. Many of the limitations with EDDS stem from the fact that the system was originally designed to measure the four and eight-hour waiting time targets in emergency departments, and not wider data on clinical issues. Wales is not alone in experiencing difficulties in securing good-quality information on emergency department diagnoses. The Hospital Episode Statistics from the Department of Health⁴⁷ show that in 2010-11, 59.6 per cent of emergency department attendances in England had a valid diagnosis code recorded, with the most common being ‘diagnosis not classifiable’ (20.8 per cent of valid records).

1.39 There is a similar challenge in primary care. The *Ten High Impact Steps to Transform Unscheduled Care (USC)* estimates that there are approximately 5.5 million unscheduled care encounters with primary care/general practice every year in Wales. However, our fieldwork has not been able to find any consistent and comprehensive data, at a national or health board level, on the demand and capacity within primary care to manage people with urgent or unplanned needs.

1.40 The recent pressures being experienced within unscheduled care services have prompted specific analyses of demand. In May 2013, all health boards in Wales and Public Health Wales submitted analyses to the Welsh Government attempting to explain the increases in demand for unscheduled care. These one-off analyses are important and represent a step forward in the information base for understanding unscheduled care demand. The analyses also mention a need to do more intensive local work to understand patterns of demand and highlight ongoing

⁴⁷ Department of Health, *Hospital Episode Statistics: Accident and Emergency attendances in England (experimental statistics), 2010-11*

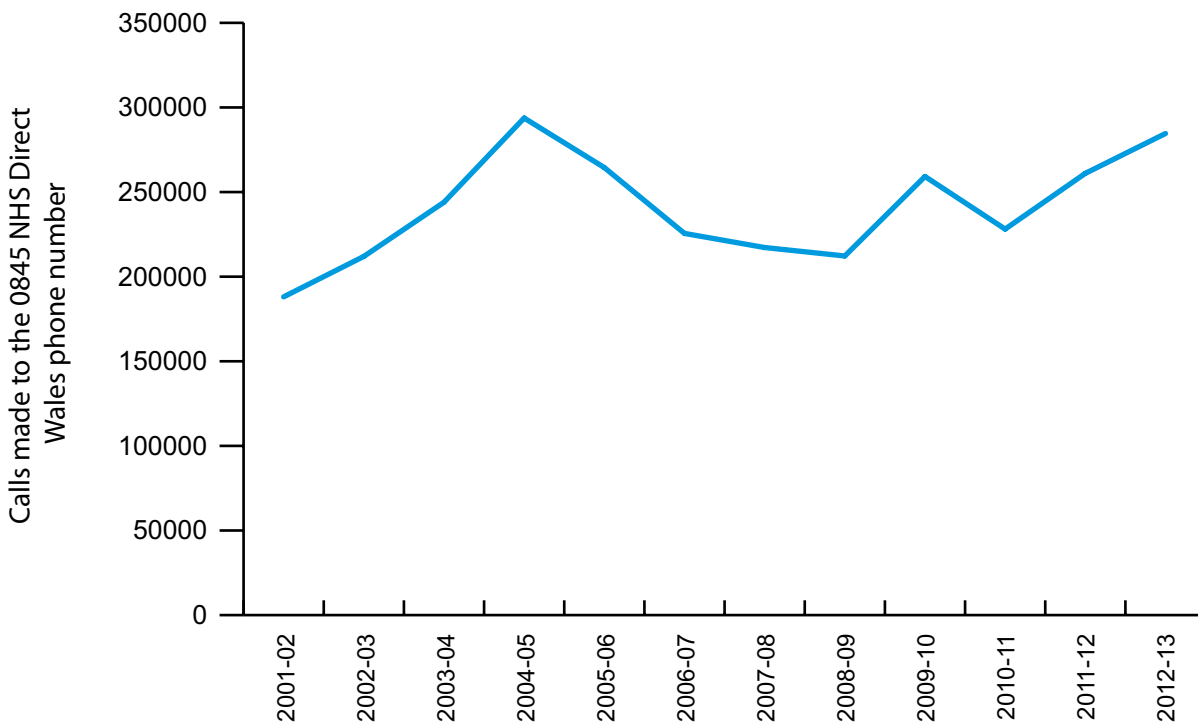
problems with the data quality regarding unscheduled care demand. There is now a need to build on the recent efforts to understand unscheduled care demand so that analysis is carried out more routinely and serves to help NHS Wales predict and pre-empt peaks in demand.

Ambulance services, NHS Direct Wales and out-of-hours primary care services are all experiencing increasing demand

1.41 The most obvious measure of demand in the unscheduled care system is the number of attendances at hospital emergency departments. However, this is just one element of the system and our work shows that other important services are experiencing increased demand.

1.42 Demand for NHS Direct Wales is growing, following a period of decline. **Figure 12** shows that calls to NHS Direct Wales’ 0845 phone number increased from 2001-02 to a peak in 2004-05. The number of calls then decreased until 2008-09 but since then there has been a general increase. The number of online enquiries to NHS Direct Wales has also increased since late 2010 and are now at their second highest rate since early 2007. There were more than two million hits on the NHS Direct Wales website in 2012-13 compared with approximately 450,000 in 2008-09. The increased use of NHS Direct Wales is encouraging as this service has the potential to help manage unscheduled care demand by offering direct advice and by signposting patients to the services most appropriate to their urgent care needs.

Figure 12 - Calls to NHS Direct Wales’ 0845 number are increasing after a period of decline



Source: Stats Wales



1.43 Demand for out-of-hours primary care services also appears to have increased, although comprehensive data are not available. Our 2009 report on the whole system of unscheduled care noted that the total number of contacts with out-of-hours primary care services in 2007-08 was 530,095. In the *Primary Care Out of Hours Review: Interim Report*⁴⁸, the total number of contacts was estimated to be 570,000 in 2011-12, which is approximately a 7.5 per cent increase over four years. It should be noted, however, that the data from 2007-08 and 2011-12 are not directly comparable as they were not collected in an identical way, and these data are not regularly collected on a national basis.

1.44 Demand for emergency ambulance services has increased. The total number of validated⁴⁹ emergency calls to 999 has increased from 377,650 in 2008-09 to 435,806 in 2011-12 (15.4 per cent increase) and the total number of verified emergency incidents⁵⁰ has increased over the same period from 325,601 to 383,315 (17.7 per cent increase).

The frequent high pressure in emergency departments is damaging staff morale and may be causing an acceptance of practices that represent higher risks for patients

1.45 The *Delivering Emergency Care Services* strategy noted in 2008 that attendances at emergency departments had been increasing at an average rate of 2.9 per cent per year, for the past five years. **Figure 13** shows that between 2008-09 and 2011-12 there was a year-on-year increase in attendances at major emergency departments, however the number of attendances decreased in 2012-13. Whilst the decrease in attendances in 2012-13 is

small, it represents a positive development in terms of the overall profile of unscheduled care demand. More recent data shows that the number of attendances at major emergency departments between April 2013 and June 2013 was three per cent lower than in the same period in 2012.

1.46 The number of people attending emergency departments is not in itself a good marker of pressure within the unit. Staff told us that the acuity of the patients' conditions, and the ability to move patients out of the unit into other areas of the hospital, are key determinants of the workload of the emergency department. However, limitations in the data collected on casemix and demand within hospital departments means this pressure is difficult to quantify. The poor completion of clinical data within EDDS (see **paragraph 1.38**) represents a missed opportunity for NHS Wales to be recording good-quality information about the demand it experiences.

1.47 Many of the clinical and managerial staff we interviewed across Wales told us about the high levels of pressure now being seen in unscheduled care services. We were frequently told about 'unprecedented demand' and about increasing demand from patients who are more acutely unwell or have many complex conditions when they present at unscheduled care services. This was referred to as an increase in the 'dependency' of patients. However, the limitations in the data on casemix and demand mentioned earlier mean that it is difficult to properly quantify the extent of this problem.

48 *Primary Care Out of Hours Review*, Dr Chris Jones, July 2012

49 Validated calls are defined as any calls that come into the ambulance control room via the 999 system. Test calls are excluded. The figure quoted here includes emergency calls to 999 only, which are categorised as AS1 calls.

50 Verified incidents are incidents that require an intervention from the emergency medical service, either via a vehicle response or via clinical telephone assessment. The following call types are excluded from verified incidents: test calls, duplicate calls, calls in error, information-only calls, calls transferred to another ambulance service.

Figure 13 - The number of attendances at major emergency departments has increased in the long term but decreased slightly between 2011-12 and 2012-13

Financial year	Number of attendances	Change in number of attendances	Percentage change (%)
2008-09	733,802	-	-
2009-10	749,099	15,297	2.1
2010-11	775,591	26,492	3.5
2011-12	788,378	12,787	1.6
2012-13	786,691	-1,687	-0.2

Source: Data covering April 2008 to June 2012 is from Stats Wales. Data from July 2012 to March 2013 is from NHS Wales Informatics Service.

1.48 There is national-level data that provides some support to the perceptions of increased dependency. The Welsh Government has carried out specific analyses regarding the age profile of patients attending major emergency departments. **Figure 14** highlights that between 2010-11 and 2012-13, the number of people that attended emergency departments aged 0 to 15 decreased, and the number of people aged 16 to 64 remained fairly constant. However, there was an increase in the number of people aged 65 and over. In percentage terms, the increase was particularly marked in people aged 85 and over.

1.49 The Welsh Government’s mid-year stocktake⁵¹ of NHS Wales in 2012-13 showed that the proportion of the population that is over 85 is higher in Wales than in the rest of the United Kingdom. This has particular consequences for the unscheduled care system because many of the older people attending the emergency department are frail and have

complex health needs which typically results in a hospital admission. Such patients are also likely to have longer lengths of stay in hospital.

1.50 The analyses carried out by health boards and Public Health Wales in May 2013 that was referred to in **paragraph 1.40** put forward a wide range of factors that are driving increased unscheduled care demand. The factors mentioned in the analyses include:

- a** increased numbers of ambulance conveyances;
- b** increased emergency department attendances from older people;
- c** a shift in casemix so that more ‘major’ cases are being seen in emergency departments;
- d** disruptive impact of service changes including reduced acute bed numbers;

⁵¹ Welsh Government, *NHS Wales Mid Year Review*, 30 October 2012



Figure 14 - There has been an increase in the number of older people attending major emergency departments

The table shows the number of patients who attended major emergency departments.

	2010-11	2011-12	2012-13	% increase between 2010-11 and 2012-13
0-15 years	166,304	169,459	160,335	-3.6%
16-64 years	477,107	487,647	479,812	0.6%
65-74 years	59,505	63,873	68,049	14.4%
75-84 years	58,215	61,875	65,186	12.0%
85+ years	38,022	41,307	44,348	16.6%
Total	799,153	824,161	817,730	2.3%

Note
The total number of attendances in Figure 14 differs from that shown in Figure 13. This is because Figure 14 includes all attendances whilst Figure 13 excludes planned follow-up appointments, patients who were dead on arrival or died in the department. Patients whose stay exceeded 24 hours in the emergency department were excluded from Figure 13 up to December 2012, but have been included from January 2013 onwards.

Source: Welsh Government

- e** environmental factors including unseasonably cold weather and air pollution prompting ill health;
- f** patients that are not classed as delayed transfers of care but are experiencing delayed discharges despite them being medically fit;
- g** socioeconomic factors that drive higher emergency admission rates in deprived areas; and
- h** changes in the peak times of demand in emergency departments.

1.51 Serious concerns were raised with us during our interviews with staff, as well as with organisations such as the CEM, the WRPS and Royal College of Nursing, that morale is very low within emergency departments. Some contributory factors are likely to include uncertainty about the future of acute hospitals in Wales and general worries about the economic climate but workload pressures in emergency departments are also a major factor. A letter sent to the Minister for Health and Social Services in March 2013 from the CEM expressed further concern at the pressures in emergency departments. The letter was signed by 24 emergency medicine consultants in Wales and stated that departments are ‘at the point of meltdown’.

The letter drew attention to overcrowding in emergency departments that 'jeopardises safety and puts patients at risk'.

1.52 There is concern amongst some staff and stakeholders that because emergency departments are frequently running at elevated pressure, some ways of working that can compromise the quality and safety of care are becoming the norm rather than the exception. Such practices include patients being treated in hospital corridors, patients more frequently having to spend entire nights on emergency department trolleys, and long delays to patient handovers between ambulance staff and emergency department staff. A report from the WRPS⁵² also raises concerns about the normalisation of working at high pressure and a desensitisation to risk within emergency departments. That report said the threshold for identifying risk is potentially reduced because of constant

and frequent workload pressures. Similarly, the letter from the CEM stated that 'each of us has seen standards of care slipping in our departments, as we struggle to look after a dozen or more patients stuck in emergency departments whilst waiting for ward beds, in addition to our normal workload'.

More people are being admitted to hospital wards as emergency admissions

1.53 Attendances at the emergency department do not represent the full emergency demand on acute hospitals. Patients can also be referred directly to the wards or to short-stay units by their GP as emergency admissions.

1.54 Figure 15 shows that since 2005-06 the number of patients admitted as emergencies to acute hospitals has increased slightly across Wales.

Figure 15 - Demand through emergency admissions has increased in Welsh hospitals

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
Emergency department	169,825	177,332	172,276	165,615	160,350	163,362	172,530	176,131
GP referral	112,529	110,210	111,428	118,600	125,149	126,774	124,721	114,862
Other	54,255	54,628	51,933	56,951	56,759	59,409	54,339	52,120
All emergency admissions	336,609	342,170	335,637	341,166	342,258	349,545	351,590	343,113

Note
 'Other' includes admissions via a bed bureau, consultant clinic, domiciliary visit by a consultant, NHS Direct Wales and other means including being admitted from the emergency department of another provider where the patient had not been admitted.

Source: NHS Wales Informatics Services, Patient Episode Database for Wales

52 Welsh Risk Pool Services, Assessment of Clinical Evidence Criteria in High Risk Clinical Areas, 2011-12



Part 2 - Whilst NHS Wales has made some progress on managing demand the work that is being done is not keeping pace with the increased pressures being placed on unscheduled care services and major challenges remain in relation to workforce, patient flow and ambulance services

- 2.1** In this part of the report we have set out what we see as the major remaining challenges to securing sustainable improvement in unscheduled care.

Actions taken to manage demand for unscheduled care have not had sufficient impact

There is evidence of some people accessing the 'wrong' service for their needs but the data are poor and often it is the system that encourages people to access services inappropriately

- 2.2** Our 2009 report found that some services were under pressure, partly due to people using a service when they might have had their needs met more appropriately by a different service. People can end up using inappropriate services because of a lack of understanding about what else is available, or because the way the system is set up pushes them towards certain services. The system of unscheduled care needs to be made clearer and alternative services need to be more consistently available so that genuine alternatives to hospital are readily accessible. Only by making the alternatives more attractive and responsive to people will this problem be solved.
- 2.3** Data from the Welsh Ambulance Services NHS Trust shows that the number of nuisance calls requesting 999 ambulances

has decreased over the past three years. In 2011-12 there were 1,912 such nuisance calls, representing 0.4 per cent of all validated calls⁵³ for an ambulance. In 2009-10 there were 2,612 such calls, which was 0.7 per cent of validated calls.

- 2.4** The ambulance service also receives a large volume of 999 calls from people who are not nuisance callers but have only minor illnesses or injuries and do not require an emergency ambulance. Calls classed as 'omega calls' are those of the lowest acuity and are safe to be transferred to other agencies without the need for any ambulance response. In 2011-12, 4.3 per cent of all verified incidents were classified as omega incidents, meaning 4.3 per cent of the demands placed on the ambulance service are potentially avoidable.
- 2.5** Too many patients choose to walk into hospital emergency departments when they would have been better off going elsewhere for their care. However, there are hugely varying estimations, and a lack of definitive data, about the true extent of this problem. Senior staff we interviewed across Wales estimated that between 5 and 10 per cent of emergency department cases could have been treated in primary care. A joint report from the NHS Alliance and the Primary Care Foundation, *Breaking the mould without breaking the system*⁵⁴, gave estimates ranging from 10 per cent to 30 per cent.

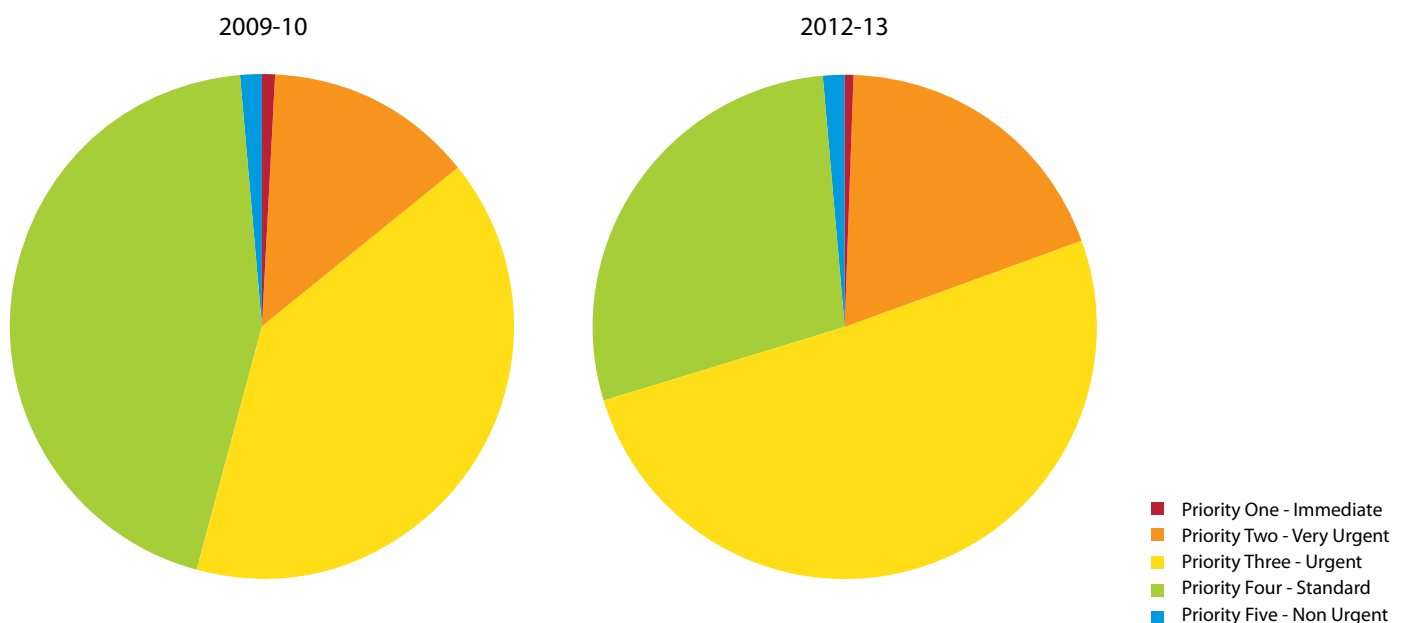
⁵³ Validated calls are defined as any call coming into ambulance control via the 999 system. Test calls generated on the 999 system are excluded.

⁵⁴ NHS Alliance and Primary Care Foundation, *Breaking the mould without breaking the system*, November 2011

2.6 In order to estimate the number of patients coming to emergency departments unnecessarily, we analysed data from EDDS about patients triaged as being ‘non-urgent’ cases. The analysis was limited because not all departments use the same triage categories and there is evidence of different interpretation of these categories. Whilst noting these caveats, **Figure 16** suggests that between 2009-10 and 2012-13 the proportion of patients classed as non-urgent was below one per cent and the vast majority of patients were classed as ‘urgent’ or ‘standard’ cases.

2.7 The EDDS also requires staff to record whether they consider a patient’s attendance at the emergency department to be appropriate or inappropriate. Only six out of 13 major emergency departments complete this field and our analysis of the data suggests that different units interpret differently the terms ‘appropriate’ and ‘inappropriate’.⁵⁵ We were also told that some clinical staff have reservations about coming to a judgement on whether a patient’s attendance was appropriate or not, and hence, they do not use this field within EDDS. In the first six months of 2012-13, the proportion of patients categorised as ‘inappropriate’ ranged from 0.1 per cent at Ysbyty Gwynedd to 18 per cent at Ysbyty Glan Clwyd.

Figure 16 - The proportion of emergency department patients categorised as ‘non-urgent’ is typically below one per cent



Source: Emergency Department Data Set

⁵⁵ The EDDS guidance describes an appropriate attendance as meeting the British Association of Emergency Medicine’s Standards for an Accident and Emergency Department.



2.8 We also analysed EDDS data regarding the proportion of patients that attended emergency departments that required no treatment or only required guidance or advice. There was massive variation between units, suggesting different recording practices and inaccuracies in the data. For example, at Nevill Hall Hospital, between January and September 2012, typically 100 per cent of patients were recorded as requiring no treatment, whereas, at Royal Glamorgan Hospital, no such patients were recorded⁵⁶.

2.9 Our fieldwork around Wales has highlighted some concerns about misplaced demand at minor injury units. Some health boards have closed minor injury units for reasons that include low attendance figures and difficulties ensuring adequate staffing. We were told about some concerning incidents where seriously ill or injured people have attended minor units. Such cases included chest pain or stroke and significant trauma, including head injury and hip fracture. Clearly these patients were in the wrong place within the system but the reasons for them attending minor units are unclear. Some staff told us that one issue is that people do not fully understand what services are provided at minor units and that the numerous different names of types of unit are confusing.

NHS Direct Wales has potential to play a major role in the management of demand but its impact is minimised by operational challenges and its lack of strategic direction

2.10 NHS Direct Wales has a potentially important role to play in helping people access the right care. The NHS Direct Wales website provides advice and guidance to help the public choose appropriate services and the 0845 phone service provides the public with health information and advice.

2.11 One of the important functions of NHS Direct Wales is, where clinically appropriate, to divert callers away from unscheduled care services by helping people to self-care or by advising them to visit their pharmacy or GP. NHS Direct Wales appears to be getting better at this as the proportion of callers directed away from unscheduled care services has increased from 49 per cent in March 2009 to an average of 53.6 per cent between April 2012 and November 2012.

2.12 Our 2009 report on NHS Direct Wales concluded that whilst NHS Direct Wales provided a valuable service, there needed to be greater clarity around its strategic and operational fit within the wider unscheduled care system. The conclusion from our most recent audit work is that NHS Direct Wales has not played the central role in the unscheduled care system that it could have and important question marks still remain over the future strategic direction for NHS Direct Wales. Many of the staff we spoke to within the Welsh Ambulance Services NHS Trust (which provides NHS Direct Wales services), as well as staff from the wider NHS in Wales, expressed uncertainty about the future direction of the service. There were particular concerns about:

⁵⁶ Cwm Taf Health Board states that since the delivery of our fieldwork the health board has reviewed and improved its use of EDDS with the aim of ensuring its data is comparable to the rest of Wales.

- a an apparent shift in priorities within the ambulance service that has resulted in resources being directed away from the 0845 phone service and towards the clinical triage service that NHS Direct Wales provides for 999 ambulance calls;
- b how NHS Direct Wales services will be provided in future so that there is no overlap or duplication with the forthcoming 111 call service; and
- c the very limited involvement, so far, from NHS Direct Wales in the development and operation of communications hubs.

2.13 Paragraph 1.42 has already highlighted that demand for NHS Direct Wales services is increasing and this represents an encouraging development. Nevertheless, the organisation is experiencing some difficult operational problems. Sickness absence rates are

reportedly high⁵⁷ (although we have been unable to secure data from the Welsh Ambulance Services NHS Trust), the number of nursing staff has decreased by 34 per cent between 2009 and 2013 (from 96.5 Whole-Time Equivalent (WTE) nurses to 63.8), the number of call handlers has decreased by 22 per cent between 2009 and 2013 (from 38.9 WTE call handlers to 30.25) and the organisation is now more focused on providing clinical triage for 999 calls than it is on maintaining its 0845 service.

2.14 These operational problems are contributing to a decline in performance of the 0845 service. Figure 17 shows that measures of access and of quality of NHS Direct Wales services have deteriorated since 2009. The figure shows that patients are now waiting longer for NHS Direct Wales to answer their call and more than 11 per cent of these callers now abandon the call without getting the help or advice they require.

Figure 17 - Measures of access and quality in NHS Direct Wales have deteriorated

NHS Direct Wales has a target to answer 95 per cent of calls in less than 90 seconds. Another target is to ensure less than five per cent of calls are not abandoned by the caller after receiving an initial recorded message. For calls categorised as Priority 1 calls, the caller requires nurse triage within 20 minutes. For Priority 2 calls, it is clinically safe for the caller to wait up to one hour for nurse triage.

	Answer rate <90 seconds	Call abandonment rate	Priority 1 calls triage commenced <20 mins	Priority 2 calls triage commenced <60 mins
2008-09	87.9%	4.9%	99.1%	96.5%
2012-13	70.0%	11.1%	98.4%	87.7%

Note

2012-13 covers April 2012 to November 2012.

Source: Wales Audit Office analysis of data from the Welsh Ambulance Services NHS Trust

57 Welsh Ambulance Services NHS Trust, papers submitted to the January 2013 Board meeting.



The *Choose Well* national marketing campaign has had minimal impact but there are so many problems with the system of unscheduled care that even the most effective campaign would struggle to result in improvements

- 2.15** In 2009 we said the system of unscheduled care was complicated and that many people are likely to be uncertain of how and where to seek help. We recommended that the Welsh Government should develop a communication strategy to improve public understanding about how to most appropriately access unscheduled care. This is an approach taken in many other parts of the world, as highlighted in the [Figure 18](#).
- 2.16** The Welsh Government launched a national campaign called *Choose Well* in February 2011. The campaign uses the branding shown in [Figure 19](#) to ask the public to think carefully before going to the emergency department or dialling 999. The national elements of the campaign have so far involved radio adverts, the publication of guides for NHS staff on *Choose Well*, the launch of a website and smartphone app, the production of a viral online video featuring a high-profile rugby player, and the distribution to older people of 25,000 thermometers that show the campaign logo.
- 2.17** In addition to the national elements of the campaign, each health board has used the *Choose Well* brand to publicise messages about local services. The actions taken by some health boards have included mailshots to all households, displaying of posters, use of hospital television screens to publicise *Choose Well* messages and proactive generation of news stories for local media.
- 2.18** The cost of the *Choose Well* campaign in Wales between January 2011 and June 2012 was approximately £90,000. This only includes the costs of the national elements of the campaign and does not include local expenditure by health boards. In order to put this cost in perspective we carried out some high-level research on the cost of other public sector marketing campaigns. We found that a similar campaign run by NHS Grampian in Scotland, called *Know Who To Turn To*, cost approximately £234,000 in research, development, piloting and evaluation. Following the development phase during 2007-08, the campaign cost approximately £16,000 per year to run and the campaign included television commercials. We also found examples of much larger social marketing campaigns, covering England and Wales, where the costs have run into millions of pounds. Examples include the *Act F.A.S.T.* stroke campaign and *Change4Life*.
- 2.19** We acknowledge that the Welsh Government considers *Choose Well* to be work in progress and we recognise that there are future plans to introduce another smartphone app, further online videos, social media pages and to make NHS Wales staff ambassadors for *Choose Well*. Nevertheless, the *Choose Well* campaign has so far had minimal impact in helping people access the right services. Immediately following the launch of the campaign in March 2011 the number of attendances at emergency departments did reduce compared with March 2010. However, the decline was temporary and there is no evidence to show that it was the campaign that prompted the reduction. Our interviews at health boards also generally concluded that the impacts of local marketing initiatives had been, at best, minimal and temporary.

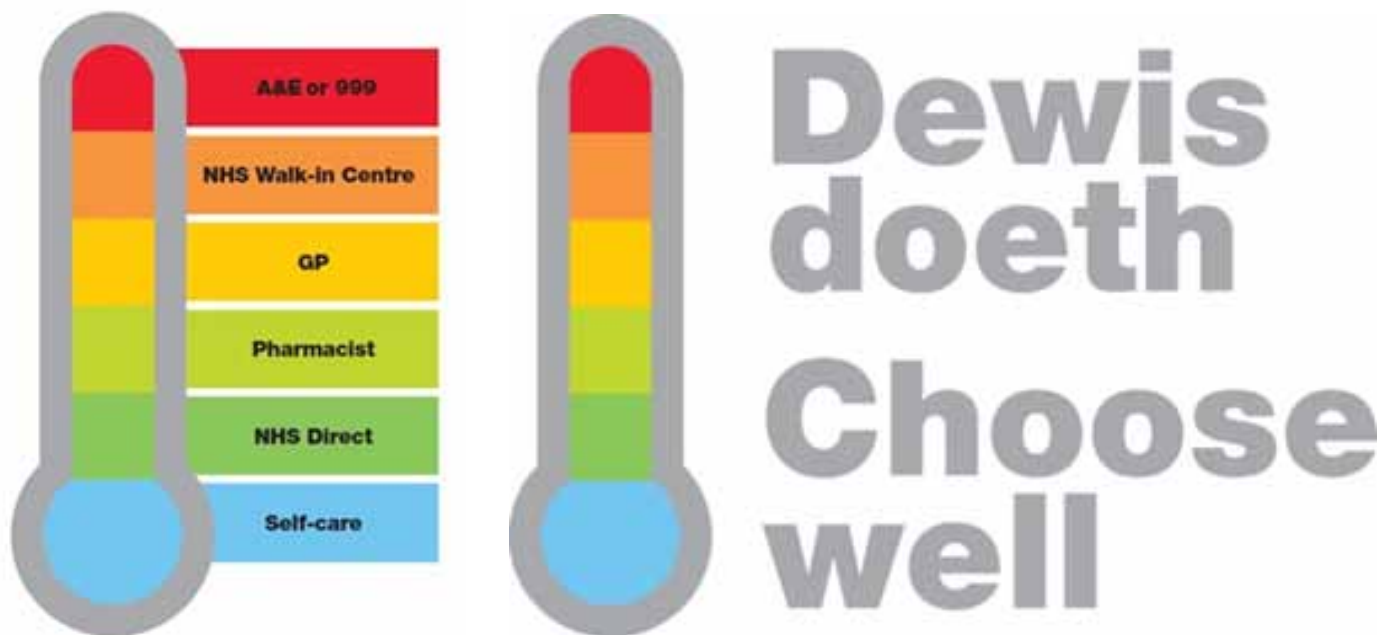
Figure 18 - There have been numerous campaigns around the world to change the way the public chooses to use unscheduled care services



Source: Wales Audit Office research, Singapore Ministry of Health, Government of South Australia, NHS Bury, NHS Knowsley, NHS Grampian, NHS Leicester City, Leicestershire County and Rutland, South Central Ambulance Service NHS Foundation Trust, London Ambulance Service NHS Trust



Figure 19 - The *Choose Well* logo uses a thermometer brand to help the public choose the most appropriate service



Source: Welsh Government

2.20 Box 1 summarises the National Social Marketing Centre's⁵⁸ eight key elements for successful social marketing⁵⁹ interventions. The Welsh *Choose Well* campaign has not fully considered these elements and future actions within the campaign should not be taken until these principles are fully considered. For example in relation to element one, *Choose Well* does not appear to have set specific and measurable goals, such as a target reduction in emergency department

attendances. Measuring the impact of *Choose Well* has focused on the number of hits on the campaign website and the number of people who have been exposed to the campaign's message. Whilst the Welsh Government has carried out some analysis of trends in emergency department attendances, there not been an in-depth evaluation and in relation to element five, there does not appear to have been a comprehensive cost-benefit analysis of the campaign.

58 The National Social Marketing Centre was originally set up by the United Kingdom Government but is now run as a non-profit community interest company that aims to improve the effectiveness of behaviour change programmes through training, mentoring and independent evaluation, www.thensmc.com.

59 Social marketing can be defined as an approach used to develop activities aimed at changing or maintaining people's behaviour for their benefit. Commercial marketing seeks to influence consumer behaviour but social marketing promotes behaviours that benefit the individual and society as a whole.

Box 1 - The National Social Marketing Centre's eight key elements for successful social marketing interventions



- 1 **Behaviour** – the intervention should aim to change people's actual behaviours and not just their beliefs, knowledge or attitudes. Clear, specific, measurable and time-bound behavioural goals should be set.
- 2 **Customer orientation** – focus on the audience by fully understanding their lives, their behaviours and the issue in hand. Use a mix of data sources and research methods. Interventions should be pre-tested with the audience.
- 3 **Theory** – uses behavioural theories to understand behaviour and inform the intervention. This should be done after carrying out the research mentioned in 2.
- 4 **Insight** – research should lead to deep insight into what motivates the target audience and whether there are emotional barriers and physical barriers to the behaviour change being sought.
- 5 **Exchange** – consider costs and benefits of adopting and maintaining new behaviours. Maximise the benefits and minimise the costs to create an attractive offer. Consider what the audience values and offer incentives and rewards to replace the benefits the audience derives from the problem behaviour.
- 6 **Competition** – understand what is competing for the audience's attention and inclination to behave in a particular way.
- 7 **Segmentation** – avoid a 'one-size-fits-all' approach. Identify audience segments which have common characteristics and tailor interventions appropriately. Understand the size of these segments and prioritise based on clear criteria such as readiness to change behaviour.
- 8 **Methods mix** – use a mix of methods to bring about behaviour change. Do not rely solely on raising awareness. Methods should be financially and practically sustainable.

Source: National Social Marketing Centre, summarised by the Wales Audit Office



2.21 The most significant limitation of the *Choose Well* campaign is that, as described throughout this report, there are so many problems with the underlying system of unscheduled care that even the most effective marketing campaign would struggle to result in improvements. The current campaign is aiming to educate people on how to use a system that remains disjointed. For people to be persuaded to use the most appropriate services, these services have to be in place and have to be readily accessible. In many cases, the most appropriate services are not readily accessible, at all times, in all locations. Until there are improvements to the actual system of services, *Choose Well* will struggle to achieve its aims.

Despite some improvement, the pace of change needs to be accelerated in shifting towards upstream prevention of unscheduled care and community service provision

2.22 One of the gaps we identified in 2009 was that there were not enough appropriate and effective community-based services to meet demand and act as genuine alternatives to acute care. *Setting the Direction*⁶⁰, the Welsh Government's framework for primary care and community-based services, provides a vision of integrated community services that will act as a bridge between primary care and the acute hospital. The vision is about changing from a reactive crisis management approach to a more proactive, coordinated and preventative approach. This would aim to allow more people to be cared for closer to home or in their home.

2.23 *Ten High Impact Steps to Transform Unscheduled Care (USC)* also highlights the importance of intermediate care services and Community Resource Teams (CRTs)

in providing a more balanced approach to community-based unscheduled care services. Step seven of the document says there needs to be 'pull' of patients from acute hospital services to community-based services. However, the document also warns that the wrong model of community services can result in increased usage of acute hospitals.

2.24 We recognise that implementing these new models of care takes time and, once implemented, more time is required to evaluate these services and ensure they are delivering the intended outcomes. There are positive signs that new models of care are having an impact as evidenced by a decrease in hospital admissions for patients with chronic conditions and the reduction in the overall number of emergency readmissions for chronic obstructive pulmonary disease, chronic heart disease and diabetes. These findings will be explored in more detail in a separate report by the Auditor General on chronic conditions management, to be published later in 2013.

2.25 Our fieldwork did, however, highlight a general acceptance that despite recent improvements, progress in shifting to a more community-based model of service provision needs to be accelerated. The Welsh Government has recently published a strategic document that aims to support this requirement⁶¹.

2.26 In response to our survey, three⁶² health boards said that problems with community services are some of the main barriers that are preventing further improvement in unscheduled care. The specific problems included differences in the level of community service provision in different population areas, a general lack of capacity in existing community and intermediate care services,

60 Welsh Government, *Setting the Direction: Primary & Community Services Strategic Delivery Programme*, February 2010

61 Welsh Government, *Delivering Local Health Care: Accelerating the pace of change*, June 2013

62 These health boards were Hywel Dda, Aneurin Bevan and Abertawe Bro Morgannwg.

a general lack of skills in the community workforce of certain areas and financial constraints inhibiting a meaningful shift in resources from acute hospitals to community teams.

- 2.27** Our local fieldwork found that even where new, potentially impactful community services have been launched, there were some examples of these services getting lower-than-expected numbers of referrals and not drawing enough activity away from more traditional unscheduled care services.
- 2.28** The *Primary Care Out of Hours Review* has further highlighted the lack of progress in bolstering community-based provision of unscheduled care. The key conclusions of the July 2012 report⁶³ said that NHS policy and strategy have been ‘blind’ to services provided outside hospitals and that transformation of the system has so far been so slow that its impact has been ‘invisible’.
- 2.29** Outside of normal working hours, limitations in community-based provision of services causes particular problems for the unscheduled care system. The *Primary Care Out of Hours Review* highlighted the problems that occur when the majority of community services shut down during the out-of-hours period. That report said there are ‘no alternatives to hospital admission for new cases’ during the out-of-hours period and that ‘everything is shut in the evening apart from the A&E’. Our work on chronic conditions management has shown that only one⁶⁴ of the 16 CRTs in Wales is available 24 hours a day, seven days a week.

There has been slow progress in developing single points of access to the unscheduled care system

- 2.30** *Ten High Impact Steps to Transform Unscheduled Care (USC)* states ‘it is well recognised that access to the USC system needs to be simplified’ and it discusses the possibility of having a new three-digit phone number for urgent care in Wales. The document says that the development of the three-digit number would be consistent with the intentions set out in *Setting the Direction*, which stated that work was underway to develop integrated communications hubs to help with signposting people to the right service, facilitate sharing of information across services and support the process of referring people to community-based services. The Welsh Government also has a manifesto commitment to provide a single number for accessing out-of-hours healthcare in Wales.
- 2.31** In a report to the Public Accounts Committee in March 2011, the Welsh Government said⁶⁵ that the development of a single point of telephone access was a key component in the new whole-systems service model. The report also stated that communications hubs were being piloted in the areas covered by Cwm Taf, Aneurin Bevan and Cardiff and Vale health boards and that there were plans in place for evaluation and further development of these hubs and roll out across Wales would take place over the subsequent 12 months.
- 2.32** Despite a clear policy steer towards the introduction of a 111 call service and communications hubs, our follow-up work found that there has been slow progress since 2009. **Box 2** gives an example of one

63 *Primary Care Out of Hours Review*, Dr Chris Jones, July 2012

64 Carmarthenshire

65 Public Accounts Committee – Update on the Welsh Assembly Government response to the Wales Audit Office report *Unscheduled care: developing a whole systems approach*.



health board introducing a new single point of access but in general, our fieldwork suggests that progress with planning and implementing communications hubs remains at an early stage. Whilst some areas have in place services that are labelled as communications hubs, no area has a fully functional and fully integrated communications hub providing call handling and care coordination services across health and social care. Some areas have more than one hub but these have separate phone numbers, staff and directories of service. Other areas are still in the planning stage and are experiencing difficulties deciding on the model they want to implement.

2.33 Our interviews suggest that some areas are cautious about progressing their communications hubs until a national steer is forthcoming in relation to 111. A report to the national Out-of-Hours Steering Group⁶⁶ concluded that whilst there was good practice in patches, the development of communications hubs has been 'stymied by the lack of clear national direction and planning of the infrastructure support that this needs'. Further discussion on the potential benefits and risks of the 111 call service are included in **Part 3** of this report.

Box 2 - Cwm Taf Health Board has introduced a new way for patients to access minor injury units

Cwm Taf 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 a minor injury enhanced service; signposting to other services such as dental, pharmacist, etc; given an appointment to attend the minor injury unit; or advised to go to A&E.

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 the emergency department 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 and across both emergency departments.

Source: *Wales Audit Office*

66 *Out of Hours Review: Interim Report for Out of Hours Steering Group, April 2012*

Challenging workforce issues are potentially compromising the safety and sustainability of unscheduled care services

Complicated recruitment problems are contributing to emergency departments not complying with the recommended number of doctors and hours of cover

2.34 Across the United Kingdom, emergency medicine is becoming an increasingly difficult specialty to recruit to. A report from the General Medical Council in 2012⁶⁷ showed that in the United Kingdom, there were on average 0.8 to 1.0 applications per vacant post in emergency departments. By contrast, trauma and orthopaedics received approximately 22.1 applications per vacancy.

2.35 *The Best Configuration of Hospital Services for Wales*⁶⁸ highlighted the following issues regarding difficulties in medical staffing:

- a** Changes to immigration rules have made overseas recruitment more difficult and significant changes to medical training and education mean fewer people are likely to go through medical school in future.
- b** There are shortages of some medical staff and recruitment difficulties in particular hotspots such as West and North Wales.
- c** Staffing problems in emergency medicine are a United Kingdom-wide problem and the General Medical Council is reviewing staff cover across the United Kingdom in response to concerns about the supervision of foundation doctors overnight

in emergency departments. There is an urgent need to review where emergency medicine training is taking place in Wales because it is currently spread too thinly across too many departments.

- d** A survey of trainee doctors revealed a perception that the workload for medical staff in Welsh emergency departments is higher than in the rest of the United Kingdom⁶⁹.
- e** All health boards except for Aneurin Bevan reported difficulties in recruiting to consultant posts in emergency medicine, as well as non-consultant grades.
- f** Some vacancies in emergency medicine may be because of consultant posts in other locations being more attractive. Simply increasing trainee numbers would be unlikely to lead to these posts being filled.

2.36 Our discussions with NHS Wales staff across the country suggest that some of the reasons for the recruitment difficulties in unscheduled care services include the current workload pressures and problems with morale (as mentioned in [paragraphs 1.51 to 1.52](#)), as well as some potentially unattractive characteristics of some acute hospitals in Wales including their rurality, small size, low activity levels and lack of specialist/centralised services. We were also told that the shortage of staff is also prompting a vicious circle where because there are few staff to fill rotas, each individual is working unsocial hours more frequently and this may be deterring people from applying for such roles in Wales.

⁶⁷ General Medical Council, *The state of medical education and practice in the UK*, 2012

⁶⁸ Welsh Institute for Health and Social Care, *The Best Configuration of Hospital Services in Wales*, The Workforce, April 2012

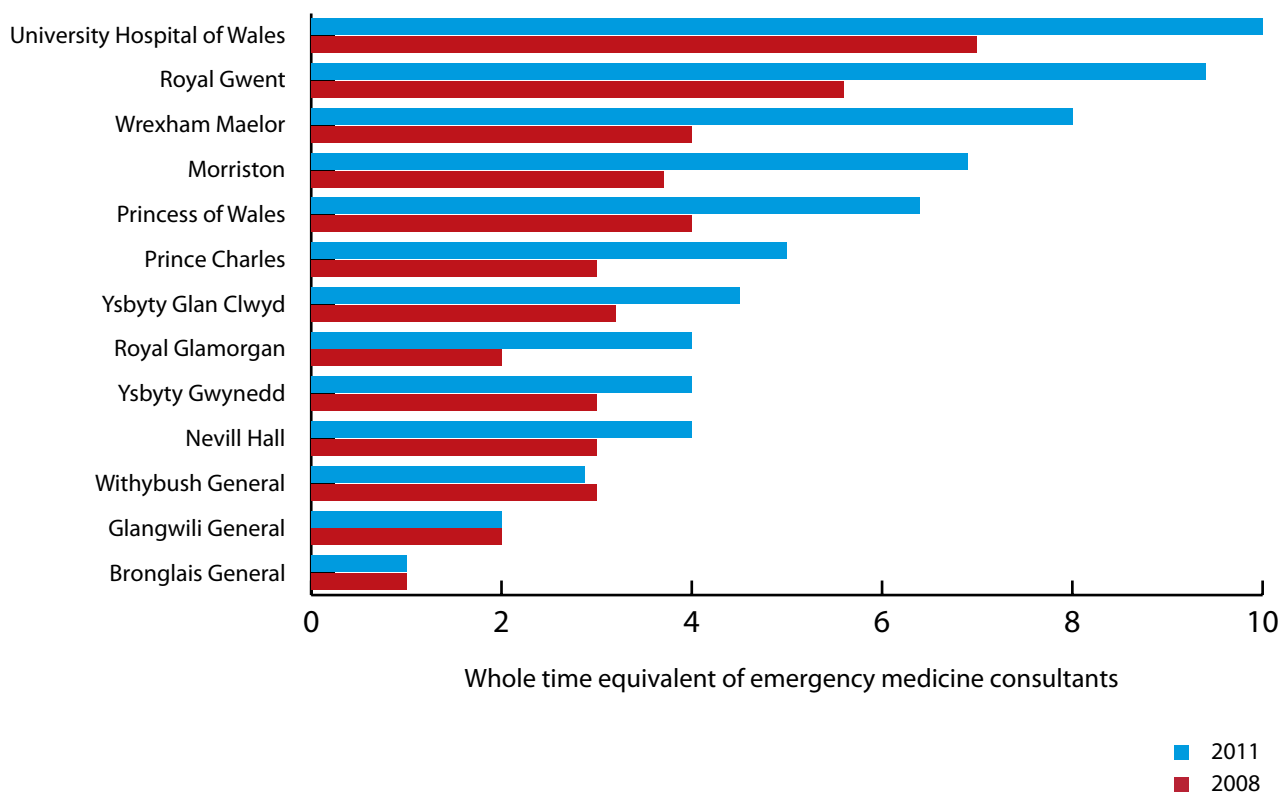
⁶⁹ General Medical Council, *National Training Survey 2012 (Trainee Survey)*



2.37 Despite these recruitment problems, **Figure 20** shows that health boards have generally succeeded in increasing the number of consultants working in emergency departments since our 2009 report, but none is meeting the guideline set by the CEM for having a minimum of 10 emergency medicine consultants in the smallest units, increasing to 16 consultants in the largest units⁷⁰.

The emergency department at the University Hospital of Wales has 10 consultants but as it has more than 100,000 attendances per year the CEM guideline states it should have 16 consultants. Across Wales, the total number of WTE consultants in emergency department establishments has increased 53 per cent since our 2009 report, from 44.5 WTE to 68.07 WTE.

Figure 20 - The number of emergency medicine consultants has generally increased at major emergency departments



Note
The data used in our 2009 report were correct as of 31 March 2008 and the 2011 data were correct as of 30 November 2011. The data show establishment figures and therefore include the number of staff in post and the number of vacant posts.

Source: Wales Audit Office, survey of health boards

70 College of Emergency Medicine, *Emergency Medicine Operational Handbook: The Way Ahead, Version 2*, December 2011

2.38 Despite the increase in establishments across these 13 departments, there were 16 WTE consultant vacancies⁷¹ and locums were in place to fill seven of these vacancies. We understand that health boards have been taking specific actions to fill vacancies, including several overseas recruitment campaigns and the Welsh Government ran a medical recruitment campaign, which promoted the benefits of working and living in Wales, in April 2012. However, many of the local efforts have failed to recruit suitable applicants. Our work at Betsi Cadwaladr University Health Board showed a reliance on locums who are retired emergency department consultants and whom may choose to stop working at any time.

2.39 Health boards are struggling to ensure there is sufficient shop floor cover from consultants at peak times in demand. One of the patient safety issues raised in the Healthcare Commission's investigation into the high mortality rate at the Mid Staffordshire NHS Foundation Trust⁷² showed that there were too few consultants to provide sufficient hours of cover in the emergency department. We found that the hours of shop floor presence from consultants in Wales has increased since 2009 but **Figure 21** shows that no unit is yet meeting the CEM guideline of 16 hours consultant shop floor presence seven days a week. Three units continue not to have any consultant shop floor cover at weekends. *Ten High Impact Steps to Transform Unscheduled Care (USC)* states that health boards should

measure the actual time that senior clinical decision makers, such as consultants, provide shop floor cover compared with that intended. We found that at the time of the audit, only four units have monitored the actual hours of consultant presence within their units⁷³.

2.40 Our 2009 report highlighted a problem with numerous middle-grade vacancies. The number of middle-grade vacancies⁷⁴ changed very little between 2009 and 2011 but the number of middle-grade doctors in emergency department establishments decreased by 10 per cent (from approximately 111 WTE to 99 WTE). This suggests that problems with middle-grade recruitment and retention remain but health boards have sought to change their staffing models in the emergency department by reducing their reliance on middle-grade doctors within their establishments and replacing them with consultants. There was little change in junior doctor establishments and vacancies between 2009 and 2011. At the time of our data collection, only Ysbyty Glan Clwyd had a GP working as part of the emergency department establishment. There are mixed views about the benefits of GPs working as part of the emergency department but a paper from the King's Fund suggested this intervention may reduce admissions from the emergency department although the evidence of cost benefits is weak.⁷⁵

71 The emergency departments that had vacancies were: University Hospital of Wales (4 WTE), Withybush General Hospital (2.87 WTE vacancies), Ysbyty Glan Clwyd (2.5 WTE), Royal Glamorgan Hospital (2 WTE), Prince Charles Hospital (1.6 WTE), Ysbyty Gwynedd (1 WTE) Wrexham Maelor Hospital (1 WTE) and Nevill Hall Hospital (1 WTE).

72 Healthcare Commission, *Investigation into Mid Staffordshire NHS Foundation Trust*, March 2009

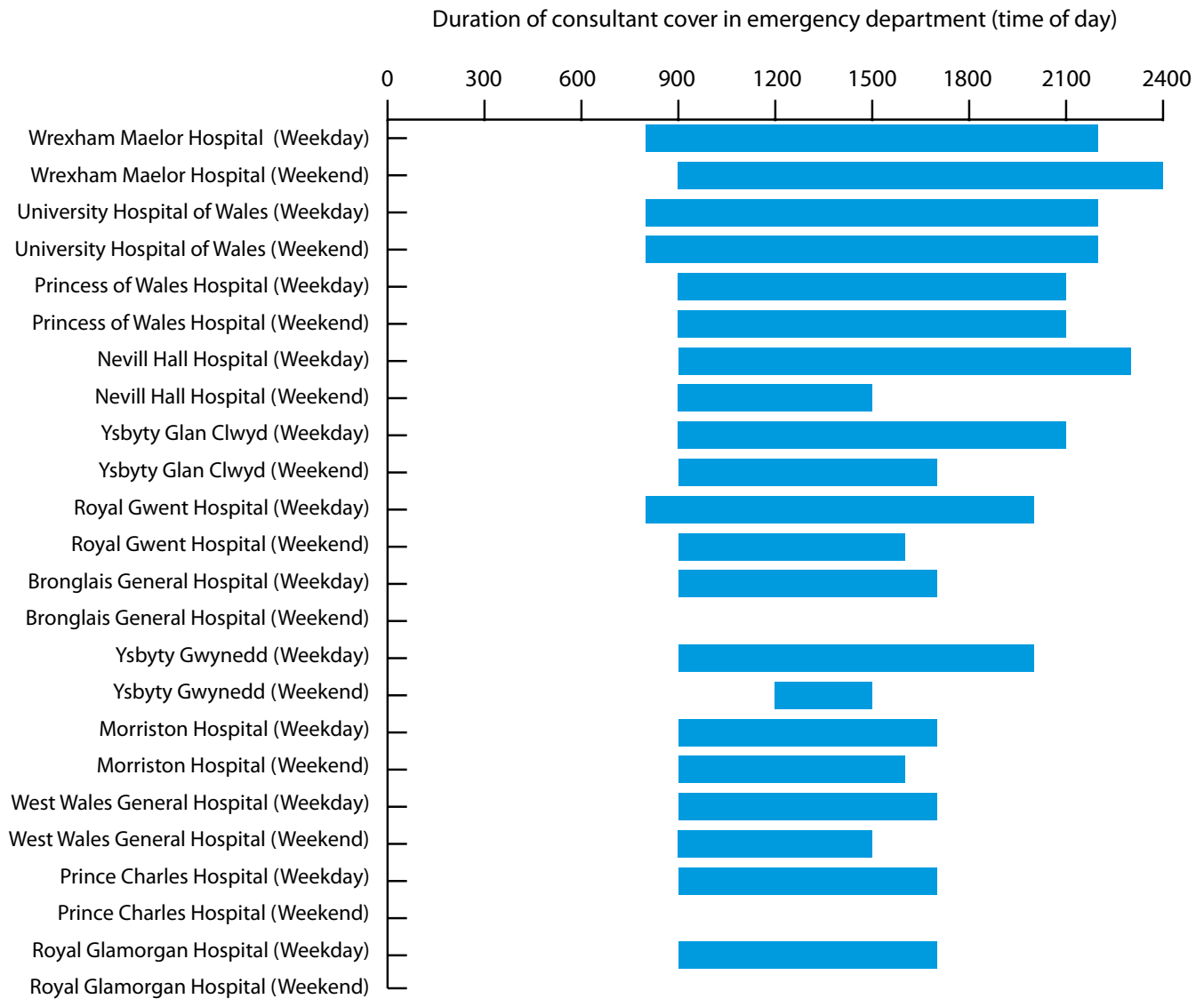
73 The units that had monitored consultant presence were Morriston, West Wales General, Withybush and Wrexham Maelor hospitals.

74 Our analysis here considers only vacancies and does not consider whether vacancies are being temporarily filled with locum staff.

75 The King's Fund, *Avoiding Hospital Admissions*, December 2010



Figure 21 - Hours of consultant presence within emergency departments have increased but no units are meeting the recommendations



Note
 Health boards were asked to provide an answer to the following question: 'Between what hours does your A&E/minor injury unit have a consultant in emergency medicine working within the unit (ie, not on-call)?' Six hours of cover are provided at Nevill Hall but the health board did not specify the start and finish times. There is no consultant cover at weekends at Bronglais, Prince Charles or Royal Glamorgan hospitals. The data were correct as of 30 November 2011.

Source: *Wales Audit Office, survey of health boards*

Recruitment problems in out-of-hours primary care services have forced some centres to close temporarily

- 2.41** Some primary care out-of-hours services are also experiencing problems with recruitment and retention. Services in Aneurin Bevan, Betsi Cadwaladr and Cwm Taf health board areas have struggled to recruit GPs with some out-of-hours centres having to close temporarily to ensure safe staffing levels can be provided at the centres that remain open.
- 2.42** A report⁷⁶ to the national Out-of-Hours Steering Group in April 2012 stated that 'the shortage of GPs willing to work OOH is of crisis proportions' and notes that in November 2011 at least five health boards were struggling to fill shifts. The report said that GPs are less prepared to work in out-of-hours services because the work is seen as 'underpaid, unsatisfactory and unrewarding.' *The Primary Care Out of Hours Review: Interim Report*⁷⁷ stated 'there is a medical manpower crisis in large parts of Wales requiring urgent recognition and actions'. That report recommended that a workforce strategy should be developed to address issues such as reluctance from GPs to working in these services, fixed rates of pay to avoid regional variations, strengthened unscheduled care training for GPs and the roll out of a survey to further understand the views of staff working in out-of-hours services. At the time of drafting our report, the issues arising from the out-of-hours review were being progressed via the Out-of-Hours Subgroup of the National Urgent and Emergency Care Board.

Progress in extending the skills of nurses and paramedics has been slow

- 2.43** Emergency nurse practitioners can play a valuable role in emergency departments as they can work autonomously of medical staff. A potential solution to the lack of emergency department cover caused by medical staff recruitment problems could be to increase the number of ENPs or other practitioners, such as paramedics, with extended skills. In our 2009 report we indicated that there had been limited progress with the development of such roles.
- 2.44** Our analysis of ENP numbers has been hampered by data quality problems, such as different emergency departments using different definitions of what constitutes an ENP. However, our limited data suggest that since 2009, there has been an increase in number of ENPs at 10 of the 13 major emergency departments⁷⁸. We also note that at Cwm Taf Health Board, an advanced emergency practitioner role has been introduced to supplement middle-grade medical staff in emergency departments. However, our fieldwork suggests that some health boards are not making optimum use of these staff's extended skills. The ENPs are sometimes drawn back into core nursing roles to cover gaps in the nursing rota and some ENPs we spoke to said they were not using their extended skills often enough and were therefore not confident in treating patients autonomously. There also continues to be no standard definition of what roles and skills an ENP should have, and no standard definitions of the groups of patients that ENPs can treat. This lack of standardisation creates difficulties for benchmarking and spreading learning across health boards.

⁷⁶ *Out of Hours Review: Interim Report for Out of Hours Steering Group*, April 2012

⁷⁷ *Primary Care Out of Hours Review, Interim Report: Executive summary*, July 2012

⁷⁸ There are limitations in these data, including variable definitions of what constitutes an ENP between different units.



2.45 There has been slow progress in up-skilling ambulance staff so that they are more able to assess and refer patients rather than just transporting them to hospital. In 2009, we noted that the ambulance trust's action plan for unscheduled care stated an intention to develop a new role called 'specialist practitioners' whose roles would include autonomous assessment and treatment of patients with primary care needs, minor illnesses and injuries, social care needs and non-immediately life-threatening conditions. At that time, the trust had begun training these staff with the intention of introducing 30 such roles per year⁷⁹. The trust has since removed the role of specialist paramedic and has now introduced the role of advanced paramedic practitioner (APP) to provide specialist care at the scene or at patients' homes. At the time of our most recent fieldwork, the trust had 21 APPs and 11 trainee APPs. Whilst this represents progress, the trust has not yet managed to introduce a significant body of staff who have extended clinical skills and the intention to introduce 30 such staff a year has not been met. Further discussion of these issues is at [paragraph 2.72](#).

Despite a great deal of focus from health boards, problems with patient 'flow' through the hospital are continuing to place pressure on emergency departments

Emergency departments continue to suffer high levels of pressure because of delayed responses from inpatient teams and delays in finding beds

- 2.46** Steps eight and nine within *Ten High Impact Steps to Transform Unscheduled Care (USC)* focus on the need to improve flow through the emergency departments and improve discharge planning.
- 2.47** The WRPS has highlighted ongoing problems with flow through emergency departments. In its 2011-12 report, *Services Assessment of Clinical Evidence Criteria in High Risk Clinical Areas*, the WRPS said that pressures remain high in emergency departments and that delayed patient throughput was 'continuing to prove extremely challenging'.
- 2.48** Health boards are working hard to improve flow, and between 2010-11 and 2011-12, NHS Wales has secured reductions in average length of stay for coronary heart disease, chronic obstructive pulmonary disease and diabetes as well as reducing elective lengths of stay in orthopaedics and general surgery⁸⁰. Over the same time period, NHS Wales has also reduced lengths of stay for emergency patients in some specific specialties. However, [Figure 22](#) shows that health boards have also been working within the context of reducing bed numbers across all NHS settings.

⁷⁹ Due to the educational requirements of such roles, these staff were due to become operational in 2010.

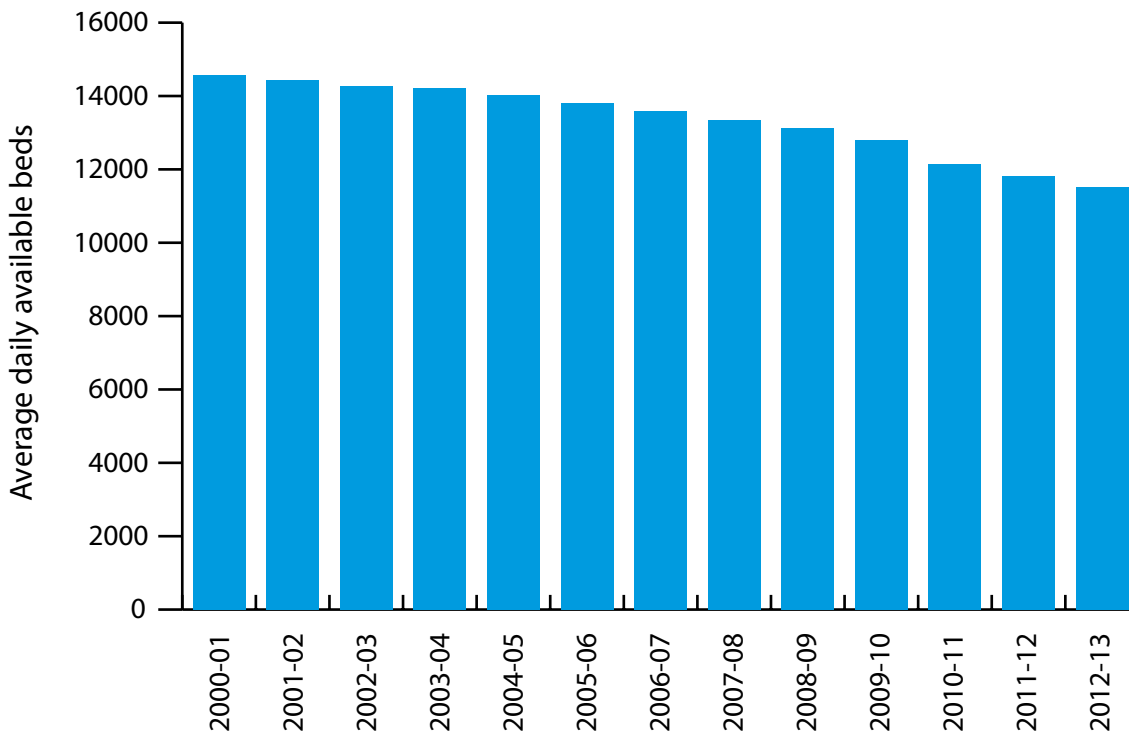
⁸⁰ Welsh Government, *2011/12 End Year Performance Against Tier 1 Priorities – All Wales*

There has been a reduction of 21 per cent in the average daily available beds in Wales between 2000-01 and 2012-13⁸¹.

2.49 Health boards commonly open and close beds temporarily as part of their ‘surge’ capacity to deal with peaks in demand, and permanent adjustments to bed numbers will typically have been informed by service planning and modelling work within health boards. However, during our interviews we were told by some senior clinicians that in some health boards, beds had been permanently taken out of the system too soon as health boards

had not yet carried out the necessary steps to support such a move, such as introducing effective discharge planning processes and strengthening the provision of community services. We have not attempted the complex analysis that would be required to confirm or dismiss this view although we note that the Welsh Government is taking positive action to understand related matters. The Welsh Government’s new work programme for unscheduled care (as discussed in paragraphs 2.63 and 3.55) will include specific actions to improve the understanding of capacity

Figure 22 - Health boards have been attempting to improve patient flow within an environment of reducing bed numbers



Note

These data consider all NHS beds, across all specialties and all settings in Wales.

Source: Welsh Government, Stats Wales, Hlth0303 NHS beds and their use: summary data

81 Welsh Government, Stats Wales, NHS beds summary data by year (Hlth0303), March 2013



across the whole system of unscheduled care. The programme will also include actions to improve the timeliness of decisions about altering capacity of services to address peaks and troughs in demand.

2.50 In 2009 we said that in some cases there was a lack of support for emergency departments from inpatient ward teams and this was delaying the movement of patients from emergency departments to the wards. Our most recent fieldwork suggests that problems continue in relation to inpatient specialties providing timely support for emergency departments. Step eight of *Ten High Impact Steps to Transform Unscheduled Care (USC)* highlights the importance of early specialist review where inpatient ward teams provide quick responses to requests to review patients in the emergency department. However, in general, the time it takes for inpatient ward teams to review patients in the emergency department does not appear to be measured routinely in Welsh hospitals. Aneurin Bevan Health Board has carried out specific monitoring of these times and found that the average time between patients being referred to Medicine at Royal Gwent Hospital and the patient receiving a review by a doctor from that specialty was approximately two hours and forty minutes. The average time between the specialty review and the patient leaving the emergency department was just under four and a half hours.

2.51 In an effort to engender greater support for the emergency department from inpatient ward teams, Cwm Taf Health Board now asks ward sisters to visit the emergency department at Prince Charles Hospital every morning so they can see for themselves the front-door pressures. The health board is

also using an 'elastic ward policy', which at times of pressure should allow patients to be transferred from the emergency department to the ward, even if a ward bed is not available⁸². However, at the time of our fieldwork we found that the policy was rarely used and staff were reluctant to comply with it. At Morriston Hospital, Abertawe Bro Morgannwg University Health Board has introduced clinical interface meetings in an effort to encourage greater ownership of unscheduled care from the in-house specialties and to improve dialogue between the emergency department and the in-house specialties but these meetings appear to have been largely ineffective. **Box 3** gives details of a communication alert system used in some English hospitals to improve the support for the emergency department from the ward-based clinicians.

2.52 Patients can face considerable delays in the emergency department even after a clinician has seen them and decided they should be admitted. Data provided to us by the health boards shows that in 2010-11, at two emergency departments, patients waited on average, more than four hours for their admission to the wards following a clinician's decision to admit. With such delays in admitting patients, there can be little hope of achieving the four-hour waiting time target.

2.53 We recognise that health boards have attempted to improve the situation in a number of ways, including:

- a** Placing a senior manager within the emergency department to facilitate flow.
- b** Capital investment in the emergency department to improve layout and increase the number of treatment areas.

⁸² The elastic ward policy is part of the health board's emergency pressure escalation plan and allows patients to be transferred to a ward where another patient is scheduled to be discharged within four hours but has yet to leave the ward. Transferred patients are cared for on a trolley in a bay or treatment room.

Box 3 - Communication alert systems are securing faster clinical decisions, improving patient care, releasing bed days and reducing admission rates

In order to speed up senior clinical decision making and ensure that patients are not admitted unnecessarily, some hospitals in England have introduced communication alert systems.

These system works by alerting nominated clinicians via emails, phone calls, text messages, bleeps or faxes when they are required to come and see a patient in the emergency department, assessment unit or elsewhere in the hospital.

The alerts include important information such as the patient name, when they arrived, where they are now and where they may be admitted to.

By specifying expected response times, these systems aim to guarantee that the patient will see the specialist clinician within a set timeframe. Different hospitals have taken different approaches to communication alerts and the timeframes for response vary from 4 to 24 hours.

Case studies on the NHS Improvement website give examples of schemes starting small by using the system for only one type of patient in one hospital, but then the schemes have expanded to be used for several types of patients over several hospital sites.

Most organisations have found that the cost of communication alert systems are minimal and are offset by cost savings as a result of reducing the use of bed days.

Key success factors include:

- mapping the current admission routes to understand where demand for the alert system might come from;
- involving IT staff in the project as soon as possible;
- clearly specifying timescales for response and clearly specifying what the clinician's response should be in certain situations;
- ensuring there are very clear responsibilities for placing alerts and for responding to alerts, at all times of the day;
- evaluating the system using clear and robust metrics; and
- assessing patient experience.

Source: NHS Improvement, *Making connections with the challenges of unscheduled care*
www.improvement.nhs.uk/documents/Unscheduled_Care.pdf
www.improvement.nhs.uk/cancer/LinkClick.aspx?fileticket=RzT1ZHOyEk0%3d&tabid=105



- c Opening additional beds (referred to as surge capacity) on the wards during times of high pressures in the emergency department.
- d Changing the working practices of CRTs so that they reach inwards to the emergency department and avoid unnecessary admissions, as well as continuing to facilitate discharges.
- e The introduction of a transport service to allow emergency department patients to return home who might otherwise have been admitted for social reasons.
- f Filtering all GP referrals for admission and assessment to the bed management team. The central coordination approach aims to prevent unnecessary admissions by offering alternatives such as same day appointments with consultants in an outpatient department or medical day unit.

2.54 The service model encouraged by *Ten High Impact Steps to Transform Unscheduled Care (USC)* includes a CDU integrated with the emergency department. The theory behind these units is that patients with specific conditions can be rapidly assessed and receive rapid investigations and treatment that is largely defined by protocols and pathways. The culture of such units should be such that only patients meeting specific entry criteria are admitted to the unit and that unscheduled admissions via the short-stay unit should be the exception and not the rule. By ensuring the CDU and emergency department are integrated, the theory is that they are managed as a whole and work effectively together, rather than competing

against one another. Whilst we did not carry out any in-depth analysis of CDUs we note that these units have recently been introduced at several acute hospitals. We found a mixture of positive and negative issues in relation to the current effectiveness of CDUs. Some problems were evident in relation to limited capacity in medical staffing, as well as strained relationships between CDU staff and emergency department staff because of competing pressures for beds. Work from the WRPS found that where CDUs or observation wards are successful in improving patient flow this tended to be where staff adhere to strict entry criteria for patients⁸³. Where the units are used to accommodate patients whilst they wait for speciality beds this often results in a bottleneck and poor patient flow and experience.

The proportion of attendances that result in admission is generally within or below the typical range although admission is particularly likely as patients are about to breach the four-hour waiting time target

2.55 Guidance from the CEM⁸⁴ in 2011 stated that in emergency departments with a normal casemix, the proportion of attendances that result in admission (conversion rate) had risen from 15-20 per cent to 25-30 per cent over the past five years. High conversion rates can contribute to problems with patient flow because of the additional demands that are placed on the hospital's inpatient beds. Public Health Wales Observatory's analysis of data from EDDS shows that in 2011-12, all major emergency departments in Wales had conversion rates that were within, or below, the typical 25-30 per cent range described by the CEM.

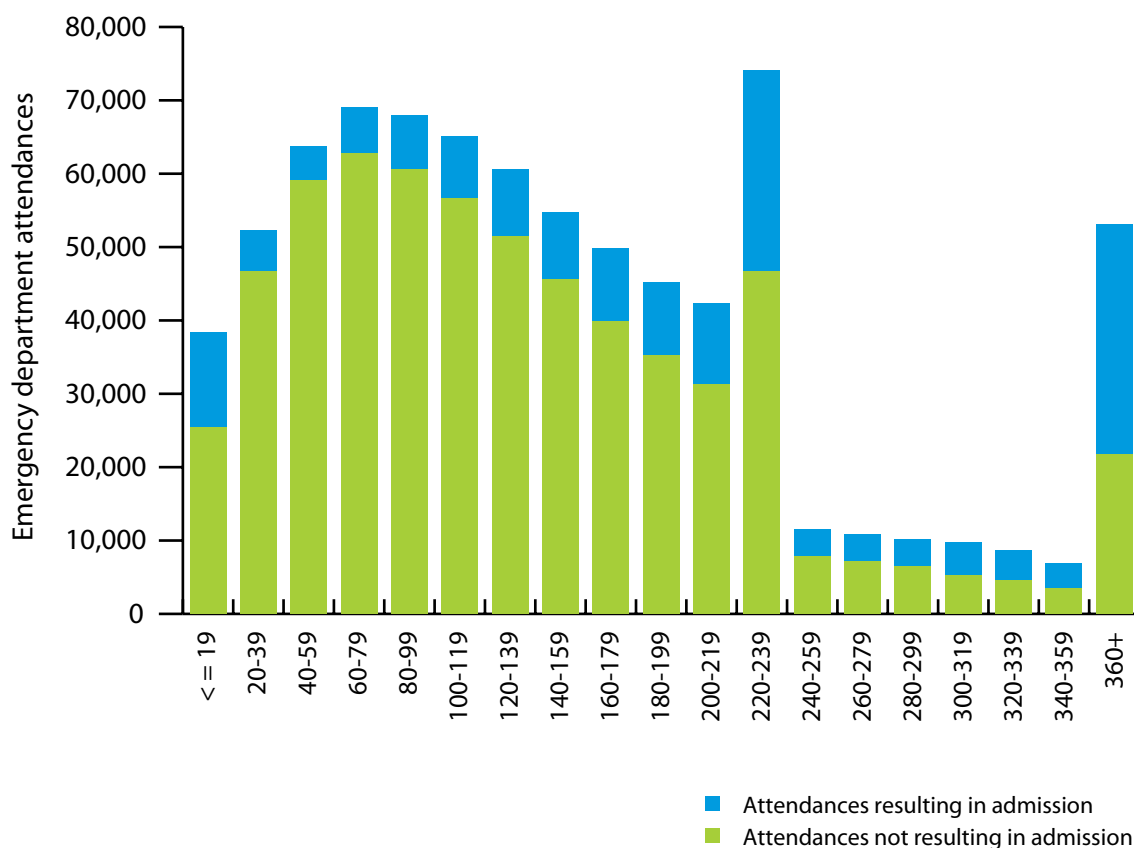
83 Welsh Risk Pool, *Services Assessment of Clinical Evidence Criteria in High Risk Clinical Areas*, 2011-12

84 College of Emergency Medicine, *Emergency Medicine Operational Handbook: The Way Ahead*, Version 2, December 2011

2.56 Further analysis from Public Health Wales Observatory suggests that emergency department patients are more likely to be admitted after a waiting time of just under four hours. **Figure 23** shows, at just under four hours (220 to 239 minutes), there is a marked peak in the proportion of attendances that resulted in admission. Whilst we have not carried out detailed analysis of the causes

for this peak, we consider it likely that the peak is related to the focus within emergency departments on avoiding breaches of the four-hour target. Public Health Wales has advised us that there are data quality issues associated with **Figure 23** and these issues relate to the completeness of data within the EDDS. The figure therefore needs to be treated with caution.

Figure 23 - People who waited just under four hours in the emergency department were more likely to be admitted to a hospital bed



Note
 The figure shows emergency department attendances by duration in minutes, for departments in Wales during 2011-12.
 Source: Public Health Wales analysis of data from the Emergency Department Data Set



Problems remain in ensuring effective discharge and there are ongoing difficulties associated with joint working between health and social services

- 2.57** Our fieldwork did not involve an in-depth assessment of discharge processes but we did identify some general problems with the effectiveness and timeliness of discharge. We found that health boards are attempting to mainstream the use of estimated date of discharge to ensure that discharge is properly planned and prepared for well in advance. However, we found that where estimated dates of discharge are used, they are often unrealistic and fall well short of the actual discharge dates.
- 2.58** Data from the Welsh Ambulance Services NHS Trust that shows the majority of health boards' requests for ambulance transport for discharges are booked on the day of discharge. Approximately 60 per cent of requests for ambulances to support discharge are booked on the day of discharge and approximately 80 per cent of requests for transfers to other hospitals are made on the day. This shows that discharge is still being managed reactively, rather than proactively.
- 2.59** Many health boards are trying to ensure that ward rounds happen earlier in the day so that discharges happen sooner. Actions taken to ensure early discharge include reviews of physician job plans, requests to specialties to carry out early-morning rounds and use of the All-Wales Bed Management Toolkit. Upon releasing £10 million in central funding for unscheduled care initiatives in July 2012, the Welsh Government stated an expectation that as a minimum, 20 per cent of patient discharges should take place before noon.
- In our fieldwork interviews we were told that in general, early ward rounds are not happening consistently and the proportion of discharges that happen before midday remains low.
- 2.60** Potentially more important than discharges happening early in the day, is the need for discharges at weekends. Our 2009 report emphasised that one of the key strengths of hospital emergency departments is that they operate 24 hours a day, seven days a week. However, the effectiveness of emergency departments can rely heavily on the performance of the rest of the hospital and if the other hospital departments operate a reduced service at weekends this causes significant problems for the unscheduled care system. Modelling work from the DSU has shown that even a small increase in the number of discharges at weekends can have significant benefits for patient flow and reducing pressures within the emergency department for the whole of the subsequent week. NHS Improvement in England has highlighted a number of successful case studies⁸⁵ where significant benefits have been secured for patients and for health bodies, by extending various health services across the whole week.
- 2.61** The need to move towards seven-day working is supported by a recent report from the Academy of Medical Royal Colleges⁸⁶ that sets out three patient-centred standards that emphasise the importance of daily consultant reviews of patients, seven days of the week.
- 2.62** Difficulties at the interface between health and social care can also contribute to delayed discharges from hospital. Our work did not focus in detail on these matters; however, we are aware that delayed transfers of care⁸⁷ are

⁸⁵ These case studies can be found at: www.improvement.nhs.uk/sevendayservices

⁸⁶ Academy of Medical Royal Colleges, *Seven day consultant present care*, December 2012

⁸⁷ Delayed transfers of care are experienced by hospital inpatients, when they are ready to transfer to the next stage of care, but this is prevented by one or more reasons. Delayed transfers of care have negative impacts on the people who become delayed, with significant implications for their independence. Delayed transfers of care also have an impact on wider service delivery and performance across the whole health and social care system but the immediate effects manifest themselves within hospitals.

increasing in some areas of Wales, although the overall trend in Wales is downwards. Our fieldwork suggests that some of the fundamental difficulties we highlighted in our 2007 report on delayed transfers of care⁸⁸ remain today. National data also show that between 2009-10 and 2011-12, the rate at which local authorities support older people in the community has decreased by nine per cent⁸⁹. During interviews with health staff, we heard that hospitals continue to have many patients who are ready to be discharged and remain in hospital because of difficulties at the interface between health and social care organisations. These difficulties typically involve funding, assessments for the ongoing care people require and a lack of availability of places in the care home of their choice.

2.63 Our fieldwork revealed some positive examples of health and social care services working together but in general there is still much work to do to provide a truly joined-up approach to community based care as a means of helping avoid unnecessary hospital admissions and facilitating timely discharge. In 2012, the Welsh Government consulted on the Social Services and Well-being (Wales) Bill. The consultation document⁹⁰ rightly recognised the urgent necessity for a step change in integrating health and social care services, particularly for frail, older people with complex needs. The document also proposes that the bill will extend the duty on social services and the NHS to collaborate in the delivery of integrated services. The bill therefore provides a key opportunity to ensure much better joint working on behalf of citizens. We note that the Welsh Government's new work programme (as discussed in [paragraphs](#)

[2.49 and 3.55](#)) for unscheduled care includes a specific objective of creating an 'integrated health and social care system for unscheduled care where priorities are aligned and owned by all sectors'. And we note that in a statement to the Senedd on 23 April 2013, the Minister for Health and Social Services mentioned plans to prevent delayed discharges when health and social care organisations cannot agree on the financial responsibility for providing certain types of care.

The Welsh Ambulance Services NHS Trust continues to face difficulties that impact on the whole system of unscheduled care but some of the key difficulties cannot be addressed by the trust in isolation

2.64 Ambulance services form a fundamental part of the unscheduled care system. The timeliness of ambulance responses to 999 calls is critical to saving lives and giving people the greatest chance of recovery. The ambulance service provides a key link in the transfer of patients and in contributing to patient flow in hospital by providing transport home for discharged patients. The ambulance service also has a vital role to play in managing demand within the system because it is often the first port of call for patients seeking help. If these people are guided to the most appropriate place as soon as possible, this has benefits for the patient as well as for those providing services.

88 Wales Audit Office, *Tackling delayed transfers of care across the whole system – Overview report based on work in the Cardiff and Vale of Glamorgan, Gwent and Carmarthenshire health and social care communities*, 1 November 2007

89 Stats Wales, National Strategic Indicators, NSIW0001, The rate of older people (aged 65 or over) supported in the community per 1,000 population aged 65

90 Welsh Government, *Consultation Document, Social Services (Wales) Bill, WG14266*, 12 March 2012



2.65 Difficulties experienced within the ambulance service can have negative impacts on the wider unscheduled care system. For example, if the ambulance service cannot provide timely transport home for patients being discharged from hospital, this affects patient flow in the hospital. And if patients are brought to an emergency department by ambulance when they could have been better cared for elsewhere, this means demand is in the wrong place within the system. Equally, problems elsewhere in the system can have major impacts on the ambulance service and its ability to provide timely responses to emergencies. The following sections that discuss the performance of the ambulance trust must therefore be considered within the context of rising demand for ambulance services and increased problems with delayed handovers at hospital emergency departments.

2.66 In November 2012 the Minister for Health and Social Services announced plans for a strategic review of the ambulance service. The announcement followed concerns about the ambulance service's emergency response time performance and financial difficulties. The review's report was published in April 2013 and proposed a number of options for strengthening the provision of ambulance services in Wales. The foreword to the report stated 'Ambulance services are one part of health and social care and, as such, they are just as much impacted upon by that system as they themselves impact upon it. The whole of the unscheduled care system is under very severe pressure affecting the staff who deliver, and patients who receive health care services.'

The Minister for Health and Social Services provided Assembly members with his first response to the review in May 2013⁹¹ and in a further update in July 2013 it was announced that ambulance services will be commissioned by health boards in order to create a clearer and more transparent set of arrangements for planning, finding and monitoring service delivery.

2.67 The Wales Audit Office has previously carried out a large body of work looking at ambulance services in Wales^{92, 93, 94}. Our current report does not provide a detailed review of the Welsh Ambulance Services NHS Trust but our fieldwork, as well as our programme of annual structured assessments of the trust, has highlighted a range of issues pertinent to improvement in unscheduled care. These issues are discussed in the following paragraphs.

Ambulance performance remains fragile and demand is increasing but there has been slow progress with up-skilling ambulance staff and there is a need to accelerate the joint development of pathways

2.68 Part 1 of this report highlighted the fragility of ambulance service performance in Wales and the challenges of rising demands being placed upon the ambulance trust. Despite a long-term improvement in emergency response time performance, there was deterioration during 2012-13. Unwarranted regional variation in performance continues and other, broader measures suggest that performance levels are lower than expected.

91 Minister for Health and Social Services, *Written Statement – Response to Strategic Review of Welsh Ambulance Services*, 23 May 2013

92 Wales Audit Office, *Ambulance Services in Wales*, December 2006

93 Wales Audit Office, *Follow up review – Ambulance Services in Wales*, June 2008

94 Wales Audit Office, *Ambulance services in Wales – further update to the National Assembly for Wales' Audit Committee*, March 2009

2.69 The introduction of the new Clinical Response Model (CRM) in December 2011 aimed to modernise services through revising the trust’s workforce profile and skill mix, as well as its fleet, IT and estate. The underlying principle of the CRM is to ensure that clinical decision making is right in the first place to improve the prioritisation of calls which should lead to more rapid responses, increases in efficiency and better patient outcomes. An important aspect of the CRM is the revised categorisation of emergency calls, introduced by the trust in December 2011 to address the Welsh Government’s new National Ambulance Performance Standards. Instead of using categories A, B and C, calls are now categorised as Red 1, Red 2, and Green 1, 2 and 3. **Figure 24** provides further explanation of the new call categories.

2.70 The re-categorisation of calls, alongside the other aspects of the CRM, aims to ensure that patients’ needs are more clearly defined and that the ambulance response they receive is more appropriately aligned to their needs. In defining the ‘green’ category of calls, the trust has reviewed the types and numbers of conditions that it now refers for telephone triage and assessment, rather than sending an ambulance. The trust now diverts some 999 calls to NHS Direct Wales nursing staff who conduct telephone triage and then provide self-care advice or referral to another healthcare provider. **Figure 25** shows there has been a marked increase in the number of calls transferred to nursing staff for telephone triage since 2010 and the number stabilised during 2012.

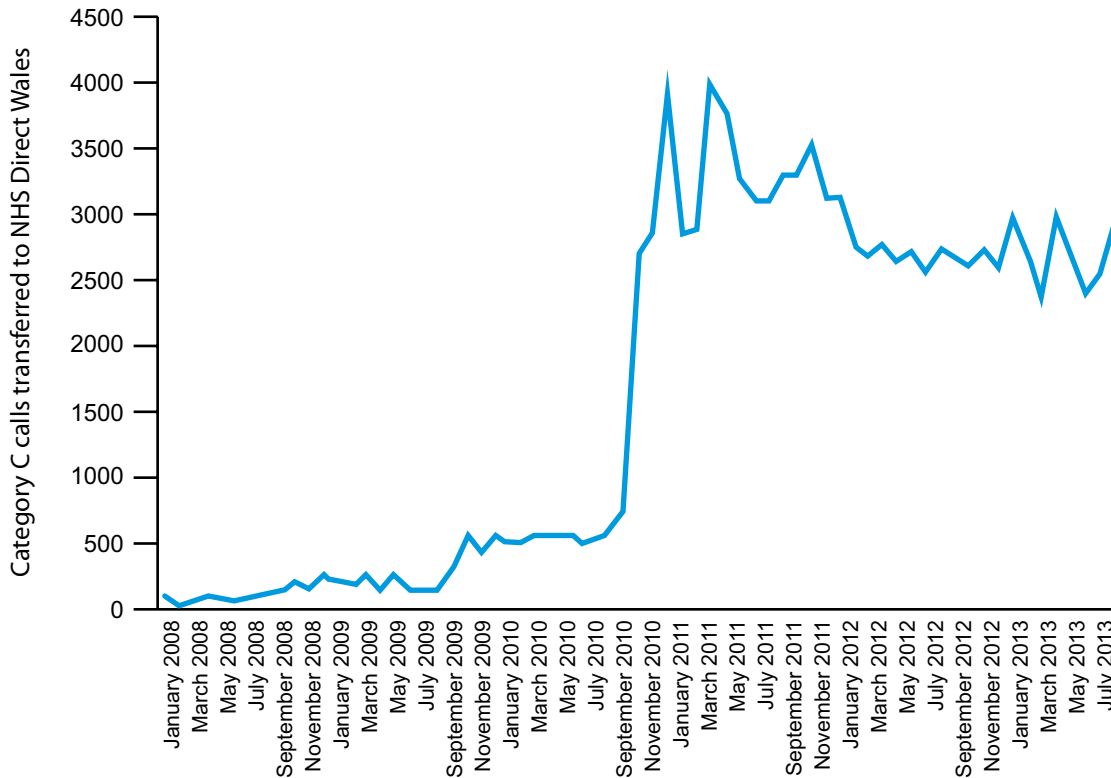
Figure 24 - New national ambulance standards have resulted in changes to the categorisation of calls

Previous standard	New trust categorisation
Category A (where there is imminent threat to life)	Red 1 and Red 2
Category B (serious but not immediately life-threatening calls)	Category B has been removed, with calls re-categorised as either red or green
Category C (urgent and planned) (serious but not life threatening and/or neither serious or life threatening)	Green 1, 2 and 3 Breaking down Category C further – categorised by seriousness of complaint

Source: Wales Audit Office, *Structured assessment and transforming unscheduled care: Welsh Ambulance Services NHS Trust, June 2012*



Figure 25 - Many more ambulance calls are now transferred to nursing staff for telephone triage and assessment



Source: Welsh Government/Welsh Ambulance Services NHS Trust

2.71 The ambulance trust has made progress in reducing the proportion of calls that result in a patient being conveyed to hospital. This conveyance rate has reduced from 71 per cent in 2009-10 to 65 per cent in 2012-13. However, there is scope to improve further by providing definitive treatment for patients at the scene of the incident. The percentage of patients treated at the scene with no transport required has reduced steadily from 17.8 per cent in 2009-10 to 11.9 per cent in 2011-12. Performance remains well below the trust's target of 20 per cent.

2.72 To secure a sustained reduction in the proportion of patients it transports to hospital the trust must transform its workforce profile and skill mix. Paragraph 2.45 highlights the limited progress there has been in up-skilling the trust's workforce. The trust is developing a new clinical strategy, workforce plan and competency frameworks that aim to increase the clinical skills of the workforce. The competency frameworks set out the expanded range of diagnostic, assessment and referral skills that will be required from all paramedics and technicians. At the time of our fieldwork,

the workforce plan was in its infancy and whilst the competency frameworks were due to be ratified in September 2012, the trust did not respond to our requests about whether or not this timescale had been met. Overall, these developments are positive steps but these issues are far from new and there will be no actual service improvement until effective plans are implemented.

2.73 In addition to up-skilling its staff, the solutions to transporting fewer people to emergency departments lie in partnership working with health boards to develop alternative pathways. The Welsh Ambulance Services NHS Trust is working with health boards on an encouraging pilot project to allow paramedics to refer patients directly to another health or care service if they are suffering from one of three specific conditions⁹⁵. At the time of our fieldwork there had not been a comprehensive evaluation of the pilot work but between 10 September 2012 and up until 28 November 2012 it had prevented 242 patients being conveyed to hospital by referring them to their GP or to a CRT. In providing his first response to Assembly members on the strategic review of ambulance services, the Minister for Health and Social Services said in May 2013⁹⁶: 'I expect Local Health Boards to work with partners to accelerate development of alternative and community care pathways for a range of conditions over the next 6 months'.

2.74 Difficulties in providing timely ambulance responses are resulting in too many patients being conveyed to hospital by the fire and police services. We raised the issue of these adverse incidents in our 2006 report⁹⁷ on ambulance services which showed that a minimum of 90 patients were conveyed to

hospital by fire and police services between January and August 2006. Between January and August 2012, a minimum⁹⁸ number of 85 patients were conveyed in this way.

The ambulance service continues to suffer considerable difficulties as a result of delayed patient handovers at hospital emergency departments

2.75 Paragraphs 1.10 to 1.12 show that the number of patients experiencing delayed handovers has been increasing in Wales and so has the frequency of severely delayed handovers. Our recent structured assessment of the ambulance service said that approximately 55,000 crew hours were lost in 2010-11 due to delayed handovers at hospital emergency departments and the estimated cost of delays in turn-around times for 2011-12 was £2.7 million.

2.76 Our 2009 report on patient handovers made a number of recommendations to improve the handover process. During our most recent visits to the 13 major emergency departments in Wales we carried out some observations to assess whether our recommendations had been implemented. Some of our findings are listed below:

- a** Health boards have taken a mixture of approaches to their model for receiving handovers from ambulance crews. Eight units have a dedicated member of staff responsible for taking the handover from ambulance crews, varying from the emergency department clinical manager, an ambulance liaison nurse, a specific triage nurse or a corridor nurse who is responsible for managing patients in a corridor.

⁹⁵ Resolved hypoglycaemia (diabetes), resolved epilepsy and patients who have fallen but have no significant injuries.

⁹⁶ Minister for Health and Social Services, *Written Statement – Response to Strategic Review of Welsh Ambulance Services*, 23 May 2013

⁹⁷ Wales Audit Office, *Ambulance Services in Wales*, 4 December 2006

⁹⁸ These data include only the occasions where fire and police services have reported to the Joint Emergency Services Group that they have conveyed people to hospital. This figure is therefore a minimum number and in reality, there are likely to have been more patients transported to hospital than reported.



- b** The ambulance trust has taken a mixture of approaches in placing specific staff in emergency departments to assist with handover. At some units and often only during busy periods, a locality ambulance officer has come to the unit to take over the care of patients and free up crews to go back on the road. The officer sometimes also had a role in facilitating discharge of patients from the wards to help with patient flow.
- c** Five units do not have posters in the department to inform staff about the local protocols/arrangements for patient handovers. We had suggested that posters would help clarify the responsibilities of staff from the hospital and from the ambulance service in the handover process. The posters would also help crews that have arrived at a hospital they are not familiar with.
- d** At two emergency departments, ambulance staff had concerns that suggested some emergency department staff were so keen to show that they were managing handovers effectively that they were prematurely recording that handovers had been completed.

2.77 The Welsh Government has stated an expectation that NHS Wales will take a zero-tolerance approach to handovers taking longer than an hour and the Ambulance Service Network has also stated that a zero-tolerance approach should be taken to all handover delays and has produced guidance including examples of good practice.⁹⁹ We also note that the Welsh Government's *Delivery Framework for NHS Wales for 2011-12*¹⁰⁰ 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. Work has also begun by the National Urgent and Emergency Care Board to consider whether the National Early Warning System (NEWS)¹⁰¹ can be used to ensure that handovers are measured in a more intelligent way to ensure efforts to speed up handovers focus on the sickest patients. These new measures of handover performance are in their infancy and are not yet being used across Wales.

2.78 Other examples of improvement actions focused on reducing the extent of delayed handovers include:

- a** The use of a flow chart at the emergency department in Princess of Wales Hospital which clinicians use to decide whether certain ambulance patients have sufficiently minor or stable conditions that they can be taken to the general waiting room and therefore do not need to remain on an ambulance trolley.
- b** The use of the national Launchpad system (see [paragraph 1.36](#) and [Box 9](#) on [page 86](#)) is a positive step as this provides NHS Wales with live information about the extent of handover delays in all units.
- c** The introduction of automatic alerts to health board executives when handovers are particularly delayed at emergency departments. The national system ensures executive leads are sent an email if ambulances are delayed by more than 30 minutes at one of their emergency departments and if delays exceed an hour, the alert is escalated automatically to the chief executive.

⁹⁹ www.nhsconfed.org/Publications/Documents/Zero_tolerance061212.pdf

¹⁰⁰ NHS Wales, *Delivery Framework for 2011/12*, August 2011

¹⁰¹ NEWS was introduced to Wales as part of a United Kingdom-wide agreement and is now used by the Welsh Ambulance Services NHS Trust as well as staff in emergency departments. The system provides a common language to describe the condition of patients and aims to ensure that the risks of a patient deteriorating are understood by everyone involved in a patient's care.

Broad and sustained improvement in the ambulance service is threatened by remaining cultural and organisational challenges

2.79 The ambulance service continues to suffer financial challenges. In January 2013, the Board of the Welsh Ambulance Services NHS Trust received a paper stating at month nine of 2012-13 the trust was in deficit of approximately £1.6 million. Local audit work by the Wales Audit Office also commented on complications caused by delays in finalising the trust's budget, and highlighted the need for a strategy to be agreed for negotiating future funds with the trust's healthcare partners to ensure that revenue is agreed in advance of the financial year starting.

2.80 The organisation continues to struggle with matching supply and demand. Whilst the CRM provides considerable opportunities, it has not been fully implemented in the south east of Wales. The CRM requires double-crewed ambulances to attend red calls but the south east region's fleet includes a large number of rapid response vehicles, which it continues to depend upon to respond to emergency calls. Our previous work commented on the need to change staff rotas to better match capacity and demand. Whilst the trust now has a rota review framework, the traditional rotas continue and the trust has not actually managed to secure any significant change to the hours worked by paramedics.

2.81 Our interviews with ambulance trust staff indicated that the negative aspects of culture and morale which we identified in our 2009 review are still present. Interviews with paramedics and technicians at emergency departments showed that 45 out of 75 staff members we spoke to said that morale was much worse or slightly worse than a year

ago¹⁰². We have noted that sickness absence rates had increased from 6.55 per cent to 6.77 per cent between the periods of August 2010 to July 2011 and August 2011 to July 2012.

2.82 There is continued scope to improve the way the ambulance service and its partners work together to improve unscheduled care. We acknowledge that there are potentially significant benefits from the recent restructure of the ambulance service to remove the three regions and introduce heads of service whose areas of remit are coterminous with those of the health boards. Each health board now has a specific, senior person to link with as part of partnership work. There are also potential benefits through the trust's chief executive being named as the joint lead for unscheduled care in Wales. Nevertheless, there is still a perception within the ambulance service that health boards do not consider it an equal partner within the decision-making agenda in Wales. More effective joint working between the trust and its partners is essential, particularly in relation to the plans for reconfiguring acute services across Wales. These plans are likely to result in a change to the locations of services which will have major impacts on the ambulance service. It is vital that health boards and the ambulance service work completely in unison to jointly own the local performance of the unscheduled care system.

¹⁰² Ambulance staff were asked: 'How would you describe morale now compared with this time last year?' The options were 'much better', 'slightly better', 'the same', 'slightly worse' and 'much worse'.



Part 3 - National and local NHS leaders are clearly committed to improving unscheduled care but real transformation will require greater focus on the whole system, better care coordination, change in primary care and a sustainable configuration of hospital services

3.1 This part of the report focuses on what we see as the major opportunities that the Welsh public sector now needs to grasp to ensure that people receive better unscheduled care in future.

The 111 call service is to be introduced and could have significant benefits but a decision on how the service will work has been delayed so that lessons can be learnt from England

3.2 In December 2011, the Welsh Government decided in principle to launch a three-digit phone number for urgent, non-emergency care in Wales¹⁰³. While there is not yet a clear plan for exactly how the 111 service would work, the basic premise is that it would provide a service for callers who needed medical help and advice fast but where the problem was not life threatening or one which required a 999 emergency ambulance. The service would be staffed by trained advisers who would assess callers' problems and either give healthcare advice over the phone, or direct callers to the local service that can best help them.

3.3 The introduction of the 111 service has a number of potential benefits¹⁰⁴:

- a** It could provide a care coordination function that is key to the step three of the *Ten High Impact Steps to Transform Unscheduled Care (USC)*. The care coordination could involve a telephone-based assessment process that is agreed with all partner organisations. This would minimise the repeated reassessments that patients sometimes face when their episode of care takes them to more than one service. The care coordination function could also provide a central point to access information on the patient's medical history and it could provide scheduling of appointments in scheduled care services where the assessment reveals an immediate response is unnecessary.
- b** It could avoid confusion and misplaced demand by signposting people to the most appropriate services and by simplifying contact points with the NHS.
- c** The introduction of the service could result in the collection of a large amount of helpful management information about demand for unscheduled care, and the range of services which are needed to meet this demand.

¹⁰³ Department of Health and Social Services, Chief Executives' Meeting, CEO(30)09

¹⁰⁴ The NHS Alliance document, *Getting to grips with integrated 24/7 emergency and urgent care*, October 2012, provides further detail regarding the potential risks and benefits of any such telephone service.

- 3.4** However, there is disquiet in some quarters about the introduction of a 111 service in Wales. The General Practitioners Committee in Wales has expressed concerns that centrally-based call-takers would not have sufficient local knowledge to assist callers. Members of the All-Wales Out-of-Hours Forum told us of their concerns that 111 could result in increased, unplanned demand within primary care. The Welsh Ambulance Services NHS Trust also considers there to be unanswered questions about the links between 111 and the dispatch of emergency ambulances. If a patient calls 111 but needs an emergency ambulance response, the trust is concerned that there may be delays that impact on patient safety.
- 3.5** The recently reported problems with the 111 service that has been introduced in England would suggest that stakeholders in Wales are right to express caution about the introduction of a similar service in Wales. Problems in England have been reported with delays in responses and abandoned calls potentially putting patients at risk. There have also been reports of the 111 service resulting in a surge of A&E attendances, and also inappropriate calls to ambulance services.
- 3.6** Formal evaluations of the 111 pilots in England have indicated a mixed picture of the potential benefits and risks¹⁰⁵. The Welsh Government has taken the pragmatic approach of waiting until the results of the pilots have become clearer before deciding on whether and how to roll out a 111 service in Wales.
- 3.7** Any model of 111 service would almost certainly fail without an effective directory of service. Our 2009 report recommended that a directory of service should be maintained and regularly updated to ensure common and up-to-date understanding of what services are available. This would have benefits for patients but also for staff who might not know what services are available. There has been little progress with this issue and a particular barrier is in deciding which organisations should be responsible for maintaining such a directory.
- 3.8** There also remain unanswered questions about whether the 111 service will be integrated with communications hubs, NHS Direct Wales' services and local government telephone services. Integrating such telephone services could simplify access to a wide range of services and could result in efficiency savings through economies of scale. However, the pattern and operating model of these other services differs in different parts of Wales and achieving integrated delivery of telephone services for callers with urgent care needs would still seem to be a long way off.
- 3.9** The Welsh Government had originally planned to develop costed options for implementing 111 by October 2012. This deadline has passed and there are not yet any costed plans in place. In a statement to the Senedd on 23 April 2013, the Minister for Health and Social Services said that the planning of 111 will now be accelerated. The Welsh Government has told us that there will be a phased approach to implementing 111 with a target date for completion in 2015.

¹⁰⁵ University of Sheffield, *Evaluation of NHS 111 pilot sites: Final report, August 2012*



Optimising the unscheduled care capacity that already exists in GP services could have major benefits for patients and for those delivering services

3.10 General practice is at the very core of the unscheduled care system. General practitioners and other practice staff are working hard to deliver approximately 5.5 million unscheduled care encounters with primary care and general practice every year in Wales¹⁰⁶. Such is the importance of the role played by GPs, even a small improvement in the efficiency and effectiveness of these services can have large-scale benefits for patients and for those providing services. This point is emphasised in intercollegiate guidance entitled the *Silver Book*¹⁰⁷ which states that: 'A timely primary care response can avert the need for a hospital attendance; for example, a 1% decrease in the primary care response to a crisis can lead to a 20% increase in demand in secondary care. This is a consequence of the gearing effect of the different urgent care delivery between primary and secondary care.' We recognise that GPs are independent contractors and as such, there can be complications when the health boards and the Welsh Government seek to change the way GPs work. However, this section highlights where opportunities exist to make better use of capacity within primary care as part of a whole-systems approach to unscheduled care.

There is potential for improved patient experience and reduced pressures on staff by strengthening local arrangements for same-day access to primary care

There remains much work to do to optimise access within core hours and some examples of extended opening hours may not be providing value for money

3.11 In paragraphs 1.2 to 1.5 we have presented evidence that there is scope to improve access to primary care appointments. Step four of *Ten High Impact Steps to Transform Unscheduled Care (USC)* is to improve urgent primary care access by encouraging practices to improve same-day access to primary care by implementing the recommendations of the Primary Care Foundation.¹⁰⁸ That work is supported by the Royal College of General Practitioners. Our primary care survey showed that just 16 per cent of practices were aware of the work by the Primary Care Foundation and fewer still (13 per cent) had used the work to review their access arrangements. **Box 4** provides sources of information on actions that practices and health boards can take to improve urgent access to primary care.

3.12 A basic way in which access can be improved is by all practices ensuring they have appointments available to the public during their core hours.¹⁰⁹ The Welsh Government's Annual Operating Framework¹¹⁰ for 2010-11 established a national requirement for health boards to review the opening hours of all practices. National data¹¹¹ suggests only 35 per cent of practices were open for their full

¹⁰⁶ National Unscheduled Care Programme Board, *Ten High Impact Steps to Transform Unscheduled Care (USC)*, June 2011

¹⁰⁷ Various authors, *Quality Standards for the Care of Older People with Urgent and Emergency Care Needs: the Silver Book*

¹⁰⁸ Primary Care Foundation, *Urgent Care – a practical guide to transforming same-day care in general practice*, May 2009

¹⁰⁹ Services provided by general practice are specified by the General Medical Services (GMS) contract which covers Monday to Friday, 8am to 6:30pm. The contract specifies that services should be provided to meet the reasonable needs of patients. It does not require GP practices to be open, or appointments to be available, for the duration of the contracted hours.

¹¹⁰ NHS Wales, *Annual Operating Framework 2010/2011*. The Annual Operating Framework has been used by the Welsh Government as one of the main mechanisms for setting out priorities and driving transformation and performance improvement within NHS Wales.

¹¹¹ Welsh Government, *Statistics for Wales, GP Access in Wales 2012*, SDR 31/2013, 26 February 2013

daily core hours¹¹² although this represents an improvement from 31 per cent in 2011. Eleven per cent of practices closed for a half day on one or more days per week during 2012. In 2011, the equivalent figure was 19 per cent.

3.13 The *Wales Programme for Government*¹¹³ included a commitment to ‘make GP services more accessible to working people and reduce pressure on A&E departments’ and stated an intention to increase the percentage of the population able to access a GP service in the evenings and weekends.

3.14 In July 2012, the Minister announced a three-phased approach¹¹⁴ to implement better access to GP services. These phases consisted of:

- a Redistributing GP appointments within the core opening hours (8am to 6:30pm) to ensure better access to appointments early in the day and between 5pm and 6:30pm. The first phase also includes a focus on reducing the number of practices that close for half-day sessions or lunchtimes.

Box 4 - There are several sources of potentially helpful guidance and good practice for those seeking to improve urgent primary care access

The Primary Care Foundation’s report, *Urgent care in general practice*, sets out key principles for improving urgent access as well as highlighting a range of case studies and evidence for improvement.

www.primarycarefoundation.co.uk/what-we-do/urgent-care-in-general-practice

Productive General Practice is a programme run by the NHS Institute for Innovation and Improvement in England. The programme aims to help general practice deliver high-quality care whilst meeting increasing levels of demand and diverse expectations. The website includes a range of case studies and online study modules.

www.institute.nhs.uk/productive_general_practice/general/productive_general_practice_homepage.html

The Deloitte Centre for Health Solutions’ report *Primary care: Today and tomorrow, Improving general practice by working differently* provides evidence about alternative models for providing high-quality and accessible primary care. The report considers the capacity and capability of general practice in the United Kingdom, and highlights the need for new ways to cope with increasing demand.

www.deloitte.com/view/en_GB/uk/research-and-intelligence/deloitte-research-uk/deloitte-uk-centre-for-health-solutions/bb6e38f609817310VgnVCM3000001c56f00aRCRD.htm

In a positive example of collaboration between the health board and general practice, Aneurin Bevan Health Board’s Primary Care Access Group has launched a scheme called *A for Access* where practices are given a rating for their access arrangements. The scheme resulted from a joint project between the health board and the Primary Care Foundation. The ratings are published on the health board’s website and each practice is asked to display a certificate showing their rating. The scheme considers whether:

- the practice is closed for any half-day sessions during the week;
- a patient can get an appointment before 8:30am;
- patients can book an appointment in just one phone call and can speak to a person between 8am and 6:30pm;
- the practice is open at lunch time; and
- the last routine GP appointment of the day is at 5:50pm or later.

Source: Research by the Wales Audit Office

112 Daily core hours mean Monday to Friday from 8am to 6:30pm each day, with no lunch time closure, as set under the General Medical Services contract.

113 Welsh Government, *Programme for Government*, 2011

114 Welsh Government, press release, 2 July 2012



- b** Improving access to GP appointments after 6:30pm. The Welsh Government aims to ensure that 30 per cent of practices offer appointments after 6:30pm by 2013-14 and 50 per cent by March 2016.
- c** Improving access to GP appointments at weekends. This will be the focus of the Welsh Government from 2014-15.

3.15 Statistics released by the Welsh Government in February 2013 showed¹¹⁵:

- a** There has been good progress in ensuring appointments are available between 5pm and 6:30pm. Ninety-four per cent of practices offer appointments between these hours on at least two nights per week. However, appointments between 6pm and 6:30pm are not so widely available with 11 per cent of practices offering such appointments on at least two days per week.
- b** Fourteen per cent of practices offer appointments before 8:30am on at least two days per week and 84 per cent offer no such appointments on any day of the week. In Hywel Dda, just two practices (four per cent) offer appointments before 8.30 am on at least two days per week.

3.16 The mechanism for extending opening hours beyond the core hours is through a nationally-negotiated directed enhanced service. The same statistics from the Welsh Government released in February 2013 show that 89 per cent of practices do not provide appointments after 6:30pm on any day of the week. No practices offered such appointments on any day of the week in Betsi Cadwaladr or in Powys. It is the health boards' decision whether or not to fund these enhanced

services and health boards take these decisions based on their knowledge of local need for extended opening hours.

- 3.17** Data from the health boards' final accounts for 2012-13 show that funding provided for extended opening hours totalled approximately £958,000. The cost in each health board varied from £0 in Powys and Betsi Cadwaladr to £318,000 in Abertawe Bro Morgannwg. Our fieldwork in Abertawe Bro Morgannwg highlighted that the health board was concerned that its enhanced services for extended opening hours were not well used and further work was required to assess whether the expenditure was justified. At the time of preparing this report all health boards were reviewing the effectiveness of their enhanced services as a vehicle for helping to manage unscheduled care demand.

Some practices would benefit from studying their patterns of demand and asking patients about their experiences of trying to access care

- 3.18** The fact that the majority of people in Wales find it easy to access GP appointments has been noted earlier in this report. For practices to improve access even further they need to fully understand the access issues that patients experience and they need to ensure their capacity matches demand. In response to our survey, 70 per cent of practices had used the results of the *Welsh GP Patient Survey*¹¹⁶ to review the way they provide same-day care and 59 per cent had sought the views of patients on how to improve same-day care. These data show that whilst the majority of practices were taking positive steps, there remained considerable scope for improvement.

¹¹⁵ Welsh Government, *Statistics for Wales, GP Access in Wales 2012*, SDR 31/2013, 26 February 2013. These data considered the availability of appointment times, defined as 'the times when the practice regularly offers consultation sessions with a GP to patients'.

¹¹⁶ Statistics for Wales, *Welsh GP Patient Survey*, SDR 103/2011, June 2011

3.19 If patients find it difficult to contact the surgery by phone this can delay them in receiving the care they need or it may prompt them to seek care from more acute services. One of the Primary Care Foundation's recommendations was that practices should assess their pattern of phone demand and make sure that sufficient staff and phone lines are available. Our survey of practices showed that only 41 per cent had analysed their pattern of phone demand. Similarly, in the *Welsh GP Patient Survey 2011*, of the patients who said they were unable to access an appointment on the same day or next day, 11 per cent said they were unable to do so because they could not get through to the surgery on the phone. **Box 5** gives some examples of the actions practices took after analysing their telephone demand.

3.20 The *Programme for Government* included a commitment to accelerate the development of online appointments for flexible GP booking. This can be convenient for patients, and can reduce demand on practice phone lines and the workload of staff. My Health Online

is a system that allows patients to book GP appointments and order repeat prescriptions online. An update to the *Programme for Government* in May 2012 said that My Health Online was live within 84 practices in Wales and more than 8,000 patients were registered users. Roll out of the system was due to finish by autumn 2012. However, data provided by NWIS in February 2013 shows that whilst the system was live in 123 practices, there were 60 other practices awaiting to go live and 159 practices where NWIS is yet to determine whether they are interested in using the system.

3.21 The *Welsh GP Patient Survey* was run through a Department of Health contract which ceased in 2011. The Welsh Government has introduced new ways to measure elements of patient access to primary care. For example, the Welsh Government has introduced regular monitoring of GP appointment times, and the new *National Survey for Wales* asks members of the public about their satisfaction levels regarding GP services and about the

Box 5 - Practices made a number of changes as a result of analysing their telephone demand

The bullet points below are direct quotes taken from our survey of general practices:

- 'We introduced triage to help patients speak to a GP without having to make an appointment. This enables us to offer more appointments to patients who genuinely need them. Things such as advice on medication, concerns about an elderly parent, hospital appointments etc.'
- 'We found that without some sort of control mechanism the doctors and nurses were inundated with telephone calls as patients started to take advantage of the doctor's willingness to deal with them over the telephone. Therefore we introduced a number-limited allocation system.'
- 'When patients phone for advice or results we take details and a contact number, place them on a 'telephone advice' list using our appointment system. The doctors will work through the list after surgery each morning. Patients usually only have to phone once.'
- 'As a result we upgraded our telephone system, increased our telephone lines and increased the number of bodies answering the calls between 8-10 from 2 to 4/5.'

Source: Wales Audit Office survey of general practices



ease of getting a GP appointment at a time convenient to them. However, the *National Survey for Wales* does not record the patient's GP practice and therefore the experience data are not available at the practice level. This represents a decrease in the value and usefulness of these data.

There is wide variation in the way practices provide same-day and advance appointments and the way in which practices use telephone assessments and consultations

- 3.22** In order to meet demand for urgent appointments as well as demand for more routine appointments, practices need to strike an appropriate balance in the number of same-day and book-ahead appointments that they offer.
- 3.23** The Primary Care Foundation's report provided general commentary that two-thirds advance to one-third same-day appointments appears to be the right mix.¹¹⁷ The results of our primary care survey suggest that the ratio of same-day to book-ahead appointments in Wales varied widely from 70:30 to 10:90. This degree of variation suggests that some practices are likely to be offering a range of appointments that is out of balance with their pattern of demand.
- 3.24** The *Ten High Impact Steps to Transform Unscheduled Care (USC)* acknowledges that telephone consultations can play a useful role in a modern primary care service. A report from the Deloitte Centre for Health Solutions¹¹⁸ said that a longstanding aspect of general practice that needs to be challenged is dependence on face-to-face consultations. The report cites evidence that triage, assessment and consultation over the phone can provide benefits including seeing more

patients who really need to be seen, higher patient satisfaction rates and a decrease in the proportion of patients who go on to attend the emergency department. Our primary care survey suggested the ratio of face-to-face consultations to telephone appointments ranged from 99:1 to 50:50. There is clearly scope for some practices to consider using telephone-based services more widely.

Many practices would benefit from implementing initiatives aimed at reducing the number of wasted appointments

- 3.25** Our survey of practices suggests that considerable primary care capacity can be created in some areas by reducing the number of appointments that are wasted by patients who do not attend. Practices estimated that up to 11 per cent of patients did not attend (DNA) for their appointments.
- 3.26** In response to our survey, several practices mentioned DNAs as a key barrier that prevented them from meeting demand for same-day or urgent care. **Box 6** shows some of the actions taken by practices in Wales to reduce DNAs.

Primary care practitioners need to be given better information and a better network of support in order to minimise the patients they send to hospital as emergency admissions

- 3.27** *Ten High Impact Steps to Transform Unscheduled Care (USC)* argues that there is a need to reduce the rate at which primary care practitioners refer patients urgently to the acute hospital. The 10 steps document says that in some practices, the rate of unnecessary admissions can be reduced by 30 per cent.

¹¹⁷ Practices should assess the local pattern of demand before deciding on the ideal balance of same-day and book-ahead appointments.

¹¹⁸ Deloitte Centre for Health Solutions, *Primary care: Today and tomorrow, Improving general practice by working differently*, 2012

Box 6 - Practices have taken a range of actions to reduce their did not attend rates

In response to our survey, general practices gave the following detail about their actions to reduce DNAs:

- A poster is displayed in the waiting room of the number of patients who DNA each week.
- We have a DNA policy, patients are sent letters where they DNA twice. They are transferred out if there are further DNAs in a certain period.
- Ring patients in advance reminding them when an urgent appointment request is made by the GP.

Abertawe Bro Morgannwg University Health Board is also attempting to reduce DNAs within its Bridgend locality by focusing on the practice receptionist's role in booking appointments. The scheme has involved the introduction of simple interventions such as asking patients to write down their appointment times and dates, and asking the patient to repeat back the time and date they have just been told by the receptionist. The health board is now seeking to roll this initiative out across all localities.

Source: Wales Audit Office fieldwork and primary care survey

3.28 The introduction of new measures into the Quality and Outcomes Framework regarding the rate of emergency admissions arising from primary care provides an opportunity to drive improvement in patient access and GP referral practices. The mechanism within Quality and Outcomes Framework requires health boards to share with practices information regarding their emergency admission rates. Practices are also required to meet to consider these data. However, our primary care survey showed that practices are generally sceptical about the value of these data. Our survey showed:

- a** only 39 per cent of practices considered the data to be helpful; and
- b** only 25 per cent believed the data would lead to changes in the way that practices provide services.

3.29 Box 7 provides details of a scheme in England that ensures general practice is given up-to-date and intelligent information in order to monitor and improve its urgent care performance.

3.30 Health boards need to ensure they provide primary care practitioners with an appropriate range of services to help them minimise their emergency admissions. Our primary care survey suggests practices consider the current support to be inadequate:

- a** 31 per cent of practices said they had good access to telephone or email advice from consultants;
- b** 34 per cent of practices said they had good access to rapid access clinics or hot clinics;
- c** 32 per cent of practices said they had good access to diagnostic services;
- d** 36 per cent of practices said there was a good range of community services that assist in avoiding emergency admissions; and
- e** 42 per cent of practices said they had enough information about the range of community services available to prevent admissions.

3.31 Box 8 provides some examples of work carried out by health boards to try to minimise emergency admissions emanating from primary care.



Box 7 - The Urgent Care Clinical Dashboard in England provides intelligent data to help practices manage their unscheduled care performance

In England, the Urgent Care Clinical Dashboard is a web-based tool that provides practices with timely information about the way in which they are interacting with the acute hospital in relation to urgent care. Practice staff can log on to the dashboard from their desktop and see the previous day's performance in relation to their patients' urgent care attendances as well as the practice's emergency admissions and discharges. The dashboard was first introduced in NHS Bolton which claims to have secured year-on-year reductions in emergency admissions since 2008 and that during 2009-10 the dashboard contributed to efficiency savings of some £600,000.

Source: Wales Audit Office research of documents including a joint report from the NHS Alliance and the Primary Care Foundation called *Breaking the mould without breaking the system*.

Box 8 - Health boards have taken a range of measures with the aim of minimising emergency admissions

Introduction of an acute care GP at Singleton Minor Injuries Unit – Abertawe Bro Morgannwg University Health Board has launched a scheme at Singleton Hospital to provide greater support for GPs referring urgent cases to the acute hospital. The acute care GP is based at the minor injury unit to carry out telephone triage for all GP referrals and the GP has access to clinical areas for face-to-face assessments. The acute care GP service is further supported by having access to specific diagnostic slots and hot clinic appointments. The health board is following a model used in a number of hospitals in the South West of England, which have managed to reduce demand on admission and assessment units by introducing the role of an acute care GP.

Secure email service to provide GPs with advice from consultants – Cwm Taf Health Board has introduced a scheme where GPs can receive advice about cardiac patients by emailing consultants. Advice is provided within 24 or 48 hours and the health board hopes to launch a similar scheme for paediatrics.

Auditing the appropriateness of GP referrals – Several health boards have undertaken local audits to assess whether the emergency referrals they receive from GPs are appropriate. Where inappropriate referrals have been identified, Abertawe Bro Morgannwg University Health Board has put in place ad hoc arrangements for the organisation's locality manager to contact the referring practice to discuss the case and to ascertain what could have been done to prevent the referral.

Rapid access clinics to avoid frail people being admitted to hospital – Hywel Dda Health Board has introduced a rapid access clinic in Llanelli which is run in partnership by primary, community and secondary care clinicians. The clinic is for patients who are frail and vulnerable to hospital admission and/or health crisis. Importantly, the clinic has direct access to diagnostics.

Source: Wales Audit Office fieldwork

A national group has been tasked with addressing the range of problems identified in the national review on out-of-hours primary care services

3.32 Our 2009 report drew attention to issues in these services including variable arrangements for providing services, poor understanding of demand and weaknesses in monitoring performance. A national review of out-of-hours primary care commissioned by the Minister for Health and Social Services produced an interim report in July 2012¹¹⁹.

3.33 The report highlights the key role played by out-of-hours services in the unscheduled care system, recognises the dedication of out-of-hours staff and mentions some excellent examples of innovative care. However, the report also warns that out-of-hours services need to be urgently stabilised and consolidated with key findings including the following:

- a** There is continued, wide variation in the way that out-of-hours services are delivered with 10 different service models currently in existence across Wales. There has been a lack of investment in these services and there is now an urgent need to commit additional resources. There are also opportunities to secure benefits through economies of scale.
- b** Problems with performance measurement remain as there is no consistent, comparable information across Wales.
- c** The report states that demand appears to be increasing, although with a lack of comprehensive information from across Wales, the report appears to rely, to some extent, on anecdotal evidence.

- d** The report states that out-of-hours services are experiencing a medical manpower crisis with many health boards struggling to recruit doctors to work in these services.
- e** Whilst there is consensus about some elements of what out-of-hours services should look like in future, further work is required to identify the ideal model for health boards.
- f** IT systems within out-of-hours services are replicated and duplicated across Wales and this is at odds with the national direction of developing systems on a 'once-for-Wales' basis.

3.34 The national review has drawn attention to some fundamental problems and has provided high-level focus on the importance of out-of-hours services. The issues arising from the out-of-hours review are being progressed via the Out-of-Hours Subgroup of the National Urgent and Emergency Care Board.

¹¹⁹ Primary Care Out of Hours Review, Interim Report, July 2012



Difficult decisions lie ahead about the reconfiguration of hospital services but this is a rare opportunity to make the right choices, and ensure the safety and sustainability of services

3.35 NHS Wales is undergoing a complicated exercise to consult the public over the future configuration of health services. A report¹²⁰ from the Bevan Commission¹²¹ in 2011 emphasised the need for change and said that brave leadership, innovation, commitment and some sacrifice is required if the NHS is to continue to meet patients' needs.

3.36 The local names for these exercises are the South Wales Programme (covering health boards in South Wales), Your Health, Your Future (covering Hywel Dda Health Board), Changing for the Better (covering Abertawe Bro Morgannwg Health Board), Healthcare in North Wales is Changing (covering Betsi Cadwaladr Health Board) and New Directions (covering Powys). The bullet points below summarise some of the context set out in the documents for changing acute hospital services:

- a** the *South Wales Programme* argues that the status quo cannot continue and that the organisation of some services means patients are not always enjoying the best results;
- b** *Your Health, Your Future* argues that by not dealing with the current challenges, the future sustainability of services could be at risk;

- c** *North Wales is Changing* says it is increasingly difficult to be confident that all of the right staff, with the right skills, can be in the right place to provide the healthcare that people need;
- d** *New Directions* says continuing its current network of services is becoming increasingly challenging for quality, safety, staffing and efficiency reasons; and
- e** *Changing for the Better* says that the current blueprint for services is out of date, doctor shortages are getting worse, patients do not always have the best outcome from their care and that the health board cannot afford to continue providing services in their current form.

3.37 There is evidence from other sources to suggest that the current network of acute hospital services is unsustainable. *The Best Configuration of Hospital Services in Wales*¹²², suggested that the current configuration of hospitals may be contributing to negative outcomes for patients. The report stated 'there is an accumulating body of evidence which suggests that patients in Wales do not always get the best possible outcomes from their hospital care, and that in some key specialty areas – notably major and general trauma and emergency care, stroke care, maternity and new-born care, and paediatrics – the way services are organised in Wales probably falls well short of what the evidence suggests is optimal'.

3.38 Our report has already presented evidence that current levels of patient experience, quality and outcome are far from ideal and that some emergency departments are under severe pressure. It is also clear that health boards are generally not meeting guidelines

¹²⁰ Bevan Commission, *2008-2011 NHS Wales: Forging a better future*, May 2011

¹²¹ The Bevan Commission was established by the Minister for Health and Social Services as an independent advisory board.

¹²² Welsh Institute for Health and Social Care, *The Best Configuration of Hospital Services in Wales, Summary*, April 2012

for emergency department staffing and are not ensuring sufficient hours of cover from senior clinical staff.

- 3.39** Wales is not the only part of the United Kingdom suffering such challenges. A report from the Royal College of Physicians¹²³ in September 2012 calls for a radical review of the organisation of hospital care. The report says that change is required to address increases in demand, the changing needs of our ageing population, the greater risk of mortality if patients are admitted to hospital at weekends and the looming crisis in the medical workforce due to high workloads and problems with recruitment and retention. The report calls for difficult decisions to be made about the future design of services and argues that reconfiguration must be led by clinicians and calls for improvements in the way the NHS communicates with the public over the need for change. Similarly, a report from the CEM highlights the challenges being faced across the United Kingdom in ensuring an 'optimal configuration of services'.¹²⁴
- 3.40** There are some key risks that NHS Wales must avoid if it is to reconfigure its services effectively. There is a risk that the public will not understand the need for change. However, we acknowledge that health boards are working in numerous, positive ways to avoid this risk, such as producing clear documents, holding a wide range of public meetings, posting videos online, utilising their skilled communications teams and proactively engaging with politicians and other key stakeholders. Critical to the success of these efforts will be a continued, honest and open debate about the issues and a continued focus on the evidence base for change.
- 3.41** There is also a risk that some reconfiguration plans will not go far enough and as a result will not sustainably solve the problems currently being faced. The current plans for Hywel Dda and Betsi Cadwaladr will not, for example, result in the health boards' emergency departments meeting the CEM's guidelines on the minimum number of consultant medical staff.
- 3.42** If reconfiguration plans are progressed without sufficient progress on transforming the system of unscheduled care, this would cause major difficulties to securing sustainable improvements. The reconfiguration plans are, to some extent, predicated on transformation to the whole system along the lines set out in the *Ten High Impact Steps to Transform Unscheduled Care (USC)*. Transformation and reconfiguration must be progressed in tandem. Similarly, the plans must fully consider the impacts of changes upon ambulance services. The Welsh Ambulance Services NHS Trust plays a vital role within the system of unscheduled care and the reconfiguration plans must fully consider the implications upon the ambulance service and the lead in time to secure any required changes.
- 3.43** Another key risk is that as currently drafted, the reconfiguration plans have little detail on the financial implications of change. Financial pressures are just one of the reasons for the need for change but further work is now required to bolster the financial modelling to ensure whatever network of services is agreed will result in a financially-sustainable model.

123 Royal College of Physicians, *Hospitals on the edge: The time for action*, September 2012

124 College of Emergency Medicine, *The Drive for Quality: How to achieve safe, sustainable care in our Emergency Departments*, May 2013



3.44 In conclusion, there are difficult decisions to be taken about the future configuration of services. There are strong arguments in favour of change, and the current phase of planning and consultation represents a rare opportunity to take the right decisions and ensure safety and sustainability of services.

Significant effort has been devoted to tackling the challenges of unscheduled care but more progress needs to be made in developing a whole-systems approach

The sustained focus on unscheduled care, at a national and local level, seeks to resolve the problems that have thus far proved difficult to address

3.45 Unscheduled care has been a priority area for improvement in the NHS in Wales, both nationally and locally, for a number of years. National strategies and specific initiatives have been produced, programme boards convened, additional funding made available, data sets and performance dashboards created, and escalation and intervention approaches implemented. Indeed, the level of scrutiny and priority on unscheduled care services is such that senior executives in NHS bodies are undertaking daily action to review and change systems and processes, and to monitor performance and outcomes. **Box 9** lists a range of initiatives and actions that have been taken in recent years to improve and monitor unscheduled care services, and gives a flavour of the extent and breadth of work that has been undertaken.

3.46 Despite all this effort the desired improvements to unscheduled care services have not been achieved, and the system remains under significant and increasing pressure. Tackling unscheduled care challenges has undoubtedly been made more difficult by wider constraints such as the financial pressures facing the NHS and its partners, medical staffing shortages, unpredicted demographic changes, and an historical configuration of hospital services which appears unsustainable.

3.47 At the time of drafting our report, the local and national focus on unscheduled care has increased significantly and much work is now ongoing that attempts to ease the problems identified in this report. The new NHS delivery framework for 2013-14¹²⁵ reinforces the focus on unscheduled care. The framework includes targets relating to four-hour waiting times in emergency departments, eradication of waits over 12 hours and timeliness of responses to Category A ambulance calls. A target that aims to improve urgent access to primary care has been elevated from a tier 2 target to tier 1, as has a target on reducing delayed transfers of care. This recently renewed focus on unscheduled care is positive and NHS Wales must now accelerate its efforts to pursue large-scale, transformational change in unscheduled care in order to achieve sustainable services for the future.

¹²⁵ NHS Wales, *Delivery Framework 2012-13 and Future Plans*, 2013

Box 9 - There has been a range of national initiatives and actions to improve unscheduled care since 2009

The Seasonal Planning Group was established in December 2010 to foster new ways of working between health boards and the Welsh Government to ensure that effective winter plans, and other plans for times of high demand, were in place. Work within that group has produced:

- A bed management toolkit, launched in February 2012 to support patient flow in acute hospitals.
- The *National Escalation and De-escalation Action Plan*, launched in 2011 with the intention of standardising and improving the way that acute hospitals escalate actions at times of high pressure, and revert back to normal practices once the pressures have been alleviated. The plan is currently being reviewed because the Seasonal Planning Group has recognised that it is not working as effectively as it should.
- A draft repatriation policy to improve the way in which patients are repatriated to hospitals close to where they live, after first being admitted to other hospitals.

The DSU has carried out a number of actions to support improvements in unscheduled care. Unscheduled care is one of the Welsh Government's priority areas and, as such, remains a priority for the DSU. Actions have included spot checks on health board implementation of the bed management toolkit and national escalation plan, bespoke modelling of the impacts of demand on acute hospitals, and development of a capacity and demand tool to assist health boards in matching their staffing levels and rotas to their peak times of demand in the emergency department.

National work to develop patient pathways has involved a focus on STEMI, stroke and fractured neck of femur. National champions are in place for these pathways and the DSU is currently leading work on developing a generic pathway for frail and older people who access unscheduled care.

A Handover Improvement Group was set up to provide a specific national focus on the problems at the interface between the ambulance service and emergency departments. The group is carrying out work to develop more intelligent metrics than the current 15-minute handover target. The group hopes to introduce measures that more intelligently focus on patients with particularly acute conditions, with the intention of ensuring the sickest patients are handed over as a priority.

Implementation of the National Early Warning System. Further details can be found at paragraph 2.77.

The *Choose Well* campaign was launched in February 2011. Further details can be found at paragraphs 2.15 to 2.21.

The work of an Intelligent Targets Group resulted in the publication of a document entitled *Quality and Delivery Indicators for Unscheduled Care*. That document set out a range of metrics and performance measures that aimed to ensure that in future there will be an appropriate balance between clinical outcomes, improved access, patient experience, clinical effectiveness, safety and efficiency whilst not significantly adding to the administrative burden of data capture and collection. There has been mixed progress in implementing these measures (see paragraphs 1.20 to 1.34), and many of the outcome and quality-based metrics have not been implemented. The paper is no longer a live document within NHS Wales.

There have been additional fields and requirements included within the EDDS. These additions intend to allow a more comprehensive set of data to be collected in the emergency department to improve the analysis of demand. Limitations with these data are described at paragraphs 1.38, 1.46 and 2.6 to 2.8.

A task and finish group has been established to guide the introduction of the 111 call service for urgent care. A national workshop was held in March 2012. Further details can be found at paragraphs 3.2 to 3.9.

The Welsh Government has also carried out ad hoc analyses of demand to explain the apparent unprecedented demand during summer 2012. Further details can be found at paragraphs 1.47 to 1.50.

The development of the Launchpad system and Unscheduled Care Dashboard have provided NHS Wales with improved live information about demand and pressures in the system. Further details can be found at paragraph 1.36. These systems have been accompanied by a new process for regular conference calls between all health boards, the Welsh Government and the ambulance trust to discuss how they can work together to alleviate immediate pressures within the system. A system of automatic email alerts has also been introduced so that senior health boards' executives are made aware of delays to patient care in their emergency department.

Source: Wales Audit Office



The previous national board for unscheduled care had limited impact but new arrangements provide additional opportunities for driving whole-systems change

- 3.48** In early 2012, the National Unscheduled Care Programme Board was replaced by the National Urgent and Emergency Care Board. During our fieldwork, we were told a number of times that the previous board had only limited impact. Whilst it produced a number of guidance documents, we were also told that it was slow in producing its outputs and ultimately did not deliver transformation.
- 3.49** The National Urgent and Emergency Care Board is chaired by the Deputy Chief Executive of NHS Wales and has a high profile amongst the health bodies in Wales. The nomination of two chief executives to provide the lead on unscheduled care within NHS Wales also appears to have been a positive step. The fact that one of these chief executives is from the Welsh Ambulance Services NHS Trust is important in ensuring that ambulance services are more closely considered and involved in attempts to transform the system.
- 3.50** The national board was given £1 million by the Welsh Government as part of a £10 million investment in unscheduled care. This money, whilst not a particularly large sum given the overall scale of the unscheduled care system, gave the board some leverage in driving transformation and was intended to be used for national initiatives that the board considered important.
- 3.51** At the time of drafting, the Welsh Government was finalising plans for a new national programme for unscheduled care. The programme will include a national clinical lead, a programme director, a national delivery team, an operational board, stakeholder

board and steering group. Whilst we have not evaluated the developing arrangements, we consider that they do provide evidence of renewed focus and an attempt to develop a more comprehensive and inclusive approach to transforming unscheduled care. We consider that the new programme has greater potential to drive improvement than the previous boards because it appears it will have more resource, be of higher profile and will be supported by a more comprehensive structure of groups and boards.

Ten High Impact Steps to Transform Unscheduled Care (USC) provides a clear vision that has potential to drive the improvements which are necessary in unscheduled care

- 3.52** Our 2009 report commented on limitations with the national strategy for unscheduled care. We said that the high-level principles of *Delivering Emergency Care Services* were widely accepted but a number of stakeholders criticised the vision as being insufficiently specific or prescriptive, particularly in terms of providing a blueprint for the model of unscheduled care that local communities should develop.
- 3.53** Since 2009, the Welsh Government and the national board have developed three potentially important, strategic documents in relation to unscheduled care. In May 2011, the national board considered a document called *A Blueprint for the Future of Unscheduled Care in Wales*¹²⁶. The document aimed to provide the clarity and direction to achieve a whole-systems approach to improving unscheduled care. However, the blueprint was never formally launched, partly because it was thought not to adequately reflect the diversity of unscheduled care challenges that existed across Wales.

¹²⁶ NHS Wales, *A Blueprint for the Future of Unscheduled Care in Wales*, 2011

3.54 In June 2011, NHS Wales released *Ten High Impact Steps to Transform Unscheduled Care (USC)*. This document does not attempt to cover all issues relevant to unscheduled care but instead, it focuses on clinical leaders' views on the 10 key steps required to transform unscheduled care. We consider that this document has many strengths. The steps that the document focuses on are clearly important, and it is a strength that the document was developed in partnership with key clinicians as this gives it greater chance of being supported and implemented by those people working within services. Despite these strengths, our fieldwork suggests that health boards have not progressed very far in implementing the steps and it appears that whilst some health boards are using the document comprehensively, others are barely using it at all.

3.55 At the time of our fieldwork, the Welsh Government was drafting a document entitled *Delivering Urgent and Emergency Care: A Delivery Plan for Wales to 2016*. The document is based on *Ten High Impact Steps to Transform Unscheduled Care (USC)* and rightly identifies many of the key problems within unscheduled care. Whilst there is little in the document that represents new thinking, it does list some specific actions that the Welsh Government now expects NHS Wales to deliver and it attempts to remove any ambiguity about who is accountable for delivering change. The Welsh Government has also proposed a new work programme for unscheduled care which includes an emerging set of objectives for improvement. The objectives include an intention to develop a collaborative for improvement in unscheduled care to be facilitated by *1000 Lives* and all but one of the objectives are intended to be delivered within 2013. The Welsh Government has told us that the *Ten High Impact Steps to*

Transform Unscheduled Care (USC) will be included within the new work programme and we consider it important that the 10 steps are considered fully within the new approach to improving unscheduled care.

The Welsh Government's emerging approach to performance managing NHS Wales has potential benefits and needs to strike the right balance between holding health boards to account and allowing them flexibility to deliver

3.56 Ongoing performance management arrangements include monthly performance meetings between the Welsh Government and the health boards. However, the Welsh Government's approach to performance management is changing. Monthly quality and delivery meetings will continue between the health boards and the Welsh Government, as set out in the new NHS delivery framework for 2013-14. However, under the emerging approach, chief executives of health boards are to be given more freedom to deliver the national objectives as they choose. The intention is that the chief executives will be held more strongly to account for their performance if they do not convert this freedom into genuine improvement. During our interviews across Wales we were told that the previous national performance management regime in unscheduled care had involved frequent and rigorous scrutiny from the Welsh Government but had not been particularly successful in driving change.

3.57 It will be important for the evolving performance management regime to monitor how the additional £10 million which was made available to NHS Wales for improving unscheduled care has been used, and whether this investment has led to improvements.



3.58 The Welsh Government had initially intended to allocate the money based on a review of bids submitted by health boards. However, after the bids were received, the Welsh Government changed its approach and decided to distribute the money to the health boards based on their population size. At the time of our fieldwork, it was unclear whether the Welsh Government and NHS Wales would be evaluating the use of this money and there appeared to be no comprehensive central record of how this money was spent. In order to maximise the benefits of this funding, the health boards should be robustly evaluating the effectiveness with which they have used the money and should be ensuring that the money is spent on sustainable, long-term solutions and not temporary 'sticking plaster' solutions to strengthen four-hour waiting time performance.

Appendix 1 - Methodology

This report is a national summary of work that we carried out at all health boards in Wales during 2011 and 2012. We supplemented our local fieldwork with a range of national-level investigations during 2012 and 2013.

Local fieldwork

We asked health boards to complete a number of audit tools including a survey covering various quantitative and qualitative information regarding unscheduled care. We also requested data about the activity and staffing levels of each emergency department. Health boards also submitted to us a status update on the progress in developing communications hubs, as well as proformas that asked for details of their CRTs and other community-based services that play a role in unscheduled care.

We carried out a wide range of semi-structured interviews with managerial and clinical staff from across the whole system of services in each health board area.

At each major emergency department we carried out a visit to speak to operational staff and to observe patient handovers between ambulance staff and hospital staff. Also during our visits, we observed waiting areas and made other observations of the emergency department patient environment.

Survey of GP practices

We sent a survey to all general practices in Wales to ask for opinions and data regarding several aspects of unscheduled care. We received 131 responses, which equates to 26 per cent of the 502 practices in Wales.

Document and data reviews

We carried out an extensive review of documents related to unscheduled care, within each community and at a national level.

National fieldwork

To supplement our local fieldwork, we conducted a range of semi-structured interviews of national-level stakeholders.



Appendix 2 - Calculation of number of contacts with the unscheduled care system in 2011-12

We estimate there were 8,792,294 contacts with the unscheduled care system in 2011-12.

This estimate includes only the services where good data were available, so the actual number of contacts with the unscheduled care system is actually higher.

This estimate includes people given urgent or unplanned treatment or advice by the following services: the ambulance service, hospital emergency departments, minor injury units, NHS Direct Wales (including calls, online enquiries and website hits), GP out-of-hours services and an estimate for unscheduled care contacts in primary care during normal working hours.

The figure includes:

- 435,806 validated calls to the Welsh Ambulance Services NHS Trust¹²⁷;
- 989,286 attendances at major emergency departments and minor/other emergency departments¹²⁸;
- 1,292,202 contacts with NHS Direct Wales (325,337 calls, 3,098 online enquiries and 963,767 website hits)¹²⁹;
- 575,000 calls answered by primary care out-of-hours services¹³⁰; and
- 5.5 million urgent primary care appointments during normal working hours¹³¹.

¹²⁷ Source: Data request to the Welsh Ambulance Services NHS Trust

¹²⁸ Source: Stats Wales

¹²⁹ Source: Stats Wales, SDR 192/2012

¹³⁰ Source: *Primary Care Out of Hours Review, Interim Report*, July 2012

¹³¹ Source: National Unscheduled Care Programme Board, *Ten High Impact Steps to Transform Unscheduled Care (USC)*, June 2011