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SWYDDFA **ARCHWILIO** CYMRU

Transforming unscheduled care and chronic  
conditions management

## **Powys Teaching Health Board**

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# Status of report

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

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# Summary report

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## Context

1. It is widely recognised that many parts of the Welsh health and social care system are under considerable pressure. The current situation is unsustainable because these services continue to face excessive levels of demand against a background of constrained financial resources and there is now an urgent need for service transformation and whole system change.
2. The need for change has been apparent for some time. In 2003, the *Review of Health and Social Care Services in Wales* (the Wanless Review) identified the need for radical redesign for health and social care services and for greater capacity of services outside the hospital setting. A number of subsequent Welsh Government policies, alongside the 2009 reconfiguration of the NHS, provide the building blocks to achieve this change. *Setting the Direction* sets out a strategic delivery programme for primary and community services in NHS Wales. It describes the pressures that Welsh hospitals experience for reasons including the large number of emergency admissions and delays in discharging patients who are ready to leave hospital. The programme states that one of the causes of elevated pressures in hospital is that, historically, the health service has gravitated services and patients towards hospitals, thus restricting the sustainability and effectiveness of community services.
3. The programme argues for a need to rebalance the whole system of care away from an over-reliance on acute hospitals and towards greater use of primary and community services, and an increased focus on preventative approaches. Such a change would have the benefit of reducing the demand on acute hospitals but, importantly, it would benefit patients. Currently, too many patients are treated in hospital when they could be better cared for in the community.
4. If health boards are to succeed in implementing these more sustainable models of care, two of the vital and interrelated service areas that must be transformed are chronic conditions management and unscheduled care<sup>1</sup>. It is vital to transform these two areas because:
  - **The considerable impact of chronic conditions is growing in Wales.** One-third of the adult population in Wales, an estimated 800,000 people, reports having at least one chronic condition, such as diabetes, emphysema or heart disease. This proportion is higher in Wales than the other parts of the United Kingdom. The prevalence of chronic conditions increases with age and given that Wales's population of over 65s is projected to increase by 33 per cent by 2020, the burden of chronic conditions on the system is likely to grow.

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

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- **Unscheduled care services are some of the most pressurised parts of the health and social care system.** The Welsh Government's 2008 *Delivering Emergency Care Services* strategy stated that unscheduled care services face ever-increasing demand. We estimate that there are more than eight million contacts<sup>2</sup> with unscheduled care services in Wales every year, with associated use of resources implications.
  - **The areas of chronic conditions management and unscheduled care are crucially interrelated.** People with chronic conditions tend to be frequent users of the unscheduled care system because when their conditions exacerbate, they often need to access services in an urgent and unplanned way. Moreover, people with chronic conditions are twice as likely to be admitted to hospital as patients without such conditions. Transforming chronic conditions services therefore has huge potential benefits for unscheduled care services.
5. The Wales Audit Office previously carried out a large body of work on the areas of chronic conditions and unscheduled care. In December 2008, the Auditor General published *The Management of Chronic Conditions by NHS Wales* which concluded that too many patients with chronic conditions were treated in an unplanned way in acute hospitals, community services were fragmented and poorly co-ordinated, and service planning and development were insufficiently integrated.
  6. In December 2009, the Auditor General published *Unscheduled Care: Developing a Whole Systems Approach*. The report highlighted a range of problems resulting in a lack of coherence in the operation of the unscheduled care system. The report also concluded that against the backdrop of the severe pressures on public funding, there would have to be radically new ways of delivering unscheduled care services and support.
  7. Given that it is now more than two years since the publication of this body of work, the Wales Audit Office has undertaken follow-up audit work on chronic conditions and unscheduled care that considers progress against our previous recommendations but also aims to provide new insight into the barriers and enablers affecting progress. As there are a number of key interrelationships between chronic conditions and unscheduled the work has been delivered as a single integrated review. One of the key enablers that we have focused on is clinical engagement, given its crucial importance in delivering the service transformation that is required.

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

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8. Powys Teaching Health Board (the Health Board) provides a range of unscheduled care services including minor injury units and out-of-hours services along with GP and community based services. It does not however provide services traditionally provided by a District General Hospital (DGH), and consequently Powys residents will also access a range of unscheduled care and chronic condition services from neighbouring Welsh and English providers. Our preliminary work on unscheduled care services,<sup>3</sup> which we reported on in August 2011, concluded that the Health Board is making progress in improving unscheduled care services and in implementing previous recommendations, but needs to maximise the benefits of collaborative working and prioritise improvements in unscheduled care. Wherever possible, this report considers the findings of neighbouring health boards which have relevance for Powys.

## Our main findings

9. Our review considered the following question: 'Is the Health Board securing the transformation that is necessary to create more sustainable models of care that reduce demand on the acute sector and provide better services for patients, specifically through the key interrelated areas of chronic conditions management and unscheduled care?'
10. **We have concluded that the Health Board has seen some positive developments but its potential to see a fundamental transformation of change which will reduce the reliance on acute services requires improvements in its management arrangements and stronger engagement with the wider NHS partners.**
11. The following table summarises our main sub-conclusions.

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<sup>3</sup> The Wales Audit Office undertook a preliminary review of Unscheduled Care Services in each of the health boards in Wales to provide a high-level overview of the progress made against the recommendations in our national report, *Unscheduled Care: Developing a Whole Systems Approach*, published in December 2009, and to inform the scoping of this follow up review.

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**There have been numerous improvements in services for chronic conditions and unscheduled care but more still needs to be done to improve performance and have a significant impact on reducing reliance on the acute sector**

**Some improvements in the management of emergencies are becoming apparent although performance within the main emergency departments to which Powys patients flow remains problematic:**

- minor injury unit activity has reduced significantly since 2008 but trend data for attendance at neighbouring major emergency departments is not yet available;
- patients are seen and treated relatively quickly in the minor injury units but continue to wait in major emergency departments with performance across the three main Welsh providers consistently below the four-hour target;
- delays in handover of patients from ambulance crews to emergency departments are problematic, which could be impacting on ambulance response times, with significant problems experienced in Nevill Hall Hospital and to a lesser extent in Morriston hospital;
- the extent to which patients are moved quickly from emergency departments is the responsibility of the provider health boards, however, the introduction of the care transfer co-ordinators has the potential to redirect patients at the front door;
- overall emergency admission rates are only recently starting to decline although some chronic conditions have seen some longer-term reductions;
- overall length of stay for patients with chronic conditions has remained stable although there has been substantial improvement in the level of delayed transfers of care; and
- the Health Board could do more to support GPs to reduce emergency admissions.

**There are examples of good progress in reshaping out-of-hospital services but more needs to be done to further reduce the reliance on acute services:**

- the range and availability of chronic condition services, including the role of community hospital beds, has improved to varying degrees, however, more needs to be done around risk stratification and the use of enhanced services to further support the chronic conditions model;
- the development of community resource teams is still at an early stage; and
- access to both in-hours and out-of-hours primary care is generally good although there has been a marginal deterioration in in-hours urgent access performance and there is variation across practices.

**The Health Board has made some small but positive steps in changing the way that the public uses services and improving the concept of self-care:**

- measures taken to improve the public's awareness of unscheduled care services have proved positive, and the appointment of a new Communications Officer and plans to engage the younger generation should provide additional benefits;
- a communications hub has only recently been established on a pilot basis and it is too early to say whether it will be effective at providing a single point of access to services; and
- the extent to which the Health Board has progressed self-care is variable with a good focus on health promotion but limited developments around patient education programmes and the use of assistive technology.



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**Achievement of the Health Board's vision for chronic conditions and unscheduled care services will require improvements in planning and management arrangements, and greater engagement with wider NHS partners**

**Although the strategic vision for chronic conditions and unscheduled care is articulated and is supported by high-level workforce plans, the Health Board lacks robust financial and planning arrangements for these services:**

- the Health Board's overarching strategic vision is aligned to what needs to be done to develop improved chronic condition and unscheduled care services;
- the Health Board lacks a comprehensive delivery plan that sets out the action it needs to take to deliver its vision for chronic conditions and unscheduled care;
- the Health Board lacks a robust financial plan which sets out the cost of service transformation and the resources required; and
- workforce plans are supporting developments although the age profile of the workforce presents future challenges and the Health Board does not yet have the appropriate governance frameworks to allow advanced practitioners to operate safely and effectively.

**The management structures and a lack of comprehensive information weaken the Health Board's arrangements to deliver improvements in chronic conditions and unscheduled care:**

- although there are clear links into the Board, engagement at Board level is weak and the multiplicity of committees to support the management of chronic conditions and unscheduled care has the potential to be inefficient; and
- the Health Board lacks comprehensive information, and performance management is predominantly focused on process outcomes, although positive arrangements are in place to capture patients' views.

**The Health Board has positive arrangements for engaging GPs and other stakeholders both internally and externally although greater engagement is needed from consultants and its wider NHS partners:**

- the extent to which GPs and non-medical clinicians are engaged is positive although structures do not support the engagement and ownership by consultants, particularly those based in secondary care, that the Health Board needs to deliver its vision; and
- the Health Board engages positively with its public and its Powys-based stakeholders, however, the ability to influence and engage with its neighbouring health bodies presents a challenge.

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## Recommendations

12. We have made the following recommendations to help support the Health Board in making the necessary transformation of services.

R1	<p>Strengthen the understanding of the demand placed on unscheduled care services to ensure that services are being targeted appropriately, Actions should include:</p> <ul style="list-style-type: none"><li>• putting in place arrangements to monitor trends in attendance rates to the main Emergency Departments (EDs); and</li><li>• determining how the previous demand for Minor Injuries Units (MIUs), prior to the Clinical Governance Support and Development Unit (CGSDU) report in 2008 and the subsequent closure of four of the MIUs, is now being met.</li></ul>
R2	<p>Strengthen planning arrangements to better support the development of comprehensive and equitable services across the Health Board. Actions should include:</p> <ul style="list-style-type: none"><li>• Developing a comprehensive delivery plan to pull together the actions required to deliver the vision for chronic conditions and unscheduled care, ensuring that there are robust links with the Health Board's <i>Strategic Outline Plan</i> and Corporate Plan.</li><li>• Developing a fully costed medium-term financial plan which identifies the level of commitment required to deliver improved chronic condition and unscheduled care services and the potential funding streams which can be used to support the necessary developments.</li><li>• Reviewing the group structures in place which feed into the chronic conditions and unscheduled care agendas to ensure that best use is made of the commitment required by key stakeholders to attend the meetings. This review should also include the role and purpose of each group and the opportunities to gain greater engagement at Board level.</li></ul>
R3	<p>Further develop primary and community based services so that patients' needs are more consistently met and unnecessary admissions to hospital are avoided. Actions should include:</p> <ul style="list-style-type: none"><li>• ensuring that 'risk stratification' of patients is supported and applied consistently across the Health Board;</li><li>• explore the potential for community hospitals to provide 'step up' from the community for patients who require a hospital admission which need not be to an acute DGH;</li><li>• as part of the pilot evaluation for the communication hubs in mid locality, ensure that the views of both professionals who interact with the hub and the public are obtained; and</li><li>• look to minimise the variation across and between community-based teams to ensure there is consistency around availability and the way in which teams operate.</li></ul>

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R4 Work with partner organisations to improve the experience of Powys patients who require unscheduled care or chronic conditions services:

- work with neighbouring Welsh health boards, in particular Aneurin Bevan Health Board and Abertawe Bro Morgannwg University Health Board, to identify local solutions which could improve performance within Emergency Departments including ambulance handovers and waiting times;
- work with the local authority to further improve the level of delayed transfers of care by focusing on those who are delayed for reasons which are the responsibility of Powys County Council; and
- take the opportunity of the regional planning arrangements to raise the profile of the Health Board with neighbouring health boards in Wales and strengthen the determination to influence the strategic vision for those health boards for the benefit of patients living in Powys.

R5 Strengthen engagement mechanisms to ensure that clinical staff are key leaders in the development and modernisation of services. Actions should include:

- exploring the potential to develop enhanced services with GPs which would further support the management of patients with chronic conditions;
- using existing forums for engagement with primary care, sharing the findings from our practice survey to:
  - promote opportunities for practices to learn from each other around areas of good practice to support the effective management of patients attending primary care with unscheduled care needs; and
  - gain a greater understanding of the perception amongst practice staff for the need for additional support to prevent hospital admissions; and
- reviewing the way in which the Health Board engages with its own consultants and those based in neighbouring NHS bodies to ensure greater ownership and 'buy in' to the strategic and operational delivery of chronic conditions and unscheduled care in Powys.

R6 Secure improvements in the performance of chronic conditions and unscheduled care services in Powys. Actions should include:

- Reducing the average time patients spend in the MIU in Llandrindod Wells.
- Using the results of the Welsh GP Access Survey 2011, strengthen the understanding of the reasons for variation across practices around urgent access performance and put measures in place to reduce the variation.
- Following the completion of the audit of emergency admissions by practice, exploring ways in which emergency admission data can be used to influence changes in behaviour.
- Developing a range of key performance indicators which measure the impact of services on admission avoidance. These should include indicators relating to:
  - the Care Transfer Co-ordinators; and
  - the Care Co-ordination Service in the north locality.

## Detailed report

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There have been numerous improvements in chronic conditions and unscheduled care services but more still needs to be done to improve performance and reduce reliance on the acute sector

13. Demand for hospital services is high and rising with increasing numbers of emergency department attendances and emergency admissions. Managing demand is about ensuring patients receive the most appropriate care in the right setting. Reducing inappropriate demand and preventing unplanned admissions should enable hospitals to operate more efficiently and ensure patients who truly need their services are seen as quickly as possible. This section of the report discusses the progress that the Health Board has made in recent years to transform its chronic conditions and unscheduled care services to help reduce inappropriate demand on the acute sector by developing out-of-hospital services, supporting self-care and helping signpost patients to the services which are most appropriate to their needs.

Some improvements in the management of emergencies are becoming apparent although performance within the main emergency departments to which Powys patients flow remains problematic

Minor injury unit activity has reduced significantly since 2008 but trend data for attendance at neighbouring major emergency departments is not yet available

14. The Welsh Government's *Delivering Emergency Care Services* strategy highlighted a year-on-year increase in the number of patients attending hospital EDs. As well as the general upwards trend in demand, EDs can also face sharp peaks in activity that, if not managed effectively, can result in congestion within the department and a slowing down in the provision of care to patients.
15. Powys does not provide any major emergency services but instead relies on provision from its neighbouring health boards and NHS trusts in England. Only since April 2011 has the Health Board been able to identify the level of attendances at neighbouring emergency departments by Powys residents, with attendance levels now routinely reported to the Board through the Integrated Performance report. This information however is only available from Welsh providers and shows on average 740 Powys residents attending Welsh EDs per month.

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16. Although the data presented to the Board suggests that Powys residents have attended many of the EDs across Wales, the majority of Powys residents flow to three main units in Wales and two across the border in England:
- In North Powys (the north locality), residents either flow east to the Royal Shrewsbury Hospital (Shrewsbury and Telford Hospitals NHS Trust) or west to Bronglais Hospital in Aberystwyth (Hywel Dda Health Board), with an average of 200 attendances at the Bronglais ED per month.
  - In Mid Powys (the mid locality), residents predominantly flow to Hereford Hospital (Hereford Hospitals NHS Trust). We do not have any data to identify the level of demand.
  - In South Powys (the south locality), residents generally flow east to Nevill Hall Hospital in Abergavenny (Aneurin Bevan Health Board) with an average of 291 attendances per month or south to Morriston Hospital in Swansea (Abertawe Bro Morgannwg (ABM) University Health Board) with an average of 172 attendances per month.
17. For the short period in which attendance data has been made available by the neighbouring health boards, there has been a marginal increase in attendance levels at EDs over the period April to November 2011, although this is likely to reflect seasonal trends within a year. As the Health Board gains more data on ED attendances, a focus should be given to monitoring year-on-year trends. More detailed data relating to attendance rates as well as other aspects of unscheduled care services is available in [Appendix 1](#) of this report.
18. The Health Board provides four MIUs across the county; Brecon, Llandrindod Wells, Welshpool and Ystradgynlais, to allow patients to access minor emergency treatment closer to home where appropriate. Prior to 2008, there were eight MIUs but following a review by the CGSDU, four units were closed.
19. Our report in November 2005 entitled *Acute Hospital Portfolio Phase 5 Review of Minor Injuries Units* identified attendance levels of 34,526 across seven<sup>4</sup> of the former MIUs in 2003/04. Attendance levels now stand at around 17,695 across the four MIUs which remained in 2010-11. This is an overall reduction of 49 per cent. The closure of four MIUs and a reduction in the opening hours of the remaining units will have had an impact on attendance levels. The trend in demand at each of the remaining MIUs is however variable as demonstrated in [Exhibit 1](#), with the unit in Welshpool showing an increase in demand over this period.

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<sup>4</sup> The Health Board was unable to collect data relating to activity in the Ystradgynlais MIU to inform our review of Minor Injuries Units in 2003-04.

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Exhibit 1: Changes in MIU attendances between 2003-04 and 2010-11

Minor Injuries Unit <sup>4</sup>	Attendance levels in 2003-04	Attendance levels in 2010-11	Percentage change
Brecon	11,500	6,283	45% decrease
Llandrindod Wells	6,579	5,682	14% decrease
Welshpool	3,947	4,797	22% increase

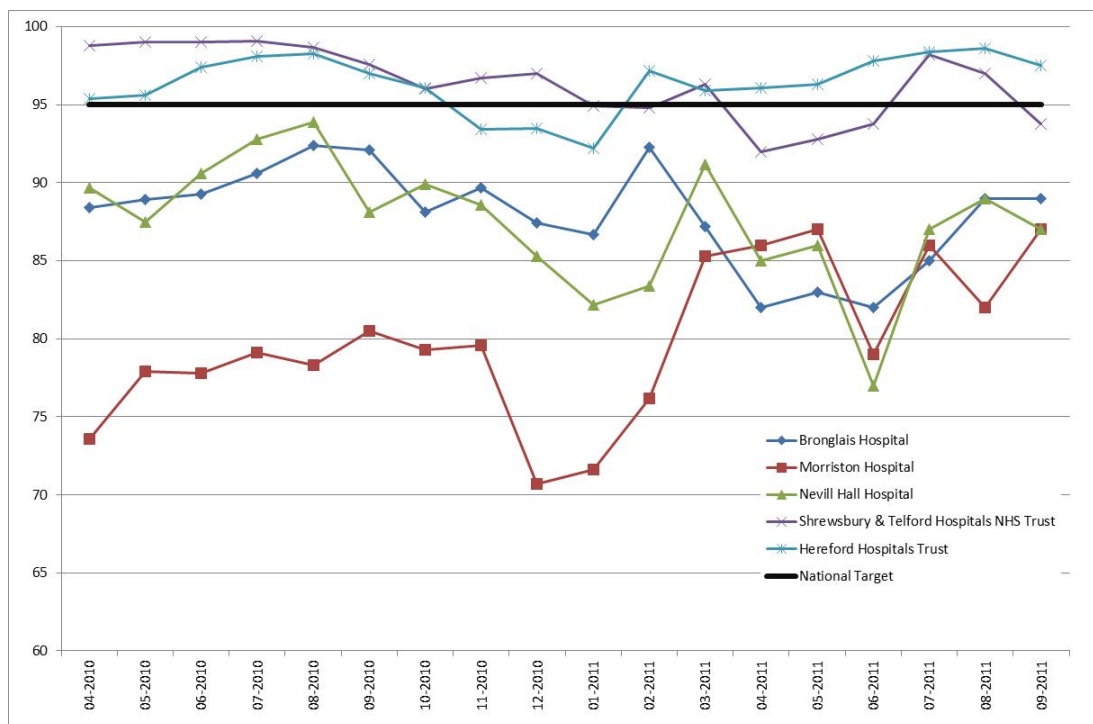
Source: Wales Audit Office

20. Our previous report on MIUs identified a high level of re-attendances, with a 42 per cent re-attendance rate reported for the Llandrindod Wells MIU at that time. Recent data indicates that re-attendance rates have substantially reduced to an overall re-attendance rate of 11 per cent, a small proportion of which are unplanned. This suggests that the Health Board has successfully reduced inappropriate demand.
21. Following the closure of the four MIUs, an Enhanced Service for Minor Injuries was developed for GP practices. We understand that this has been adopted by eight of the Health Board's 17 GP practices, although it is noted that the Health Board's own website reports 11 GP practices providing 'minor injury services'. It is likely that the demand for the MIUs that have closed is now being met by these GP practices; however, the Health Board needs to be assured that this is the case and that the demand has not been inappropriately diverted to major EDs.

Patients are seen and treated relatively quickly in the minor injury units but continue to wait in major emergency departments with performance across the three main Welsh providers consistently below the four-hour target

22. People accessing hospital emergency departments are, in the majority of cases, in need of rapid assessment and treatment. For this reason, hospital emergency departments have been set a national target of ensuring at least 95 per cent of their patients spend no longer than four hours in the department.
23. Exhibit 2 shows that the performance of the main providers of major emergency services to Powys residents is variable with none of the hospitals in Wales meeting the four-hour target.

Exhibit 2: Percentage of patients who spend less than four hours in major emergency departments used by Powys residents



Source: Stats Wales and Powys Teaching Health Board Integrated Performance Report

24. Although performance in both Bronglais and Nevill Hall Hospitals was around the Welsh average, Morryston Hospital performance was consistently the worst in Wales until February 2011. However, since March 2011 performance has substantially improved in Morryston Hospital following intervention from the Delivery Support Unit, although it is still some way from achieving the target of 95 per cent. In the main, performance is largely being met in the English hospitals.
25. With any target there is a risk that in seeking to meet the required performance level, health organisations will focus less on other important aspects of care. With the four-hour target, there is a risk that health boards focus too much on the four-hour threshold at the expense of looking more broadly at the timeliness of their care. For this reason we requested information from health boards on their average waiting times in hospital emergency departments.
26. For the three main Welsh emergency department providers to Powys residents, the average time spent in the department ranged from one hour and 45 minutes in Bronglais hospital to three hours and 18 minutes in Morryston Hospital. Of note, average waiting times in these departments have increased since our last data collection exercise in 2009.

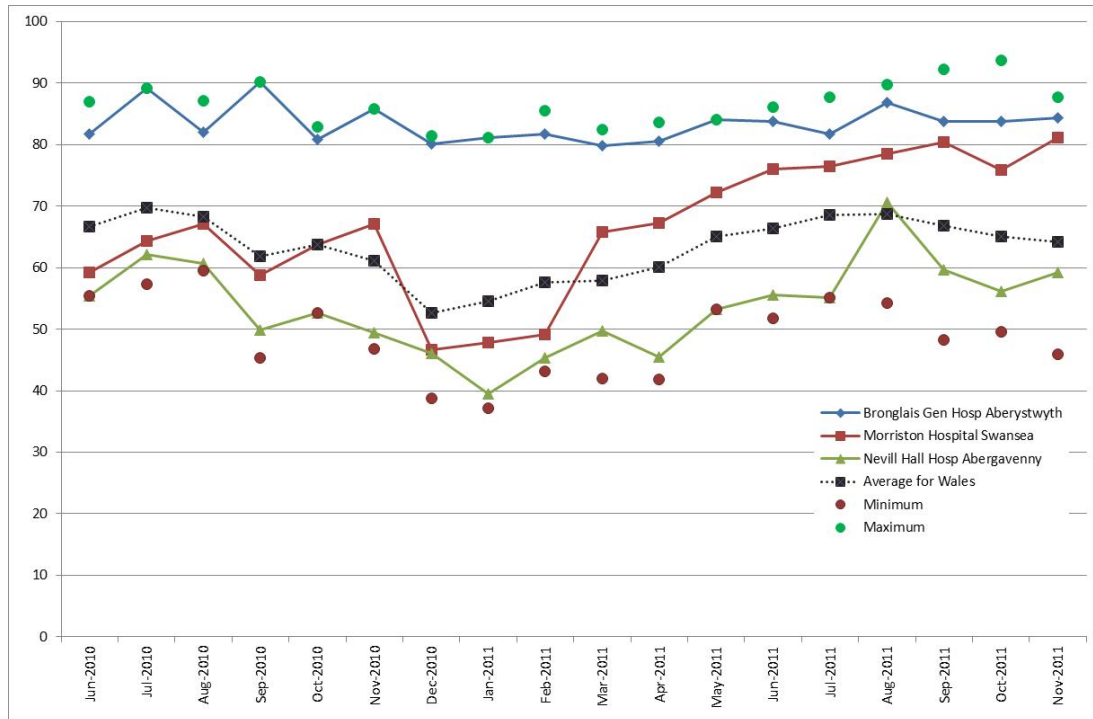
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27. For the Health Board's own MIUs, nearly all patients are seen within the four-hour target, with an average time of 30 minutes spent in the units at Brecon, Welshpool and Ystradgynlais. The average time spent in the Llandrindod Wells unit was, however, reported to be longer at one hour.

Delays in handover of patients from ambulance crews to emergency departments are problematic which could be impacting on ambulance response times, with significant problems experienced in Nevill Hall Hospital and to a lesser extent in Morryston Hospital

28. When emergency departments and the rest of the acute hospital experience elevated pressures, this can have the impact of delaying the handover of patients from ambulance crews to hospital staff. Such delays have detrimental impacts on patients who often await medical attention in the back of an ambulance or in trolleys in hospital corridors. These delays also have a detrimental impact on the ambulance service's ability to respond quickly to emergencies because when crews are delayed at hospital they are prevented from responding to other emergency calls.
29. Response times for ambulance crews to Category A calls in Powys are regularly some of the lowest performances in Wales with an average of 58 per cent of Category A calls responded to within eight minutes, although this is only marginally below the target of 60 per cent. The rural nature of Powys will clearly have an impact on the ability of the ambulance crews to respond to these calls, however, delays in being freed up from emergency departments will also be a factor.
30. Although some way off the target of 100 per cent of patients having their care handed over to hospital staff within 15 minutes of arrival, handover performance in Bronglais Hospital is amongst one of the best in Wales ([Exhibit 3](#)). While handover performance has improved in Morryston Hospital, the performance in Nevill Hall Hospital is regularly less than 60 per cent. We are unable to ascertain the handover performance in the two main English emergency departments used by Powys residents.



**Exhibit 3: Percentage of patients whose care is handed over to hospital staff within 15 minutes of arrival**



Source: Welsh Ambulance Services NHS Trust

31. The impact of delays in handover of patients from ambulance crews to nursing staff in the emergency departments can be substantial. For the first eight months of the financial year 2011-12, on average 400 hours of ambulance time per month was lost beyond the time allowed for handover in Nevill Hall Hospital, with an equivalent 228 hours in Morryston Hospital. The lost time at Bronglais Hospital is much lower at around 45 hours per month. Although this lost time does not specifically relate to Powys residents, delays in the process and the patient flow within these hospitals will impact on ambulance crews who serve the population of Powys. In comparison, response time performance in Monmouthshire is also one of the lowest in Wales, with patients also predominantly flowing into Nevill Hall Hospital which appears to be where the biggest problems for ambulance crews based in Powys lies.
32. We do not have the handover data for the Royal Shrewsbury and Hereford Hospitals, but we are aware that the Welsh Ambulance Services NHS Trust (WAST) has put arrangements in place with the West Midlands Ambulance Service NHS Trust to transfer patients between ambulances should there be significant delays at either of these units, which will free ambulance crews to return to Powys.

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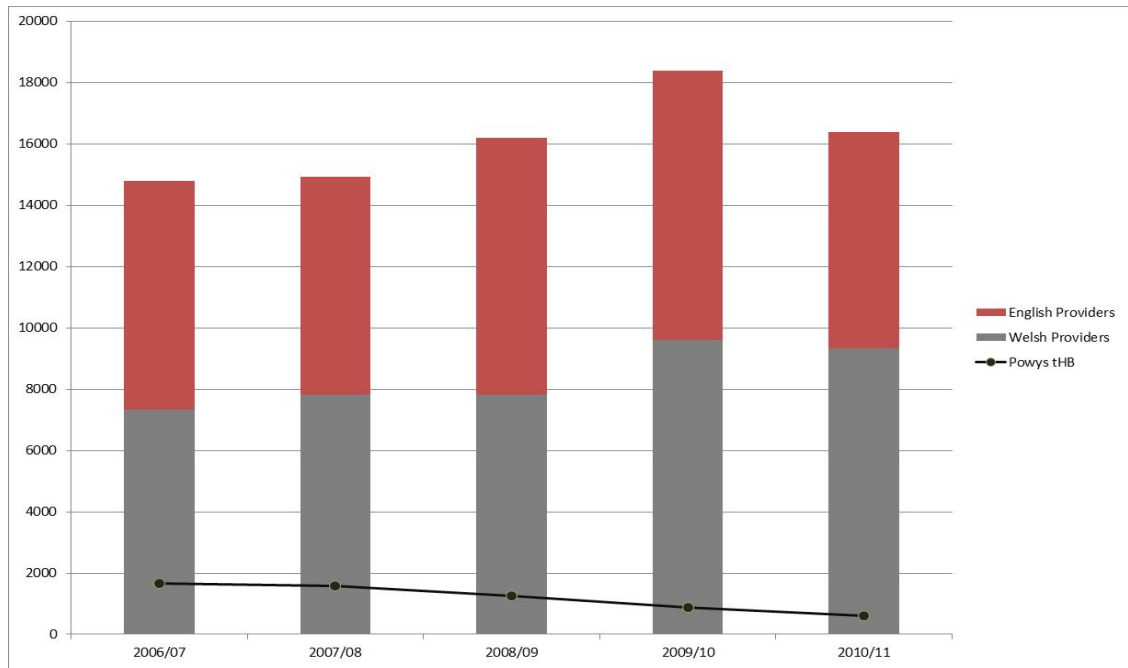
The extent to which patients are moved quickly from emergency departments is the responsibility of the provider health boards, however, the introduction of the care transfer co-ordinators has the potential to redirect patients at the front door

33. Once Powys patients are within the management of the major emergency departments, they become the responsibility of the provider health bodies to deal with the acute phase of that individual's treatment plan. How soon a patient is referred onto the appropriate specialty will depend on the arrangements in place within each of the hospitals. Our review of unscheduled care in the neighbouring health boards that provide emergency services to Powys residents identified some arrangements which had been put in place to move patients efficiently to the most appropriate service, although all areas needed to improve patient flow from their emergency departments.
34. Since our previous review of *Chronic Conditions* in 2007, the Health Board has reinstated the discharge liaison function in the form of the Care Transfer Co-ordinator (CTC) role. Although plans are in place for one CTC for each of the five main DGHs, only four of the hospitals are covered as there is a vacancy in the mid locality and Hereford Hospital. While the CTC role is predominantly focused on managing the discharge process, the co-ordinators will work with EDs as there is the potential to identify patients who, with the appropriate support in Powys, could have avoided an acute hospital admission. As there is no performance data available which reports the number of admissions avoided from EDs, the extent to which this has happened is unknown.

Overall emergency admission rates are only recently starting to decline although some chronic conditions have seen some longer-term reductions

35. One of the key aims of the Chronic Conditions Management (CCM) model and framework was to reduce the number of avoidable emergency admissions and readmissions, and ensure that lengths of stay were not excessive. Achieving this will help ensure that acute sector resources are used more appropriately, and support a more efficient 'flow' of patients through the hospital. Problems at a ward level caused by high emergency demand, long lengths of stay and delayed discharges can also have a knock-on effect on the transit of patients through the emergency department.
36. Between 2006-07 and 2009-10 emergency admission rates of Powys residents to neighbouring DGHs grew incrementally by 25 per cent ([Exhibit 4](#)). Although in 2010-11 emergency admissions fell by 11 per cent on the previous year. However, the level of emergency admissions direct to Powys based community hospitals fell by 63 per cent from 1,657 in 2006-07 to 614 in 2010-11. Although the total number of beds available in the community hospitals has decreased since 2006-07, the extent to which bed numbers have decreased does not account for the reduction in emergency admissions to community hospitals. The Clinical Governance Support and Development Unit report in 2008 limited the types of patients admitted to the community hospitals resulting in more patients being admitted elsewhere or managed alternatively.

**Exhibit 4: Emergency Admissions for Powys Residents to Welsh (including Powys Teaching Health Board) and English Providers 2006-07 – 2010-11**



Source: Powys Teaching Health Board Integrated Performance Report, June 2011

- 37.** The rate of emergency admissions for some chronic conditions has steadily declined over the last five years indicating that the Health Board has had some success in preventing unnecessary admissions. This is particularly the case for patients diagnosed with angina, asthma, stroke and heart failure. Emergency admission rates for Chronic Obstructive Pulmonary Disease (COPD) have slightly increased since 2006/07.

**Overall length of stay for patients with chronic conditions has remained stable although there has been substantial improvement in the level of delayed transfers of care**

- 38.** Efficient discharge processes are another key determinant of good hospital flow. If discharge processes do not work well, patients spend too long in hospital which can pose risks to their independence as well as prevent flow from the emergency department to the wards. The primary focus of the four Care Transfer Co-ordinators (referred to in paragraph 34) is to manage the discharge of Powys residents from the main neighbouring DGHs. These roles work alongside ward staff to promote early discharge from hospital and to facilitate the discharge of those patients with more complex needs.

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39. The average length of stay for Powys patients admitted to hospital (either DGH or community) with chronic conditions has remained stable since 2006-07 and is comparable to many other health boards. An exception to this is patients admitted with a diagnosis of stroke, where the average length of stay has increased from 16.6 days in 2006-07 to 21 days in 2010-11. Prior to 2010-11 the average length of stay for patients diagnosed with a stroke was decreasing, with an average of 13.5 days reported in 2009-10.
  40. When a patient is ready to be transferred to the next stage of care but for one or more reasons transfer is prevented, patients will experience a 'delayed transfer of care'. Delayed Transfers of Care (DTOC) have negative impacts on the people who become delayed, with significant implications for their independence. Delayed transfers of care also have an impact on wider service delivery and performance across the whole health and social care system but the immediate effects manifest themselves within hospitals. The Welsh Government's *Delivery Framework for NHS Wales for 2011/2012*, includes a Tier 2 target of continuing to improve performance in relation to DTOC.
  41. The level of DTOC within Powys' own community hospitals is amongst the lowest in Wales with an average of 23 patients per month delayed in the first eight months of the financial year 2011-12. This is a significant improvement in performance from the previous financial year when DTOC levels peaked at 45 patients. The majority of patients delayed are as a consequence of unavailability of care home provision or delays in receiving community care provided by social services. This emphasises the need for the Health Board to work effectively with its local authority partners to minimise such delays. A small proportion of patients are delayed due to problems accessing health care provision, which reflects the provision of community services which is discussed later in this report.
  42. Very few residents from Powys experience delayed transfers of care whilst in other hospitals, with patients generally transferred back to a Powys-based community hospital before a delay occurs. In the first eight months of 2011-12, five patients on average per month were delayed in hospitals outside of Powys. The main reason for these delays was also unavailability of care homes.

#### The Health Board could do more to support GPs to reduce emergency admissions

43. Part of the solution to reducing unnecessary admissions involves sharing information with GP practices about their admission rates. By analysing such information and comparing with peers, practices become more aware of their current ways of working and may be able to learn from the ways in which other practices work.

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44. Emergency admission rates by GP practices are not routinely shared with practices across Powys with the exception of through the Quality Outcomes Framework (QOF) annual report. The findings of our practice survey<sup>5</sup> identified that only one of the practices responding in Powys found the data on emergency admissions within the QOF framework useful. Issues around the quality of data were raised by practices as being the main barrier to its effectiveness.
45. The Health Board has recently started to undertake a three-month audit of emergency admissions by GP practices in the mid and south localities to provide a more detailed review of admission profiles. The findings of this review have yet to be reported. We are not aware of any similar exercises being undertaken in the north locality.
46. Minimising unnecessary admissions will not be possible if GPs are not aware of, or do not have access to, an adequate range of support services such as rapid diagnostics, access to consultant advice and hot clinics. If such services are not available, or are hard to access or to contact, GPs may be dissuaded from using them. Our practice survey showed that, of those responding, more needed to be done to help avoid emergency admissions, hospital attendances and ED attendances, with:
- only two practices (25 per cent) reporting that they have good access to either telephone or e-mail advice from consultants (or other specialists) to help manage a patient's acute condition and avoid an emergency admission/ hospital attendance or ED attendance when appropriate (compared with 32 per cent across Wales);
  - only one (13 per cent) reporting that they have good access to 'rapid access clinics' or 'hot clinics' to help avoid emergency admissions/hospital attendances and ED attendances when appropriate (compared with 34 per cent across Wales); and
  - two practices (25 per cent) reporting that they have good access to diagnostic services to help avoid emergency admissions/hospital attendances and ED attendances when appropriate (compared with 32 per cent across Wales).

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<sup>5</sup> Eight out of 17 practices (47 per cent) in the Powys teaching Health Board area responded to our survey. Across Wales we sent the survey to 498 practices and received 131 responses (a 26 per cent response rate).

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## There are examples of good progress in reshaping out-of-hospital services but more needs to be done to further reduce the reliance on acute services

The range and availability of chronic condition services, including the role of community hospital beds, have improved to varying degrees, however, more needs to be done around risk stratification and the use of enhanced services to further support the chronic conditions model

47. Our previous audit work highlighted the fact that community services were often fragmented and poorly co-ordinated with many services unavailable 24 hours a day. We found that patients who were at risk of readmission to hospital were not consistently identified or offered adequate support to reduce that risk. In addition, health and social care professionals reported a lack of information about what services were available to care for and support individuals in the community as alternatives to hospital referral or admission.
48. The Welsh Government's CCM model and framework signalled the need to rebalance services on a whole-system basis meaning relocating care and treatment closer to home. It identifies four levels of care, ranging from primary prevention through to complex case management, to ensure support is targeted and effectively co-ordinated, according to individuals' risk and care needs.
49. Delivery of the proposed model relies on health boards identifying the needs of their communities and to 'stratify' practice populations according to levels of risk. Those individuals identified at the greatest risk of unplanned admissions should be actively managed to ensure they receive the right care in the most appropriate place.

### *Risk stratification is inconsistent and has not been fully implemented*

50. Following the allocation of transitional funding in 2008, the Health Board appointed three Care Service Co-ordinators (CSCs) in 2009 to take forward developments needed in the management of chronic conditions and the provision of services in the community. These roles included a focus on putting processes in place to identify patients with a high risk of unplanned hospital admission. Working with existing services in the community, the CSCs adopted the Emergency Admission Risk Likelihood Index (EARLI) tool to identify those in social care settings at high and medium risk. Patients identified at high risk were discussed in multidisciplinary meetings to examine what services could be put in place to support these patients and where possible prevent any unplanned admissions, and offered a comprehensive district nurse assessment. Those patients identified at medium risk were signposted by the CSCs to appropriate support, alongside the development of a plan which identified how the patient could self-manage their condition.

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51. The CSCs were discontinued in March 2011 when transitional funding ceased, and the role of stratification of patients was handed over to district nurses in each of the localities. The extent to which this has continued varies by locality with some practices awaiting the all-Wales decision on PRISM before this is further progressed. Challenges around information storing and sharing have been identified which are preventing risk stratification being fully implemented. These are particularly in relation to the storing of stratification data within primary care and the sharing of information between DGHs and the Health Board on patients who have frequent admissions to hospital. In addition, the timescale for rolling out the Individual Health Record (IHR) in Powys is unknown with the likelihood that it will not be until the end of the national timetable in 2013.

*Improvements have been made to chronic condition services resulting in more comprehensive coverage but there remain problems, with inconsistency between localities, unsustainable funding mechanisms and limited resources*

52. When we last reported on chronic conditions in 2008, we identified that while there were some good initiatives in place in the community, overall schemes to support patients to maintain chronic conditions and to minimise reliance on the acute sector were limited. Over the last three years, the Health Board has further developed these services and introduced some new initiatives which have had a positive impact on the wider unscheduled care services:
- District nursing services have been extended to seven days a week and are now available from 8 am through to 9 pm every day across all areas.
  - Services to support patients with diabetes have continued to flourish with wider access to the diabetes specialist nurses than previously reported. Specialist nurses are now aligned to localities and work much more closely with the communities and GP practices. A hypoglycaemia pathway has also been set up in partnership with WAST which includes the referral of patients to the specialist nursing service for follow-up.
  - The Coronary Heart Disease (CHD) Specialist Nurses are now supported by a heart failure pathway and a TIA pathway which routes appropriate patients into the service.
  - The Respiratory Specialist Nurses provide support for patients with respiratory conditions, particularly those requiring oxygen. A pilot COPD rehabilitation team was established in the north locality in 2010 to provide an intensive package of rehabilitation for six weeks. This is supported by a COPD pathway developed in partnership with Hywel Dda Health Board. There are plans in place to roll this out across the other two localities.

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- A new falls service has been set up in each of the localities, although the services in the north and mid localities were only established in 2011. The service allows patients who suffer with a fall, or are at high risk of falls to access specialist services to provide rehabilitation and prevent falls in the future. A falls pathway has also been introduced which allows professionals and paramedics to refer patients to the service.
  - The Parkinson's Specialist Nurse service has now been extended to cover the whole of Powys. Multiple Sclerosis (MS) services have been developed and established in the north locality and plans are in place to roll this out across the other areas. An epilepsy pathway has also been developed alongside the Epilepsy toolkit which has been disseminated to all GP practices.
  - An end-of-life pathway has been developed to support the work of the Specialist Palliative Care Nurses although further work is required to fully implement this in practice.
  - A rehabilitation team established in the mid locality provides six weeks of intensive support to patients who would benefit from a programme of rehabilitation. The Powys Urgent Response Service at Home (PURSH) team, a service provided by the voluntary sector, has also been established in the north locality and recently rolled out to the mid and south localities.
- 53.** Services to support the management of chronic conditions in Powys are now available to a much wider population than those that were previously in place in 2008. Access to the services can be made from a wider range of professionals, including patients and carers, and most services can be accessed relatively quickly, with a maximum waiting time of one week reported. Protocols are in place for referrals and all services provide admission avoidance. All but the CHD and Respiratory Specialist Nurse services also facilitate early discharge from hospital. Many services are not time limited.
- 54.** However, funding for these services is largely on a short-term recurring basis with concerns raised by staff that they are unsustainable. With the exception of the rehabilitation team, district nursing service and the specialist palliative care nurses, services are only provided during normal weekday hours and no services report having single integrated records for all professions. Geography and demand for services also mean that many of these services have limited staffing levels which can be stretched when under pressure, for example, staff absence or vacancies, and capacity within these teams can be small. Although some services are Powys wide, others have been established on a locality basis and this can mean that the way in which services are provided can vary slightly from locality.



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*The community hospital beds continue to be largely used for step down from a DGH as opposed to step up from the community*

55. Our previous work on chronic conditions found that the role of community hospitals in helping to manage chronic conditions was unclear. Community hospitals were typically not used to prevent or divert acute hospital admissions or to facilitate early discharge home for patients with chronic conditions. Across Wales there has been a reduction in the number of community hospital beds, from just over 2,500 in 2004-05 to just over 2,200 in 2009-10. In line with the national picture, the number of community hospital beds in Powys has reduced from 360 in 2004-05 to 278 in 2009-10. In contrast, the level of acute beds available across Wales has remained relatively static at around 1,100. This is despite emergency admissions to acute hospitals increasing and elective waiting lists reducing, suggesting that average lengths of stay for acute hospital episodes are generally reducing and patients are flowing through the system more efficiently than in 2004-05.
56. As discussed in paragraph 36, the emergency admission rate to community hospitals in Powys has declined over the last five years. The rate of decline in admission is, however, much steeper than the decline in the number of beds. Occupancy levels in the community hospitals have stayed consistent, which would indicate that the admission route into community hospitals is predominantly direct from DGHs. GPs are reported to have greater access to community beds, including the out-of-hours service than when we previously reported in 2008. However, Powys-based consultants in age care continue to manage a large proportion of community-based beds. Developments in stroke and orthopaedic rehabilitation suggest that the role of community beds has become more focused over time.

*Despite a wide range of enhanced services, the use of primary care contracts for chronic conditions remains limited*

57. Historically, the use of primary care contracts in creating capacity to care and support patients in the right place has been limited. In 2008, we reported that the Health Board had only made use of three enhanced services to support the management of chronic conditions. In 2010-11, although the Health Board reported a wide range of enhanced services, there are now only two enhanced services which are specifically focused on managing chronic conditions; diabetes care and heart failure (which has been new since 2008). The Health Board has, however, introduced a number of broader, enhanced services which will include patients with chronic conditions. This includes an enhanced service for patients in care homes and a lifestyle and dietary advice enhanced service which is discussed later in this report.

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58. The total expenditure projected for enhanced services in 2011-12 is £1.8 million. This accounts for less than three per cent of the total expenditure on primary care services. The proportion of the expenditure on enhanced services specifically for chronic conditions is around 15 per cent.

**The development of community resource teams is still at an early stage**

59. *Setting the Direction* and the CCM model and framework both advocate the need for an integrated multidisciplinary team that focuses on co-ordinating community services across geographical localities for individuals with complex health and social care needs. These Community Resource Teams (CRTs) will target care and support to help individuals identified as at the greatest risk of hospital admission to maintain independence in their own communities.
60. The Health Board has yet to establish formal CRTs. A paper, developed by the Care Service Co-ordinators, on a proposed CRT model in Powys was submitted to the Board in March 2011 but was not endorsed. Following the disbandment of the CSC role, the responsibility for developing the CRTs was passed onto the locality management teams to take forward. Based on the principles set out in the original Board paper, each of the localities are taking forward a four-staged approach to developing the CRTs:
- Stage 1 – identifying the component members of the community resource team;
  - Stage 2 – health professionals working together informally around GP practices;
  - Stage 3 – informal team extended to non-health professionals; and
  - Stage 4 – team formalised with generic referral pathways.
61. Each of the localities is at varying levels of the first stage of development. The mid locality has decided on the constitution of the CRTs. Initially focused on the Builth Wells practice, the mid locality CRT will be a fundamental part of the health and social care model being developed in this area through the capital programme scheme. Other areas are less developed, with discussions around the make-up of the CRTs still to be decided. However, by aligning the specialist nurses to the localities who will work closely with the CRTs, the Health Board has taken a step in the right direction.

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Access to both in-hours and out-of-hours primary care is generally good although there has been a marginal deterioration in in-hours urgent access performance and there is variation across practices

*Access to primary care is generally good with some positive action being taken to make improvements although variation in performance across practices and an overall deterioration in the ability for patients to access urgent primary care during normal working hours suggests more focused attention is needed*

- 62.** The urgent care provided by GPs and other primary care professionals is a vital part of the unscheduled care system in Wales with roughly 5.5 million unscheduled encounters each year. When patients are unable to access primary care services urgently, not only do they have a poorer experience but they often default to acute services. Defaulting to acute services, such as ambulance and emergency department services, is costly and results in increased demand elsewhere in the system.
- 63.** In a 2009 report supported by the Royal College of General Practitioners and the British Medical Association's General Practitioners' Committee, the Primary Care Foundation highlighted a wide range of issues for practices to consider that have the potential to free up capacity within their core hours and have resulting benefits for patient access. No practices in Powys have, however, used the Primary Care Foundation report in any way to review arrangements for providing urgent access.
- 64.** The Health Board has 17 primary care practices, providing services across 29 surgery locations. Sixteen of the 17 main surgeries are open during the core hours<sup>6</sup> from Monday to Friday with the exception of the Cemmaes Road practice which is closed on a Thursday afternoon. This practice is the smallest in Powys with a list size of around 2,300 although discussions are being held with the practice to review its opening hours. Many of the 12 branch surgeries are only open for half-day sessions, although patients are able to access the main surgeries during core hours. None of the practices in Powys has taken up the enhanced service for extended surgery opening hours.
- 65.** The results of the Welsh GP Access Survey 2011 showed that:
- When patients tried to access urgent primary care within 24 hours, 79 per cent were able to do so. This is marginally below the Welsh average at 80 per cent. This performance has, however, deteriorated since the Access Survey in 2010 which identified that 86 per cent of patients were able to access urgent primary care within 24 hours.

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<sup>6</sup> Core hours are defined as being from 8 am through to 6.30 pm.

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- Urgent access performance in 2011 varies across the practices with some achieving above 90 per cent. However, whilst many practices achieved between 72 and 85 per cent, there are two practices which only achieved 64 and 66 per cent respectively in 2011. For both practices, this performance was a significant deterioration from their performance in 2010.
- 66.** Following the 2011 review, discussions were held with the Community Health Councils (CHCs) within Powys to take the findings of the access survey forward with individual practices. The findings of our practice survey suggest that in the main this has worked well, with six of the eight practices which responded to our survey reporting that they had used the Welsh GP Access Survey to review access issues, as well as review issues around same day and urgent access. As a result some changes had been made to improve access including adjusting the mix of book-ahead and same-day appointments, providing extra appointments later in the evening and amending the appointment system to keep one GP free as a designated duty GP operating 24 hours a day.
- 67.** Analysis of other primary care access indicators indicates that generally patients in Powys are able to access services when they need to, with:
- 71 per cent of patients able to access an appointment with a GP or healthcare professional more than two full days in advance, compared to the Welsh average of 69 per cent;
  - 87 per cent of patients reported that it was 'very easy' or 'fairly easy' to get through to the practice on the phone, compared to the Welsh average of 80 per cent; and
  - 88 per cent of patients reported that it was 'very easy' or 'fairly easy' to book an appointment, compared to the Welsh average of 84 per cent.
- 68.** When reviewing the indicators at a practice level, there is, however, a number of outlier practices. The Health Board needs to be assured that performance within these practices, particularly around ease of access, is not resulting in patients diverting to other services inappropriately.
- 69.** The receptionist is the first point of call for a patient in a GP practice. Four out of the eight practices (50 per cent) responding to our survey identified that they have formal protocols in place to deal with requests for appointments (compared with 55 per cent across Wales). Receptionists in six of the practices receive training on induction, and five subsequently received refresher training on identifying urgent and emergency calls. Over the last two years, four practices had reviewed receptionists' effectiveness in identifying emergency/urgent calls and as a consequence one practice now gets the receptionists to ask patients if they are happy to give some basic details concerning their need to see a GP so that their request can be prioritised.

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70. Findings of the practice survey would suggest that patients can occasionally exploit the primary care system with examples given of patients specifically phoning on the day when they know that the duty GP is the doctor of their choice. Our survey also identified that the average 'did not attend' rate in primary care was 7 per cent, ranging from 5 to 10 per cent irrespective of appointment type and approximately 10 per cent of appointments are used for patients with non-clinical needs in a week, ranging from 0 to 30 per cent across practices.
71. The full results of our practice survey can be found in [Appendix 2](#).

*The out-of-hours service for Powys works well and the care co-ordination service in the north locality is having a positive impact on admission avoidance*

72. The aim of primary care out-of-hours services is to ensure individuals with urgent primary care needs which cannot wait until the next available in-hours surgery, are met and that other patients accessing the service are given appropriate advice and information. The primary care out-of-hours period is defined as from 6.30 pm until 8.00 am on weekdays, and all weekends, bank holidays and public holidays.
73. In Powys, the out-of-hours service is provided by Shropshire Doctors Co-operative Ltd (ShropDoc). ShropDoc provide triage of all Powys patients through its central team based in Shrewsbury. Patients who require a consultation are then referred to the treatment centres in Brecon, Llandrindod Wells, Newtown and Welshpool where they will either be required to attend the centre or will receive a home visit from the out-of-hours GP. Consultation for patients registered with the Machynlleth and Cemmaes Road practices in the north locality, and the Ystradgynlais practice in the south locality is provided by Betsi Cadwaladr University Health Board and ABM University Health Board respectively.
74. ShropDoc also provides a Care Co-ordination Service (CCS) for the north locality to co-ordinate urgent GP referrals to hospital. This service is provided between 8 am and 7 pm by nurse practitioners whose role it is to assess the reasons for urgent referral to hospital and to ascertain whether there are alternatives to admission. This service on average has been able to divert 22 per cent of urgent GP referrals away from hospital to more appropriate services. In addition the CCS also co-ordinates Powys-wide referrals to the Macmillan service and referrals to the PURSH and the sitting service for elderly patients.
75. The Welsh Government's *Ten High Impact Steps to Transform Unscheduled Care* states that primary care out-of-hours units should ideally be 'functionally integrated within emergency departments'. This means the unit and the emergency department should have a common reception and common operational processes.

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- 76.** All of the out-of-hours treatment centres in Powys are located closely to the MIUs in each of the respective hospitals, with the exception of Newtown which does not have an MIU. Staff in the MIUs have identified good working relationships with the out-of-hours service with opportunities to refer patients between the two services. The out-of-hours service also supports the hospital wards by providing the out-of-hours medical cover. This includes supporting admissions to the community hospitals and undertaking the ‘track and trigger’<sup>7</sup> process which triggers when a patient’s needs to be referred on to a DGH.
- 77.** Approximately 80 per cent of the out-of-hours GPs are from within the Health Board, and the service is not reliant on the use of locum doctors. This means that there is continuity for both patients and other professionals working with the service.
- 78.** In 2010-11, the Health Board spent just over eight per cent of its GMS expenditure on the out-of-hours service. This is marginally above the Welsh average of 7.24 per cent and the second highest in Wales. However, the average spend on the out-of-hours service is the highest in Wales at £18.43 per registered patient, although this has decreased since 2005-06 when it was £20.26 per registered patient.
- 79.** The population of Powys and the geographical spread of the county makes it difficult for the Health Board to provide a service which is in line with the cost of other services across Wales, however, the performance data provided as part of this review suggests that the out-of-hours service performs well with:
- between 95 and 98 per cent of urgent calls per month assessed and triaged within 20 minutes; and
  - of those requiring urgent face-to-face consultations, all patients are seen within one hour at the primary care centre or treatment centre and on average 92 per cent of patients are seen within one hour at home.
- 80.** Forty per cent of calls to the out-of-hours service require face-to-face consultation and 16 per cent of patients go on to have face-to-face consultations at home. This rate of home visits is slightly higher when compared with other out-of-hours services in Wales, and the distance to the treatment centres can be a factor in deciding whether a patient comes into the treatment centre or whether the GP goes out. Our previous review of *Unscheduled Care* considered data from 2007-08 which showed the average across Wales at that time was 12 per cent.
- 81.** When asked, six of the practices responding to our survey perceived out-of-hours services to be ‘very good’ or ‘good’ at meeting the needs of patients while the other two had no strong views. Reference was made to the challenges in providing an out-of-hours service in such a rural area although the use of local GPs was seen as a positive.

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<sup>7</sup> ‘Track and Trigger’ is a modified early warning system which alerts staff if a patient’s condition is deteriorating, requiring the patient to be transferred to a neighbouring DGH.

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- 82.** With the exception of the Cemmaes Road and Machynlleth practices which link directly to Betsi Cadwaladr University Health Board, the Individual Health Record, which would support the sharing of information between in-hours and out-of-hours primary care services, has not yet been rolled out across Powys. To improve the sharing of information, however, ShropDoc has developed a 'flagging system' for GPs to allow them to identify patients who are likely to require the out-of-hours service such as those with complex needs or requiring palliative care. The out-of-hours team also routinely provides an email to relevant GPs by 8 am the following day in relation to patients who have been referred into the service. For complex patients, the team will also contact the practice prior to the start of clinic to speak to the GP. This communication channel was reported to be working well.

## The Health Board has made some small but positive steps in changing the way that the public uses services and improving the concept of self-care

Measures taken to improve the public's awareness of unscheduled care services have proved positive, and the appointment of a new Communications Officer and plans to engage the younger generation should provide additional benefits

- 83.** Our 2009 report on *Unscheduled Care* noted that as a consequence of the complexity of the system of health and social care, the public can be uncertain about how and where to seek help. Part of this uncertainty stems from the wide range of different access points within the system. For example, a person suffering a minor injury may have a choice of attending an emergency department or minor injury unit, going to see their GP, phoning NHS DirectWales or caring for themselves. People face further uncertainty because of the variation in services that are available at different times of the day and night, and at weekends, in different areas of Wales.
- 84.** The 2009 report recommended that a national communications strategy should be developed to improve public understanding about how to most appropriately access care. In response to this recommendation, in March 2011 the Welsh Government launched the national 'Choose Well' campaign which aimed to 'facilitate the use of more informed and effective decision making by the public when accessing NHS services and to allow pressurised healthcare resources to be appropriately used based on clinical need'.
- 85.** The 'Choose Well' campaign is considered by the Health Board to be a key component in managing demand for services and following the launch of the national campaign, links were made available on the Health Board's internet and intranet site, with briefings made available for all staff. An article was also included in the Red Kite newsletter which is a local-authority-led paper issued to all residents in Powys every quarter.

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- 86.** Communication within the rural localities is recognised as the biggest challenge for the Health Board. Initial work around the campaign identified that the younger generation in particular was the most challenging group to target. As a result plans are in place to target the young farmers' community, with a stand proposed at the annual Royal Welsh Show. Other media which would attract the younger generation such as Facebook pages and YouTube videos are also being looked at as well as wider public health campaigns. At the time of our fieldwork, the Health Board had recently appointed a Communications Officer whose role includes taking some of these ideas forward.
- 87.** The Health Board has also undertaken a pilot project, with the support of Communities First funding, in the Bro Dyfri area in the north locality following the closure of the MIU and the transfer of services to the local health centre. The team undertook a baseline survey of the local patient population to establish their understanding of which services to access based on a range of differing scenarios. The pilot team then developed a leaflet on unscheduled care services, based on a sample survey developed in Betsi Cadwaladr University Health Board. The survey was rerun following the introduction of the leaflet.
- 88.** Findings from the pilot work identified a positive shift in public awareness around which services to access and when, with an increase from 78 to 84 per cent of responders identifying self-management as the best way to deal with a hangover, and an increase from 31 to 55 per cent of responders knowing how to access local minor injury services. The Health Board has also increased its uptake of the enhanced service for contraception in the local area as a result of the findings of the survey.
- 89.** Findings of the pilot work have recently been reported to the Health Board's Unscheduled Care Board with plans to share key messages across the whole of the county. The partnership board has already recommended that on discharge from hospital or an MIU, patients should be provided with adequate telephone numbers and details of support arrangements.
- 90.** At an individual patient level, there are a number of initiatives in place to redirect patients at the point of access, if a patient is deemed inappropriate. These include:
- The introduction of the falls pathway, already discussed in paragraph 52, which allows paramedics and MIU professionals to redirect patients into the falls service.
  - Open access to urgent in-hours GP appointments for MIU professionals as well as access to out-of hours GPs who are co-located with the MIUs.
  - The CCS in the north locality run by ShropDoc, also already discussed in paragraph 74, which allows urgent GP referrals to hospital to be redirected if alternatives to admission are available.
  - A protocol for '999 diversion' by ambulance crews following an audit of a sample of 999 cases which identified a number of cases could be more appropriately managed either in MIU or through the out-of-hours service. This protocol is applied by ambulance control staff.



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91. For some patients in Powys, the distance to the nearest major ED can be up to 50 miles so the likelihood of patients attending the ED inappropriately is perhaps lower than would be in other health board areas. The distance for some patients to the Health Board's own MIUs can also be substantial, so there is a general perception amongst staff that patients will generally only attend EDs and MIUs if it is absolutely necessary.

A communications hub has only recently been established on a pilot basis and it is too early to say whether it will be effective at providing a single point of access to services

92. Our 2009 report on *Unscheduled Care* recommended that health boards should seek to provide better access points to services. Part of the vision described in *Setting the Direction* includes the development of communications hubs acting as single points of access for the co-ordination, scheduling and tracking of care across the interface between the hospital and community setting. The vision states that integrated access to information would support better decision-making and improved co-ordination of care.
93. In January 2012, the Health Board established a pilot communications hub for the mid locality, based in local authority offices in Llandrindod Wells. The hub has been developed to provide a central point of contact for both patients and professionals to a range of services, as well as a low level multi agency assessment which could prevent potential hospital admissions. The range of services includes all requests for adult social services in Radnorshire and district nursing services across the mid locality, as well as signposting to services identified through an up-to-date service directory. The hub is available during normal working hours and is an eight-seat centre consisting of social workers, district nurses, local authority occupational therapists and the voluntary sector, as well as a number of call handlers. Work is underway to embed integrated IT systems through the IT manager who is appointed jointly between the Health Board and the local authority.
94. The Health Board plans to evaluate and revisit the pilot after three months with the potential to include access to specialist nurses and patient transport via the hub. Benefits to the district nursing service have already been identified as the administration of the service such as responding to low level requests will be diverted to the hub, allowing the qualified staff to focus their time on essential calls. The Health Board has been working with the National Leadership and Innovation Agency for Healthcare (NLIAH) to establish a number of outcome measures which include:
- release of professional time measured in hours;
  - patient/user satisfaction of the service;
  - number of appropriate calls closed by call handler; and
  - the outcome for the patient if the hub had not intervened.

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95. However, during our fieldwork, some staff were less optimistic about the communications hub. There were concerns that staff within the hub would be divorced from the services that they cover and the relationship that staff had built up with individual workers, such as social workers or district nurses, would be lost. Other concerns included the potential of adding another layer to the process, possible confusion within the public around the role of the hub compared with that of the contact centre already in place in the local authority, and the view that the hub can only be effective if there are services to transfer patients on to.
96. It is important that when the hub is evaluated the Health Board engage with staff to address any concerns that they may have and demonstrate how these can be mitigated through the communications hub. The Health Board also needs to be clear as to how the communications hub interrelates with all centres providing similar roles, including the potential links with the CCS in the north locality which currently provides a single point of access to the palliative care service.

The extent to which the Health Board has progressed self-care is variable with a good focus on health promotion but limited developments around patient education programmes and the use of assistive technology

97. It is essential that individuals are encouraged and supported in looking after their own health and well-being. Our 2008 report on *Chronic Conditions* found that the provision of patient education to support self-care was insufficient given the high prevalence of chronic conditions and a growing population of older people across Wales. Self-care is associated with positive outcomes for individuals, such as improved knowledge of their condition and better coping behaviours. Other benefits include reduced reliance on healthcare services, which helps to sustain services long-term.
98. The Welsh Government's framework for self-care<sup>8</sup> describes a continuum starting with healthy living, self-care of minor ailments with or without the support of professionals, like GPs or pharmacists, to more formal help in managing complex health problems. There are four key elements of self-care support covering this continuum. These are:
- information and signposting;
  - skills training for patients and professionals;
  - peer support networks; and
  - assistive technologies, like telehealth.

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<sup>8</sup> Welsh Government, *Improving Health and Well being in Wales, A Framework for Supported Self-care*, October 2009.

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99. The Health Board has introduced an enhanced service for lifestyle and dietary advice, although the uptake of this has been low with only six of the 17 practices providing the service. This service promotes wider health promotion aspects such as diet and exercise, and will link patients into such schemes as exercise programmes. The Health Board has recognised that this enhanced service needs to be revisited due to the low uptake. Also seven of the 23 pharmacies across the county provide the 'Stop Smoking Service', and the majority of GP practices are able to access the stop smoking service co-ordinators. As well as the 'Choose Well' campaign, many of the GP practice websites across Powys provide some high level self-management of minor ailments and signpost patients to wider information sources. Links are also available to the NHS Direct Wales website.
100. The *One Powys Plan*<sup>9</sup> for 2011-14, which sets out the approach to jointly planning and delivering public services across Powys, includes a key outcome for people in Powys to be healthy and independent. To achieve this outcome, the Health Board has committed to implement the key actions identified within *Our Healthy Future* including the production of an annual report that demonstrates the health needs of the population of Powys and progress made against each of the top 10 priorities within it. The Health Board's public health team, in its strategic framework for 2011-14, has set out the actions that need to be taken to deliver the 10 priorities which include increasing physical activity rates and reducing unhealthy eating. This includes such activities as stepping up the level of 'active health promotion' and ensuring targeted support where needed to encourage active lifestyle choices.
101. Enabling patients to self-manage chronic conditions is a key component of effective care and improved patient outcomes. It is well recognised that self-management education programmes, bringing together patients with a variety of chronic conditions, can improve clinical outcomes and reduce costs. Expert patients are defined as people living with a long-term health condition who are able to take more control over their health by understanding and managing their conditions, leading to an improved quality of life. In particular they make fewer visits to the doctor, communicate better with health professionals, take less time off work, and are less likely to suffer acute episodes requiring admission to hospital.
102. Education programmes for patients (EPP) is a national generic self-management programme, supporting people with long-term conditions and those caring for someone with a long-term condition. The programmes aim to give participants the confidence to look after their own health needs. **Exhibit 5** shows the number of Chronic Disease Self-Management Programmes (CDSMP) and Looking After Me (LAM) programmes provided at each health board in Wales during 2010-11.

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<sup>9</sup> 'One Powys' is the single delivery plan of Powys Local Service Board which encompasses the Powys Children and Young Peoples Partnership Plan, the Powys Community Safety Plan, the Powys Community Strategy Plan and the Powys Health, Social Care and Wellbeing Strategy.

Exhibit 5: Number of Education Programmes for Patients (and carers)\* provided during 2010-11 along with numbers of participants and completion rates

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

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

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

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

103. The Health Board's main focus on education programmes is around the management of diabetes, with the DAFYDD and XPERT patient education programmes being held across the county. On average, the Health Board runs two programmes a quarter, and in the last quarter of 2010-11 the majority of patients attending the programme had learnt about it through the local press. This is in contrast to many other areas across Wales, where the biggest route of referral to self-management programmes is direct referral by health professionals. There is also an education programme for patients suffering with Parkinson's disease. Since our previous review, the number of volunteer trainers to run education programmes has increased from two to five, allowing courses to be held across a wider catchment area. However, the overall level of education programmes available to patients in Powys remains low.

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- 104.** In partnership with the voluntary sector agencies across Powys, the Health Board has established a number of support groups for patients to access. One example is the Leg Club which offers treatment and information in a non-medical setting to people with leg wounds and circulatory problems. There are two clubs established, one in Llandrindod Wells and a further one in Llanidloes. There are also falls prevention and exercise programmes run throughout Powys.
- 105.** Telecare is a modern day solution to helping to keep people in a lower care group for longer. The idea of telecare is about enabling people to remain independent in their own homes by providing person-centred technologies to support the individual or their carers. In its simplest form, it can refer to a fixed or mobile telephone with a connection to a monitoring centre through which the user can raise an alarm. It is understood that telecare services are in use in all 22 local authorities across Wales. One extension to telecare within the NHS is telehealth which allows the delivery of health services to be provided via telecommunications. One of the most significant increases in telehealth usage is the home monitoring of conditions by patients whose clinical trials in the UK have shown to improve mortality by around 47 per cent. There are currently no plans in place for telehealth to be implemented in the Health Board.

## Achievement of the Health Board's vision for chronic conditions and unscheduled care services will require improvements in planning and management arrangements, and greater engagement with wider NHS partners

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

Although the strategic vision for chronic conditions and unscheduled care is articulated and is supported by high-level workforce plans, the Health Board lacks robust financial and planning arrangements for these services

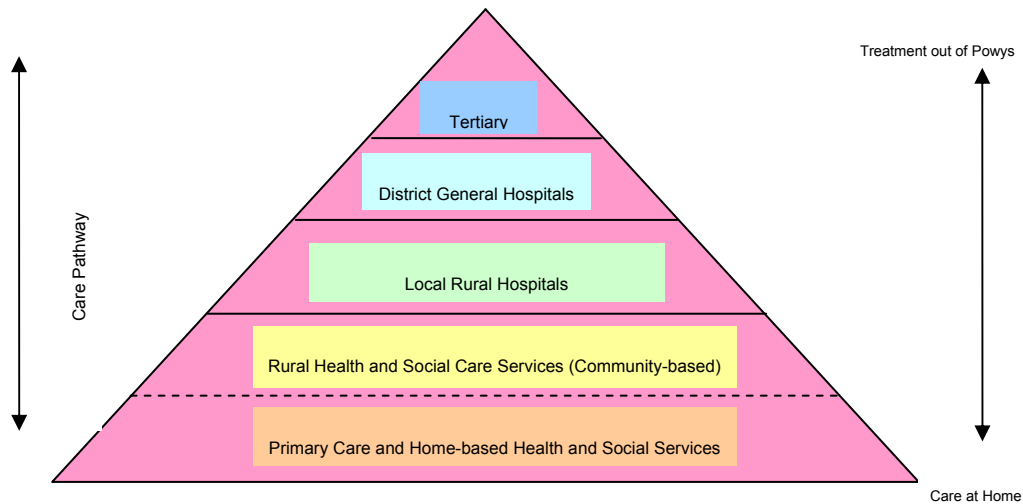
The Health Board's overarching strategic vision is aligned to what needs to be done to develop improved chronic condition and unscheduled care services

- 107.** In 2009, the Health Board set out its overarching mission to deliver truly integrated care at a local level centred in the community. In its revised Service, Workforce and Financial Framework (SWaFF) for 2011-16, the Health Board also set out its transformation programme to achieve this mission which is built on a series of key principles, many of which are in line with *Setting the Direction*. These include:

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- clinical safety being at the heart of all services and being assured through strengthened governing arrangements for clinical services;
  - clinical teams, including GPs, at locality level being empowered to actively engage in managing pathways of care with the appropriate incentives in place to provide more care closer to home;
  - community services being more focussed and productive to provide a greater level of support to the chronically ill in anticipatory care and the management of chronic conditions;
  - local 'one-stop service hubs' supporting people in the maintenance of their own health, and a single gateway to access services across the health, social care and third sector interface;
  - seamless, integrated health and social care teams delivering services in people's homes; and
  - a greater range of care options being developed in the context of integrated facilities that meet social, health and housing needs, and that act as hubs from which support is provided to people in their own homes.
- 108.** More specifically, the SWaFF recognises the need to improve the quality of services for people who are at risk of, and those who have, chronic conditions. It goes on to identify how improved management of chronic conditions will be achieved through the locality structures and the strengthened management of care pathways by the multi-disciplinary team with a focus on promoting independence and avoidance of hospital care. It also identifies the need to reduce the number of emergency admissions to avoid patients being admitted to hospital unnecessarily.
- 109.** It is clear from reviewing the high level strategic documents for the Health Board that chronic conditions and unscheduled care are strategic priorities. The Health Board recognises that the existing service infrastructure 'pushes' patients in and out of hospital, rather than proactively 'pulling' patients through primary, community and secondary care in a co-ordinated way. To address this, the strategy proposes an Integrated Health and Social Care Model which allows the patient pathway to flow through a tiered model as is appropriate to their needs ([Exhibit 6](#)).

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### Exhibit 6: Proposed integrated health and social care model



Source: Powys tHB

- 110.** To deliver the integrated model, the Health Board has focused its strategic vision around the first two tiers of the overall model, which are predominantly around integrated community services. It refers to its need to focus on developing and maintaining individuals' independence through supporting the development of a strong community network and services at home (tier 1), and refers more specifically to such aspects as health and well-being, community and voluntary support and access to primary care services. It also refers to enhanced community based services (tier 2) to enable more people to be cared for and treated at home, reducing avoidable admissions to secondary care with specific aspects as community nursing services and in and out-of-hours primary care.
- 111.** The Health Board, by its very nature, is well placed to strive towards its overarching mission given its community focus, its infrastructure and culture. However, the recognition of the need to rebalance services to maintain and manage more patients in the community is not a new one, with one of the key aims of the former Health Board's strategy *Doing More, Doing Better*<sup>10</sup> to shift the emphasis of care away from hospital admission towards prevention and care in the community and at home. Our work on chronic conditions and unscheduled care would indicate that although there has been a subtle shift in rebalancing the focus on the community, services have not fundamentally changed since *Doing More, Doing Better*, which is reflected in our findings outlined in the first section of this report.

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<sup>10</sup> *Doing More, Doing Better*, Service Modernisation Plan for Powys – April 2006.

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**112.** Implementation of the Health Board's vision and specifically the integrated model is dependent on three key components, locality networks centred on the local primary care teams, community resource teams and the communications hub. This report has already discussed the progress made by the Health Board so far in developing and further improving these main components. The challenge for the Health Board now is to ensure that the enablers are in place to fully deliver on its vision.

**The Health Board lacks a comprehensive delivery plan that sets out the action it needs to take to deliver its vision for chronic conditions and unscheduled care**

- 113.** For the Health Board to deliver on its strategic vision, it needs to have detailed and well-developed service delivery plans which set out clearly the action that the Health Board needs to take and the measures it will use to monitor its progress.
- 114.** In the past, there has been a detailed focus on chronic conditions management with the development of a Local Delivery Plan (LDP) linked to the receipt of the transitional funding in 2008. This has been supplemented by separate LDPs for diabetes and cardiac services. The LDP has provided a focus on what needs to be done to achieve the Health Board's vision around chronic condition management at an operational level although it was set up prior to the Health Board's SWaFF and the publication of *Setting the Direction* in 2010. However, despite the detail, the LDP appears to work in isolation to the wider operational plans for the Health Board.
- 115.** There has been less of a focus on the detailed planning for unscheduled care. Although there had been a previous Annual Operating Framework (AOF) requirement for the production of an LDP for unscheduled care, we have not seen any evidence during fieldwork that would suggest that this has been in place. The AOF requirement has since been overtaken by the national document *Ten High Impact Steps to Transform Unscheduled Care*. This now forms the basis for service developments within Powys, although this is at a high level and does not contain the detail of actions required at a Health Board and locality level. This is particularly important in relation to the MIUs which need greater clarity as to the role they play within the wider unscheduled care model. To deliver on the *Ten High Impact Steps* will require the Health Board to have a robust delivery plan for the next 12 months to two years. The progress made to date around unscheduled care services appears to have been as a result of the work plan for the Unscheduled Care Board.
- 116.** A critical planning document for the Health Board is its *Strategic Outline Programme* (SOP) which focuses on the re-shaping of services in Powys through capital investment in line with the SWaFF. A fundamental element of the SOP is the Health Board's community hospitals. Currently the Health Board has 10 community hospitals that have a long history of providing health care for local communities. Taking community hospitals alongside primary care centres, the Health Board recognises the need to have integrated health and social care centres in each of the main towns in Powys to bring together the different types of options for care and build on the locality networks outlined in the SWaFF.



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- 117.** Progress has already been made in developing this model in Builth Wells. Working with the community and statutory partners, the Health Board has developed a plan that will see a new health and social care centre that will be fit for the challenges of the future. The proposed facility will provide a modern, high quality environment to replace the current hospital and a residential care home. The Health Board has already secured £4.9 million from the Welsh Government to build the first phase of this scheme which is planned to open in 2013.
- 118.** The Health Board recognises the need to work towards similar solutions for each community in the county. They see this as a five to ten-year process of renewal of health and social care services. Each area of Powys has a different history, community, care needs and local facilities, and the solution for each community will therefore be different according to local circumstances. Early plans are already in place for the reconfiguration of the community hospitals in Machynlleth and Brecon.
- 119.** The interlink relationship between chronic conditions, unscheduled care and the services provided not only in community hospitals but across the community as a whole suggests that for the Health Board to move forward on its strategic vision, it needs to have a single comprehensive delivery plan. This plan should draw together these interrelationships and provide a clear and detailed delivery plan for both chronic conditions and unscheduled care which feeds directly into the SOP. Although the Health Board has made some improvements in the delivery of services, as discussed in the first section of this report, strengthened planning arrangements would provide the Health Board with a stronger foundation to move services forward in the future.

**The Health Board lacks a robust financial plan which sets out the cost of service transformation and the resources required**

- 120.** A fundamental transformation in services not only takes well thought-out plans but also financial recognition and commitment to develop and reshape services. This can be a substantial challenge given the financial constraints that the Health Board, and more generally the NHS as a whole, currently faces.
- 121.** To date, we have not seen any evidence which indicates that the Health Board has identified how much it would cost to deliver its vision for chronic conditions management or unscheduled care. More importantly given the lack of additional funds available, it is also unclear as to how the Health Board will reinvest financial resources in shaping the services across the county.

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- 122.** The Health Board's cost improvement plan is reliant on repatriation of activity from English providers, which does allow some resources to be reinvested in services in Powys through the payment by results framework. However, this is not the case for Welsh providers where activity is tied into service level agreements. The focus of the Health Board's vision to bring services closer to patients' own homes and reduce admission to hospital requires it to release resources currently flowing through to the provider health boards. However, the inability to release these resources means that there is no financial incentive for Powys to transform services without a fundamental renegotiation of contracts with its neighbouring Welsh health boards. Moreover, the financial challenges faced within the neighbouring health boards also mean that there is no incentive on their part to reduce their income through service level agreements. This presents a significant challenge for the Health Board which will require some challenging and potentially difficult conversations with its neighbouring health boards. We are aware that this is slowly starting to happen across the localities although we recognise that it will take time to reach agreement where all parties are happy.
- 123.** To transform services often requires a period in which traditional services and pathways are run alongside the development of new services. To do this, however, requires the Health Board to pump prime developments, again within already constrained financial resources. Between 2008 and 2011, the Health Board received in the region of £422,000 of transitional funding for chronic conditions. Much of this funding was used to pump prime service changes through the co-ordination of the three Care Service Co-ordinators which were appointed, as previously discussed. This provided a real opportunity for the Health Board to get new services up and running, and some of the progress identified in the first section of this report is as a result of this additional funding. However, this funding ceased in March 2011 and as a consequence the services developed either needed to be mainstreamed into core services or became reliant on short-term funding which puts them in a vulnerable position, as referred to in paragraph 54.
- 124.** To some extent, progress in improvements and developments has slowed down since March 2011 for the very reason that additional financial resources are no longer available to pump prime services. For the Health Board to further progress its vision and to implement the chronic conditions model, as well as transform unscheduled care services, it needs to have a comprehensive financial plan which clearly sets out the cost of transformation and the financial resources required.

Workforce plans are supporting developments although the age profile of the workforce presents future challenges and the Health Board does not yet have the appropriate governance frameworks to allow advanced practitioners to operate safely and effectively

- 125.** For successful implementation of new, sustainable models of care, it is crucial that there are sustainable changes in the workforce. *Together for Health* recognises that creating a sustainable workforce is a particular challenge in some specialities and workforce issues are becoming a real limitation on certain services.

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**126.** In its integrated workforce plan for 2011-16, the Health Board recognises the need to develop a sustainable workforce to achieve its vision for chronic conditions and unscheduled care services. However, it also recognises that this is against a backdrop of:

- an ageing workforce with a substantial proportion of staff (40 per cent) currently aged over 50, and a predicted 70 per cent of staff to be over 50 by 2020;
- the rurality of the Health Board and the consequent challenges it has in recruitment, particularly alongside a decreasing population of those at working age;
- the predicted increase in the older population and the associated predicted demands on services; and
- the Health Board's financial constraints and the need to improve workforce efficiencies within a decreasing budget.

**127.** The Health Board's vision will see an increase in demand within the primary and community setting, shifting resources and demands away from institutionalised care such as community hospitals, DGHs and care homes. It will also see patients with greater complex needs being managed within the community. As a result the Health Board has recognised that it needs to focus its skill areas around increasing capacity within the community, particularly:

- nurses with extended skills, including clinical assessment, prescribing and managing chronic conditions, who are able to work across all care settings;
- senior therapists with extended skills able to manage the overall care of individuals;
- developing the role of the case manager for nurses, therapists and social workers; and
- new integrated carer roles working with people at home in support of nurses, therapists and social work teams.

**128.** Our review of services has identified that in some areas, the Health Board is starting to make headway in developing these skills with examples including the increase in specialist nurses, the development of case management particularly with district nurses and the extension of integrated services such as the rehabilitation team. However, as more patients become more appropriately managed within the community, the need for additional staff becomes greater.

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- 129.** Because of the ageing workforce and the challenges in recruitment, much of the workforce plan is based on training and re-skilling existing employees in new ways of working and modernised roles, through a programme of skills development. However, the Health Board recognises that its training and development budget is currently largely consumed by statutory and mandatory training requirements. It also recognises that it lacks a comprehensive understanding of what skills it has available in its existing workforce to know where to target its training and development programme. However, plans are in place to develop a longer-term programme of training which is responsive to service needs and to strengthen the appraisal system to ensure that the skills and knowledge of the existing workforce are captured.
- 130.** As well as robust training and development packages, the Health Board's focus on increasing its level of advanced practitioners, including specialist nurses, Emergency Nurse Practitioners (ENPs) and enhanced district nurses or complex care case managers also means that there needs to be robust frameworks in place to support these staff to operate in a predominantly isolated environment. This is particularly pertinent to ENPs operating in the MIUs. At the time of our fieldwork, the Health Board was working through a governance framework for the MIU based in the south locality in partnership with Aneurin Bevan Health Board. This framework provides the Health Board with the assurance mechanism that the ENPs within the unit are operating safely and effectively. Discussions were taking place around the need to put similar arrangements in place in the other MIUs although these were yet to formalise into frameworks.
- 131.** The governance framework can be supported by the use of telemed<sup>11</sup> which has been installed in the MIU in the mid locality following the securing of monies. This provides an open network to expertise and advice from the ED in Hereford Hospital, where patients would naturally flow. This is a positive development although it is thought that the governance framework for this area is likely to be drawn up with Hywel Dda Health Board, which may present some challenges in terms of clinical pathways and behaviours.
- 132.** The Health Board also recognises the need to look at workforce planning with its partners; in particular the need to work collaboratively with the local authority around joint posts and also look at what services could be provided by the independent and voluntary sector. This has already started to some extent with the development of the Builth Wells project, which will not only see a shift away from staff working in a traditional hospital-based environment but will also see resources move to the independent sector which will take overall management of the facility. A greater increase in the provision of voluntary sector services has also taken place with the role out of the PURSH service across Powys as discussed earlier in this report in paragraph 52.

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<sup>11</sup> Telemed or Telemedicine is the use of telecommunication and information technologies to provide clinical health care at a distance.

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- 133.** Whilst general practitioners are independent contractors and are not directly employed by the Health Board, there is a role for the Health Board in working with primary care to ensure its communities have an appropriate primary care workforce. Health Board data for 2009-10 indicates that the level of primary care resources, in terms of GPs is in line with the rest of Wales with the average list size per WTE GP between 1,400 and 1,500 patients, which compares with 80 per cent of practices across Wales. Although there is no comparative data for practice nurses, the level of practice nurses in Powys is reported to have increased in recent years and capacity issues have not been raised. However, in line with the wider workforce for the Health Board, the age profile of the GPs and practice nurses also poses challenges within the next five years as staff reach retirement age.

### The management structures and a lack of comprehensive information weaken the Health Board's arrangements to deliver improvements in chronic conditions and unscheduled care

Although there are clear links into the Board, engagement at Board level is weak and the multiplicity of committees to support the management of chronic conditions and unscheduled care have the potential to be inefficient

- 134.** If the Health Board is to deliver on the ambitions set out in its vision, it must have an organisational and management structure that supports clear responsibilities and lines of accountability. Within that structure there must be individual leaders and groups of staff and stakeholders that are well positioned and empowered to drive transformation.
- 135.** Within the Health Board's structure, the Medical Director holds responsibility for unscheduled care services. Previously the former Director of Planning held responsibility for chronic conditions but the merger of the Director of Public Health and the Director of Planning roles in the revised structure now means that responsibility for chronic conditions transfers to the new Director of Public Health and Planning. Both aspects are fundamental parts of the Health Board's strategic vision, delivery of which rests with the Chief Executive and the Board.
- 136.** For some time, the Health Board has had an established Unscheduled Care (USC) Board. The Board meets every two to three months and has wide representation from all stakeholders both internal and external to the Health Board. It has a clear work programme, focused predominantly around the *Ten High Impact Steps to Transform Unscheduled Care* and reports directly into the Board and the Executive Management Team (EMT) through the Medical Director, who chairs the USC Board. Findings from our review indicate that the USC Board is working well and there is a good focus on the key elements of unscheduled care, with regular performance monitoring around aspects of out-of-hours performance, primary care access, MIU activity and DTOC. Attendance levels at meetings can, however, fluctuate and key members are often unable to attend.

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- 137.** Arrangements for chronic conditions management have been less straightforward. Up until 2010 the Health Board maintained a Chronic Conditions Management Board (also referred to as steering group) although poor attendance and a lack of a clear focus resulted in the Board being disbanded. With no other obvious alternative forum, many staff adopted the USC Board as the only mechanism at that time to maintain the profile for chronic conditions. In 2011, at a time when the Health and Well Being Strategy was being revisited for 2011-16 and following the publication of *Setting the Direction*, the Health Board established the Setting the Direction Board (also referred to as the steering group) to take chronic conditions forward chaired by the Director of Planning.
- 138.** In parallel, the local authority and Health Board were establishing the Integrated Care Pathways Project Board (ICPOP), a work stream of the Care and Wellbeing Programme Board, with a dominant focus on older people services. Chaired by the Health Board's Chief Executive, there are clear links between the ICPOP and the chronic conditions agenda, and consequently over the last few months, the Health Board has been working through the terms of reference of the Setting the Direction Board with regard to its relationship with the ICPOP. The Setting the Direction Board is now seen as the forum responsible for operational delivery and, although still in its infancy, is now well represented by a wide range of stakeholders, although attendance by key members can also be a problem.
- 139.** One of the challenges for the Health Board is tackling the same agendas faced by its bigger neighbouring health boards but with less staff. Managers within the Health Board are routinely responsible for a multiplicity of areas whilst counterparts within neighbouring health boards often only have one responsibility. As a consequence, the Health Board's managers are routinely required to attend a raft of forums and meetings which can place demands on their time. The geographical spread of the Health Board also presents challenges as meetings are often held in the south of the county, at the Health Board's headquarters, which requires substantial travelling commitment. Although the Health Board is making better use of video-conferencing facilities, the factors outlined above can be the main reason for key members not being able to attend forums.
- 140.** Representation from clinicians can also be a particular problem as attendance at a meeting in the south of the county can often mean a whole day of clinical activity is lost. When faced with pressure to deliver frontline services and restrictions on financial resources to provide backfill cover, clinicians and managers will often need to make a judgement call as to whether it is necessary for them to attend meetings.
- 141.** The lack of a chronic conditions forum at a crucial time when *Setting the Direction* was published is viewed by some within the Health Board as being detrimental to its early implementation. Although aligned with the Health Board's strategic vision, *Setting the Direction* did not necessarily have the detailed attention at Board level it required in terms of understanding exactly what it means for Powys and instead has been delegated to locality teams to implement.

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142. Following the disbandment of the CSCs in March 2011 which, although specific in some aspects, kept a Health Board wide view on *Setting the Direction* and the wider chronic conditions model, the task of taking forward this agenda is now the responsibility of the locality management teams. Similarly the changes needed to improve unscheduled care services are also the responsibility of the locality management teams. While we recognise that the focus on primary and community services needs to be done at a locality level, some aspects of service developments need a corporate and Health Board wide approach. Staff felt that there were limited mechanisms to share and learn from each of the localities within the Health Board, and for some areas of service development, take a common approach which needed the high level steer from the Health Board as a whole.
143. Although there has been positive involvement from the Independent Member responsible for primary and community services, particularly in chronic conditions management, the arrangements that have been in place for both chronic conditions management and unscheduled care to date have lacked full Board engagement. Over the last 12 to 18 months, there has been very little detailed reference to these areas in Board meetings which provides Independent Members of the progress being made by the localities and the challenges that are being faced. Greater Board engagement needs to be reflected in the arrangements going forward.
144. In addition to the main steering groups, the Health Board also has a range of condition specific forums which meet on a regular basis. Not all of these groups appear to integrate with the main forums for either chronic conditions or unscheduled care, with some groups reporting directly to the Board, namely the stroke steering group. Given the linkages between all of the groups that the Health Board has in place and the time requirements on staff to attend these meetings, with often the same people attending the different meetings, it is important that the Health Board is clear as to its structure for moving these agendas forward. The role that each of the groups play also needs to be reviewed to make the best use of the time that needs to be invested by internal and external stakeholders.

The Health Board lacks comprehensive information and performance management is predominantly focused on process outcomes, although positive arrangements are in place to capture patients' views

145. Information is crucial for informing the planning and delivery of effective services for unscheduled care and chronic conditions as well as monitoring service provision and patient outcomes. Our previous reports highlighted the absence of financial information and activity data which undermines the ability of NHS bodies to evaluate existing services, plan new services or to support the shift of resources from hospital to community settings.

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- 146.** Myrddin in Powys (MIP) is the core information system used by the Health Board; however, this only provides information on activity undertaken within the boundaries of the Health Board. Information relating to patient episodes in neighbouring providers is recorded on the respective systems for those organisations and as a consequence the Health Board is reliant on being allowed access to that information by those bodies. More detailed information on activity within the community, such as interventions by district nurses is also not captured. This lack of information presents significant challenges to the Health Board in terms of a lack of robust information to make planning decisions, reliance on specific data collection exercises, audits or data requests to neighbouring health bodies with risks that data is not consistently captured across the English and Welsh providers.
- 147.** To inform performance management arrangements, the Health Board has adopted a maturity matrix for monitoring the progress made by the localities on all aspects of chronic conditions outlined in the initial LDP. These are monitored on a regular basis and reported to the bi-monthly *Setting the Direction* Board. The matrix covers five key aspects:
- hospital interface, including opportunities to shift resources to the community, extended community services and reductions in admissions;
  - localities, including the development of GP leads and a focus at a neighbourhood level;
  - communication hubs;
  - community resource teams; and
  - chronic conditions management, including self-management programmes, care co-ordination and risk stratification.
- 148.** The matrices provide a traffic-light report as to the progress made by the localities within each of their community areas. However, the purpose of the matrix is viewed very differently across the localities with some viewing it as a tool to proactively drive forward change whilst others see it as tool to hold the localities to account for non-delivery. As a consequence comparability across the localities and accuracy of progress are raised as concerns by staff within the Health Board.
- 149.** The matrices on the whole focus on progress against process outcomes as opposed to whether services are improving for the patients, although a few outcome measures exist. These are predominantly hospital based and centre on length of stay and DTOC. Specific outcome measures have been developed for the communications hub but again these tend to focus on process and efficiency, rather than outcomes for the patients.



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- 150.** One of the key actions of the *Ten High Impact Steps to Transform Unscheduled Care* is to agree a set of clinical outcomes to measure the success of the whole system from chronic disease management, through intermediate care to acute hospital services. To date, the Health Board has made limited progress to identify any relevant clinical outcome measures. Much of the data reported for both unscheduled care and chronic conditions relates to hospital activity. The Integrated Performance Report presented to the Board focuses on ED performance, emergency rates, average length of stay and DTOC. This, in the main, is the responsibility of the provider health boards with a focus on ‘pushing’ patients through the system as quickly and efficiently as possible. There is very little emphasis on the performance of the Health Board to ‘pull’ patients out of the hospital setting and into the community, such as the impact of the CTCs to redirect admissions and the care co-ordination centre to avoid hospital admission, which would provide some assurance to the Board that the services in place across the Health Board are having an impact. Some of this information is available to the USC Board, however, the Health Board is often reliant on manual and cumbersome data collection exercises to produce it.
- 151.** The Health Board is making some positive progress to capture patients’ views of the services in place. Therapies staff have all been trained in capturing patient stories which are feeding into the Health Board’s Quality and Safety Committee as well as to the *Setting the Direction* Board. The patient experience has been factored into the outcome measures of the communications hub and the survey undertaken as part of the pilot around the Choose Well campaign has provided a baseline of the public’s and patients’ understanding of services available to them. Some of the condition specific work streams have engaged with voluntary support groups to capture views of patients to inform service developments, for example, the Multiple Sclerosis Society and the Health Board’s wider engagement framework have helped gain feedback from the public and patients on service developments. This is particularly around the role of the community hospitals and the repatriation of services back into Powys.

### The Health Board has positive arrangements for engaging GPs and other stakeholders both internally and externally although greater engagement is needed from consultants and its wider NHS partners

The extent to which GPs and non-medical clinicians are engaged is positive although structures do not support the engagement and ownership by consultants, particularly those based in secondary care, that the Health Board needs to deliver its vision

- 152.** Effective engagement of clinical staff is a critical success factor in driving forward the scale of transformational change required to develop new models of care. Without strong clinical leadership and ‘buy in’ from the wider base of clinical staff, service transformation plans will be difficult to implement.

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- 153.** Like all health boards across Wales, the structure within the Health Board has been in place since its establishment in 2009. The structure has been designed to promote clinical leadership and engagement, and after a long period of interim arrangements, the Health Board has recently been working its way through the appointment of permanent Executive Directors. Once completed, half of the senior Executive Management Team (EMT) will be of a clinical background providing a prominent level of clinical leadership and engagement at senior management level.
- 154.** The EMT is supported by a locality structure, with three localities led by a locality manager supported by a locality lead nurse and therapist. The locality managers report directly to the Chief Executive and are invited to attend EMT. There is also a Powys-wide clinical directorate for Women and Children which reports directly to the Director of Nursing.
- 155.** Focusing primarily on medical staff, the Health Board currently employs 8.5 WTE consultants. These consultants cover two clinical areas; paediatrics and services for older people. Whilst the Women and Children directorate feeds operationally into the Director of Nursing, professional lines for the consultants fall to the Medical Director. The Health Board has appointed a Clinical Director for paediatrics whose responsibility is to drive forward service improvements within the service. This is relatively new and is a positive step forward, however, there is the potential that this post holder is too far removed from the EMT, as they are not included in the membership. To engage clinicians and promote clinical leadership, the clinicians need to be held to account for delivery, and also be more directly engaged in strategic developments so they understand, and can influence, the reasons for change. Although the Clinical Director has direct access to the Executive team, involving them at EMT could strengthen the level of leadership and engagement amongst clinicians that the Health Board requires.
- 156.** Consultants for older people services, although they also report professionally to the Medical Director, are more closely aligned to the locality structures. Within the Consultant body, there are clinical leads for condition areas although a nominal Clinical Director has not been appointed. This could present a challenge for the Health Board as the clinicians for older people are not visible at an Executive level nor are they engaged at a corporate strategic level as their focus is solely on the localities. This may be appropriate given the community focus within the Health Board. However whilst all other health boards in Wales have clinicians at the helm of their directorate management teams, the model in Powys places the emphasis on driving through operational and strategic change with the locality general manager, again removing the accountability from clinicians to lead and be engaged in change.

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- 157.** With much of the planned transformation relying on rebalancing care towards primary and community services, it is vital that primary care practitioners are fully engaged. The majority of medical staff within the Health Board are primary care practitioners, all of which are independent contractors. When the Health Board was established in 2009, it inherited a history of poor relationships with GPs, with a sense of distrust between GPs and management. Feedback during our fieldwork suggests that the relationship is now much improved, with a general view from both GPs and the EMT that GPs are on board with the direction of travel for the Health Board.
- 158.** Within each locality, the Health Board had anticipated appointing a lead GP to work alongside the locality team as part of its structure. This has only been successful in the south locality. Although two lead GPs were appointed on a job share basis in the mid locality, pressures on clinical workload meant that both GPs had to resign from the role. No GPs came forward to take up the role in the north locality. However, the lack of formal lead GPs in the north and mid localities does not appear to have been detrimental to engaging GPs. All of the locality teams meet on a regular basis with their practices, each of which has its own lead GP, and this has provided opportunities for GPs and wider primary care teams to engage with service transformation within their locality. Across the Health Board, there are a number of GP champions for specific areas, for example prescribing, and through network arrangements which also provide a good opportunity to influence service developments.
- 159.** The Medical Director and Chief Executive routinely attend the Local Medical Advisory Group (LMAG) and Local Medical Committee (LMC). Both forums meet on a regular basis, and the LMAG in particular is well attended by GPs. This forum provides an opportunity for GPs and Consultants to put forward options for service developments and to influence the transformation agenda, with evidence that there has been a good discussion around both unscheduled care and chronic conditions.
- 160.** The findings of our practice survey also supported a generally positive view about involvement in planning and the redesign of unscheduled care and chronic condition services with:
- three-quarters of practices agreeing or strongly agreeing that they were actively involved in planning (much higher than the 31 per cent across Wales); and
  - similarly, five practices (63 per cent) agreeing or strongly agreeing that they were actively involved in the redesigning of unscheduled care and chronic condition services (much higher than the 21 per cent across Wales) with:
    - specific reference to the involvement by GPs in the development of the Bwlth project; and
    - all practices agreeing to be actively involved in planning and redesigning chronic condition services specifically (compared with 45 per cent of practices across Wales); and
  - two-thirds of practices in Powys feeling adequately informed of plans for USC services (compared with 43 per cent across Wales).

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- 161.** Whilst engagement with GPs is reported to be good, the extent to which GPs are actually 'bought in' to developments can vary. To date the majority of developments around chronic conditions and unscheduled care have been beneficial to GPs, however, should the Health Board need to make some controversial decisions, then the extent to which GPs are bought into decisions could well be tested.
- 162.** As previously mentioned, it can be difficult for the Health Board to engage with clinicians due to the geographical nature of the county. Where possible the Health Board tries to provide locum cover to release clinicians from their clinical activity. However, this is within the financial constraints faced by the Health Board. Half of the practices perceived the Health Board as providing support to become involved in the planning and redesign of services. It was reported, however, that only on a few occasions had locum cover been able to be provided and this had impacted on the ability of the clinicians to be engaged.
- 163.** The ability for the Health Board to implement the changes it needs for unscheduled care and chronic conditions is reliant to some extent on secondary care clinicians also being on board with plans. This presents significant challenges to the Health Board because of its need to work closely with five differing health bodies, each with their own clinicians who bring differing practices and views to the table. As a consequence, engagement with secondary care consultants is done primarily at a locality level focused on specific areas of work, for example, engagement with secondary care physicians around the diabetic pathway. This level of engagement does clearly enhance the locality focus, however, for some aspects of service development; it may be useful and necessary for the Health Board to have secondary care engagement at a corporate level. None of the secondary care consultants that we spoke to who are involved in providing services in Powys or to residents of Powys within the neighbouring health bodies were aware of the strategic vision of the Health Board nor its plans around unscheduled care and chronic conditions.
- 164.** Engagement with wider clinical professions such as nurses and professions allied to medicine was identified as being positive. The lead roles within the locality structures and directorate, and the supporting hierarchical frameworks underneath, provide a formalised structure to engage with staff in strategic developments and planning. Professional networks and forums are also seen as positive vehicles for engagement and both Executive Directors were seen as being visible across the Health Board as much as they could within the geographical constraints.

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The Health Board engages positively with its public and its Powys-based stakeholders, however, the ability to influence and engage with its neighbouring health bodies presents a challenge

- 165.** Transforming the system of health and social care relies on changes across organisational barriers and requires involvement and agreement from a wide range of partners including the public, health boards, local government, the ambulance service and many more.
- 166.** *New Directions for Powys* sets out the framework for public engagement on the strategic vision for the Health Board. It clearly states how services need to move forward and outlines what this means for unscheduled care and chronic condition services in a language that is understandable to the general public. Consultation sessions have been held across the county and these are understood to have been well attended and well received. More focussed public engagement exercises have also taken place around specific aspects such as the Builth Wells project which have also been well attended. The county's CHCs play an active role within the Health Board. There is a strong CHC focus within the Health Board Stakeholder Reference Group (SRG) and there is CHC presence on both the USC Board and the Setting the Direction Board. The CHCs have also been proactively involved in operational aspects of service delivery such as primary care access.
- 167.** The Health Board works closely with Powys County Council, with a focus on supporting the integration of services over time. This is evident from the integrated nature of the Integrated Care Pathways Project Board which forms part of the local authority's infrastructure but is chaired by the Health Board's Chief Executive. Social services are routinely represented on the relevant health board committees and Boards, and there are good examples of joint working at an operational level including:
- the ongoing establishment of a Section 33 agreement to provide joint IM&T management arrangements;
  - the use of local authority premises for the communication hub in mid locality, with joint 'buy in' to the resources allocated to the project; and
  - the integration of services in the proposed model for Builth Wells.
- 168.** Our previous work recommended that the Local Service Boards (LSBs) should get more involved in leading unscheduled care services. In Powys, there has been no specific reporting to the LSB on unscheduled care services, however, a number of the LSB's objectives, outlined in the *One Powys* document cover aspects of unscheduled care. The Chief Executive is a member of the LSB and the Health Board's strategic document are aligned to the *One Powys Plan*.

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- 169.** Engagement with other NHS bodies is variable. The Health Board has experienced positive and proactive engagement with WAST. There has been a good level of representation on the USC Board. and the ambulance service at a local level has been fully involved and engaged in service developments including:
- the increased allocation of paramedic practitioners to support the provision of unscheduled care services in a rural area;
  - the development of the 999 diversion pathway to reroute patients more appropriate for local out-of-hours or MIUs; and
  - engagement in the development of the falls service.
- 170.** The WAST Regional Director for the area has, however, recently changed roles and his replacement for the Central and West region is only on an interim basis. Whilst engagement with the locality manager remains good, the interim arrangements at a higher level may impact on the momentum for change which has been seen over the last 18 months.
- 171.** Similar to the level of engagement with secondary care consultants, the Health Board engages with its neighbouring health boards and NHS trusts predominantly at a Powys locality level. Although there is discussion at an executive level between organisations and opportunity for the Health Board to engage in the strategic vision of its neighbouring bodies, the proportion of activity within each of the secondary care providers which relates to Powys is relatively small. This presents challenges in the ability of the Health Board to influence the strategic direction of each body. As a result the way in which services are delivered in different parts of Powys often varies depending on which health board or NHS trust patients flow through to.
- 172.** One opportunity for the Health Board to influence the wider NHS strategic planning is through the Regional Planning arrangements which have recently been established. However, this brings its own challenges, as its neighbouring health boards fall within different regions meaning that the Health Board needs to engage with all three regional groups. In addition, these arrangements do not involve English providers.
- 173.** The key to influencing the strategic vision for Powys and that of other health boards and NHS trusts is through the Health Board's unique position in being a purchaser, or commissioner of secondary care services. The Health Board's *Strategic Outline Plan* (SOP) starts to address this by identifying the need to repatriate patients and negotiate the amount of financial resources that are committed to the individual health bodies. This is more straightforward with the English trusts where financial resources are based on payment by results, which allows a direct relationship between activity and cost. The service level agreements currently in place with the Welsh health boards are less flexible and give less opportunity for the Health Board to influence how the service is provided, as previously discussed in paragraph 122. Our local work on commissioning arrangements, which is currently being undertaken, should help the Health Board consider how it can improve its position in influencing the services provided by others on behalf of the residents of Powys.

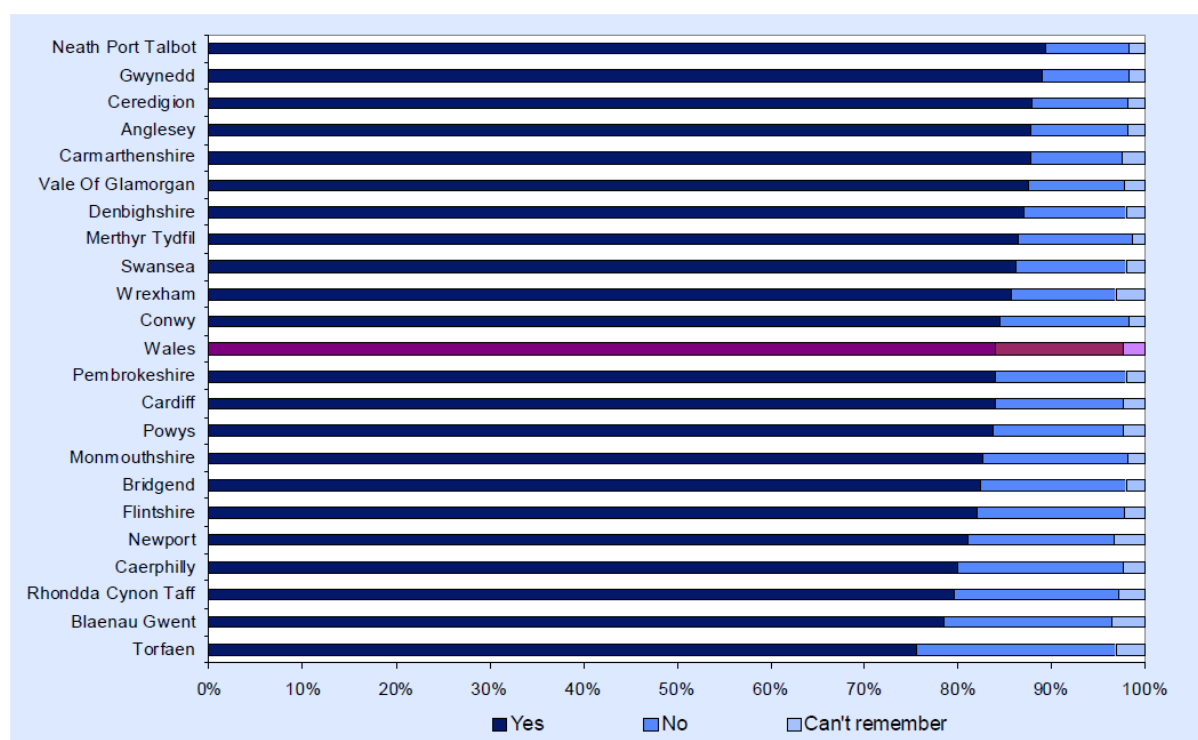
# Appendix 1

## Detailed performance information

### Urgent access to primary care

#### Exhibit A1: Patient experience of urgent access to primary care

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



Source: Welsh GP Access Survey 2011.

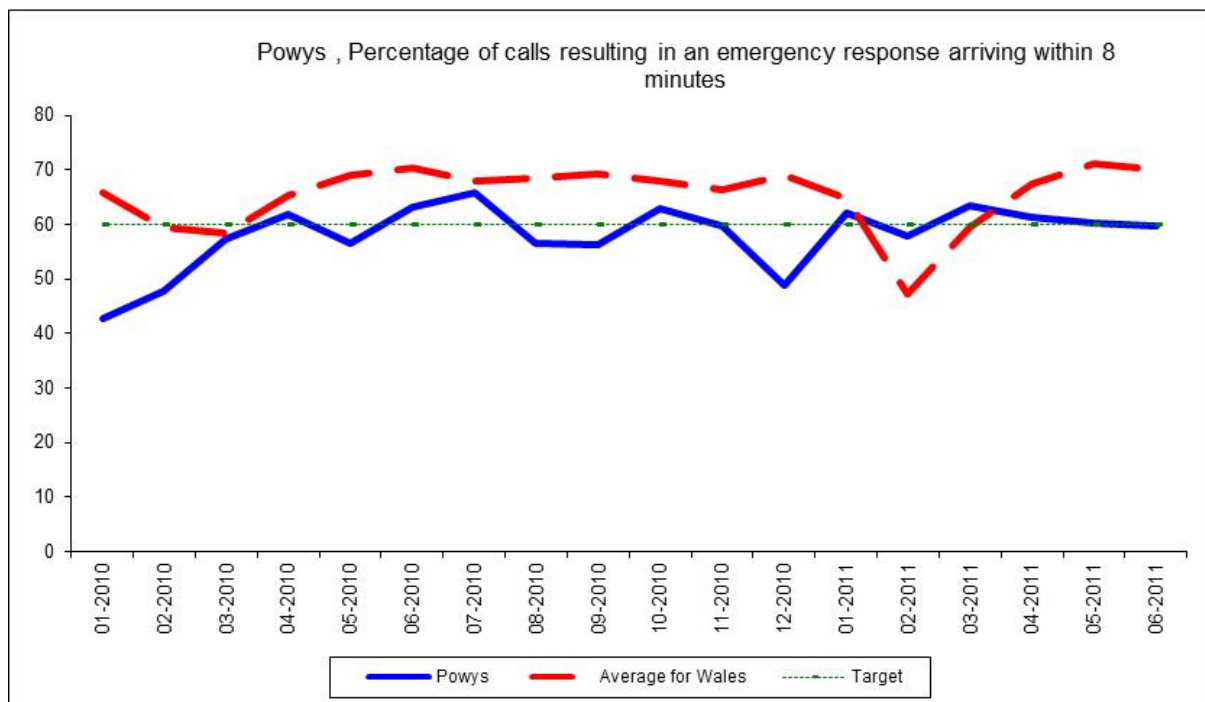
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## Ambulance performance data

### Exhibit A2: Emergency incidents responded to within eight minutes

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

- a monthly all-Wales average of 65 per cent of first responses to Category A calls to arrive on scene within eight minutes, 70 per cent within nine minutes and 75 per cent within 10 minutes;
- a monthly minimum performance of 60 per cent of first responses to Category A calls arriving within eight minutes in each local authority area; and
- performance in all geographical areas needs to reflect continuous improvement in achieving the overall target.



Source: Stats Wales.

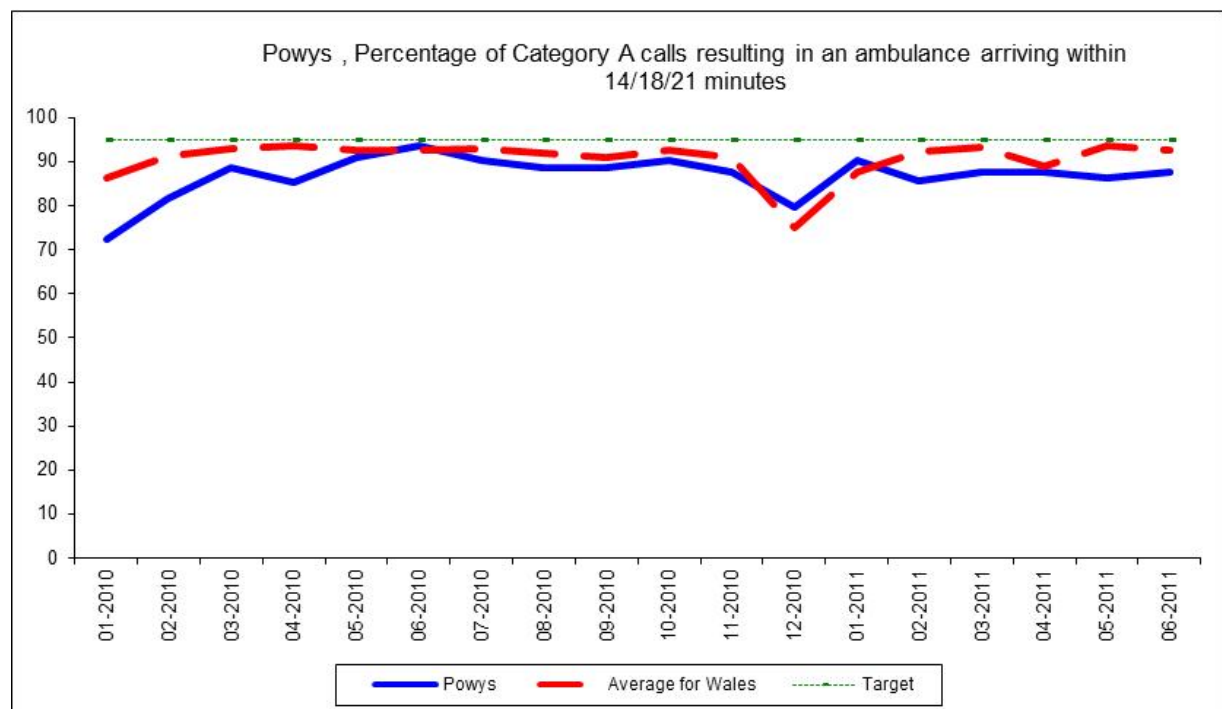


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### Exhibit A3 : Backing up initial responses with a fully equipped ambulance

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

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

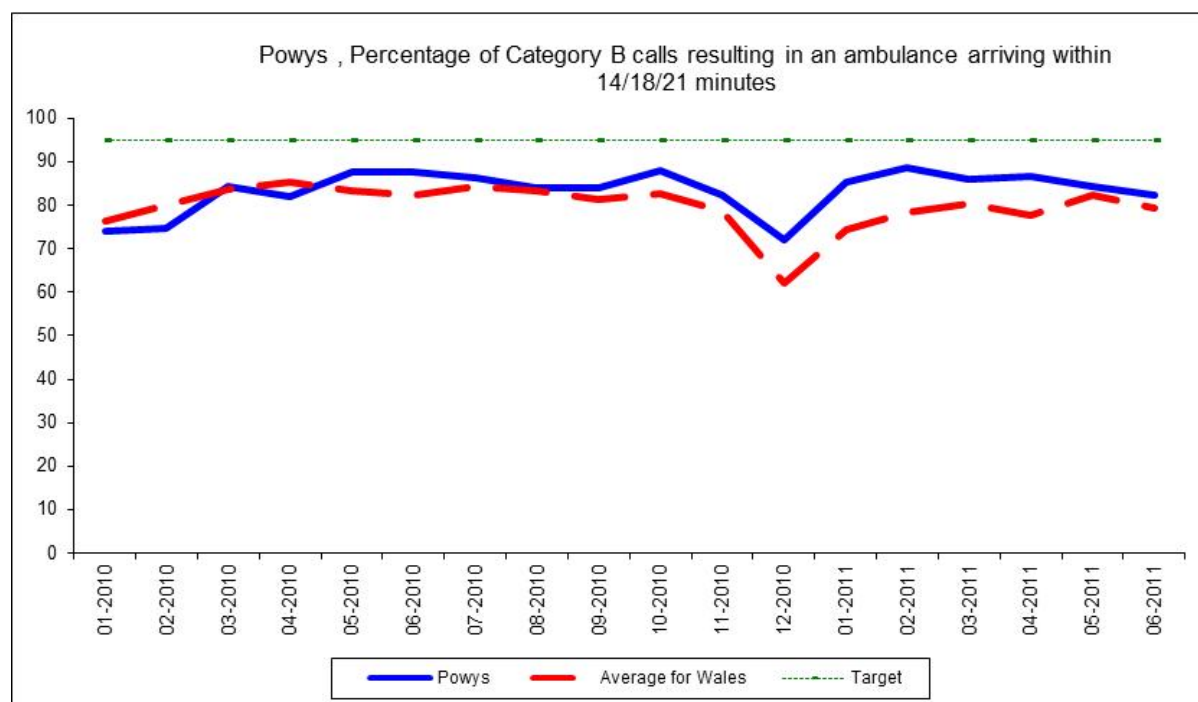


Source: Stats Wales.

### Exhibit A4: Responses to Category B incidents

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

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



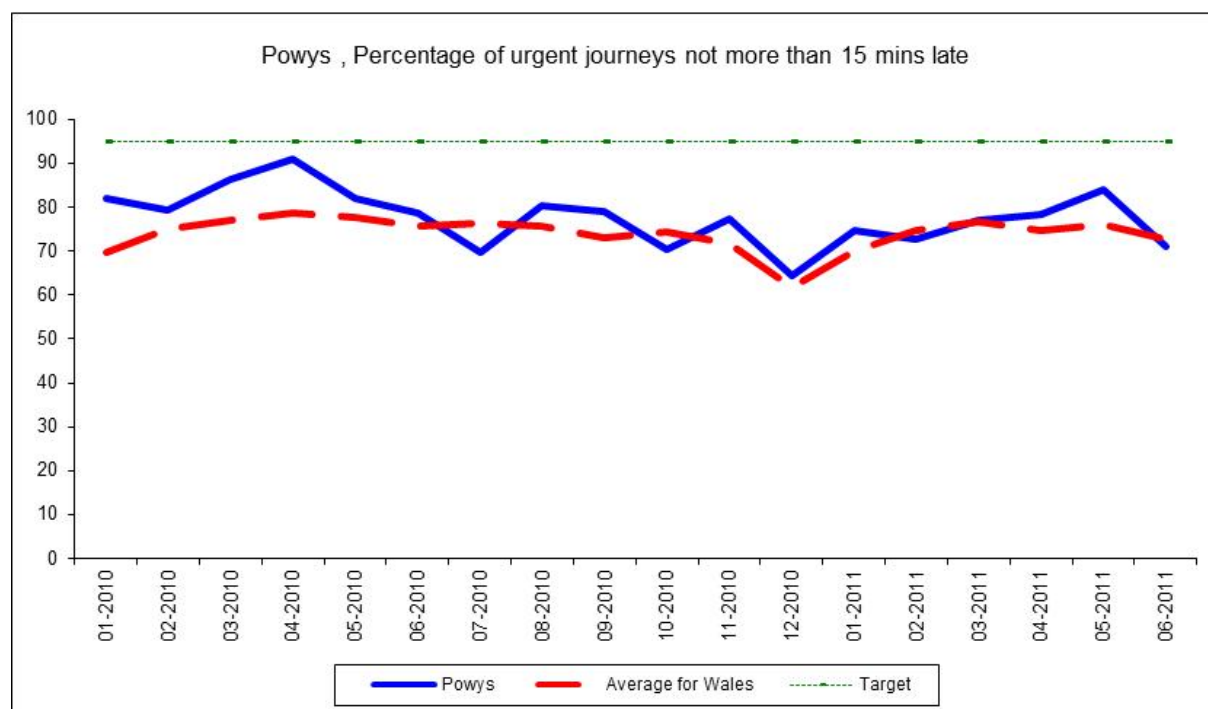
Source: Stats Wales.

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### Exhibit A5: Responses to urgent calls from doctors

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

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



Source: Stats Wales.

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## Emergency department performance

### Exhibit A6: Demand at hospital emergency departments

The Exhibit shows the number of attendances at emergency departments between April and September 2011.

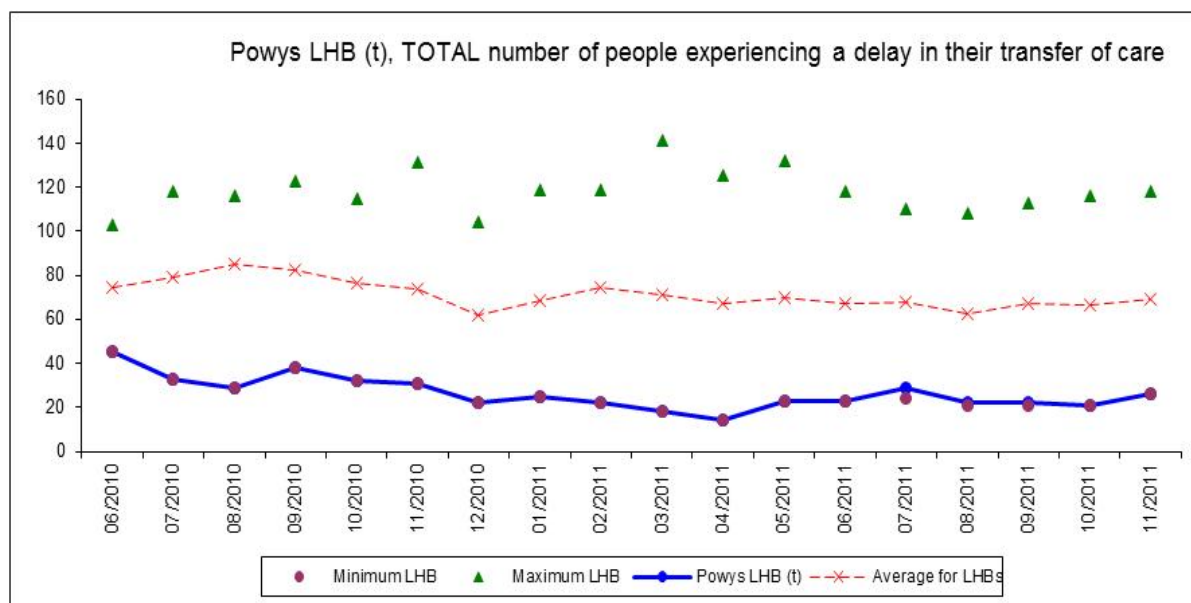
Hospital	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Total
Bronglais Hospital	203	192	179	226	195	202	1,197
Morrison Hospital	194	149	150	175	186	175	1,029
Nevill Hall Hospital	302	312	272	286	288	286	1,746
Prince Charles Hospital	13	5	7	17	20	11	73
Princess of Wales Hospital	3	4	3	3	4	3	20
Royal Gwent Hospital	2	7	5	9	5	5	33
Royal Glamorgan Hospital	0	1	3		0	3	7
University Hospital of Wales	10	15	21	15	8	21	90
West Wales General Hospital	15	13	6	22	7	21	84
Withybush Hospital	9	5	1	5	4	3	27
Wrexham Maelor Hospital	18	22	10	14	22	13	99
Ysbyty Glan Clwyd	5	1	1	4	3	2	16
Ysbyty Gwynedd	1	1	5	3	5	8	23
<b>Total</b>	<b>775</b>	<b>727</b>	<b>663</b>	<b>779</b>	<b>747</b>	<b>753</b>	<b>4,444</b>

Source: Powys Teaching Health Board Integrated Performance Report.

## Delayed transfers of care

### Exhibit A7: Number of people experiencing a delayed transfer of care

The Exhibit shows the number of people who experienced a delayed transfer of care in the Health Board area.



Source: Welsh Government

# Appendix 2

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## Findings from the primary care survey

Eight out of 17 Powys practices responded to our survey:

- Six had sought patients' views on how to improve access (across Wales 59 per cent)
- Three-quarters (six) had used the GP Access Survey to review access issues, as well as reviewing issues around same-day and urgent access (compared with 70 per cent across Wales). Practices listed changes they have implemented as a result:
  - adjusting the mix of book-ahead and same-day appointments to ensure there is enough of each to suit patients' needs/demands;
  - providing extra appointments later in the evening;
  - amending the appointment system to keep one GP free as a designated duty GP, which operates 24 hours a day; and
  - trailing triage.
- Other work that practices have done to review the way they provide same-day/urgent/unscheduled care:
  - Frequently reviewing the demand for urgent appointments and occasionally adjusting the ratio of urgent to pre-bookable appointments. Identified issues with same-day/urgent/unscheduled care during significant event reviews.
  - Patients occasionally play the system by phoning on a day when they know the duty doctor is the doctor of their choice: this restricts the access of genuine, unforeseeable contact, particularly to pharmacy services.
  - Patients are told to contact their doctor by the out-of-hours doctors. Same-day appointment slots are then fully booked within a very short time of opening (ie, particularly on Monday mornings). GPs then spend a great deal of their time telephoning patients after surgery if patients tell us they cannot wait until the following day.
- No practices have used the Primary Care Foundation report in any way to review arrangements for providing same day/urgent/unscheduled care (13 per cent across Wales).
- Reported barriers to improving same day/urgent access included:
  - All patients now expect to be given same-day appointments, misuse of some same-day appointments by patients/patients bring all their social as well as physical problems to the surgery and expect urgent appointments.
  - Variability of demand, lack of information for patients about self-management of minor ailments.
  - High volume of chronic disease throughout the practice.
  - Capacity.
  - If a GP or nurse is off sick, locum cover is difficult to obtain in the area.

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- Geography, rural practice covering 450 square miles.
  - Lack of financial resources – GP contract again has received no uplift, therefore making it difficult to employ more clinicians.
  - The local MIU at Ystradgynlais is frequently closed due to staffing problems at the hospital: this means patients presenting at the practice, even though the practice does not offer an MIU service. However, in reality patients who present with open cuts/wounds cannot be referred to A&E without being seen by a GP or nurse.
  - One quarter of practices (compared with 41 per cent across Wales) had analysed the number and pattern of telephone calls to the practice but, for those that did the changes made included:
    - Due to high demand on a Monday offering more urgent appointments on that day and not holding any miscellaneous clinics on that day when possible. Changed the new telephone system to channel calls to a specific extension/option so that an appropriate trained member of staff is able to deal with the patients' requests/needs.
  - Just over half the appointments provided by practices were for the same day although this did vary from 25 per cent to 100 per cent. (NB: This is not a weighted average.)
  - The 'Did Not Attend' (DNA) rate was seven per cent, ranging five per cent to 10 per cent, irrespective of appointment type. (NB: This is not a weighted average.)  
Tackling DNAs, practices reported:
    - writing to patients who persistently did not attend advising that further action may be taken if they continue not to attend, and allowing patients to book their own appointment rather than sending them pre-booked appointments; and
    - displaying DNA rates and information in the practice premises.
  - Most consultations are carried out face-to-face.
  - Over the last two years, three practices had reviewed their systems for home visits (compared with 59 per cent across Wales); seven practices had systems in place for facilitating home visits, four have protocols for responding to home visits, and five offer initial telephone assessment by a clinician.
  - Four out of eight practices have formal protocols in place to deal with requests for appointments (compared with 55 per cent across Wales). Receptionists in six out of eight practices receive training on induction, and five out of eight subsequently receive refresher training on identifying urgent and emergency calls (compared to 88 per cent and 75 per cent respectively in Wales).
  - Over the last two years, four practices had reviewed receptionists' effectiveness in identifying emergency/urgent calls and as a consequence:
    - one practice gets the receptionists to ask patients if they are happy to give some basic details concerning their need to see a GP so that the GP can prioritise their requests, and held in-house training for all medical records/administration staff to review their telephone technique, scripts and protocol.

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- Roughly 10 per cent of appointments are used for patients with non-clinical needs in a week, this ranges from 0 per cent to 30 per cent across the practices. (NB: This is not a weighted average.)
  - Six of the practices perceived Out Of Hours (OOH) services to be very good or good at meeting the needs of patients out of hours while the other two had no strong views (across Wales 76 per cent of practices reported that OOH services were good or very good). Only four practices reported receiving information about frequent attenders of OOH services (this is lower than the rate of 62 per cent across Wales). Main opinions expressed included:
    - in rural areas, OOH can be difficult to access;
    - older patients tend not to use the service if at all possible and would prefer to wait until the practice is open;
    - lack of patient awareness of the OOH service holds patient surgeries at the local hospital on weekends and bank holidays, patients are concerned that they will have to travel to the primary care centre;
    - OOH services uses local GPs, which means they are aware of the various patient pathways; and
    - OOH service has improved and the practice receives fewer complaints now.
  - Perceptions about practice involvement in the planning or redesign of USC/CCM services:
    - Powys practices were generally positive about their involvement in planning and redesign of USC/CCM services. Three-quarters of practices agreed or strongly agreed that they were actively involved in planning (much higher than the 31 per cent across Wales). Similarly, five practices agreed or strongly agreed that they were actively involved in the redesigning of USC/CCM services (much higher than the 21 per cent across Wales. One respondent stated: 'Builth is the centre for a healthcare project, the first one in Wales. GPs have spent many hours giving input into the design, sitting on committees etc, only on a couple of occasions have we had any locum support.');
    - Half of the practices did perceive the health board as providing support to become involved in the planning and redesign of USC services. Similarly, two-thirds of practices in Powys did feel adequately informed of plans for USC services (but this compares with 43 per cent across Wales).
    - In relation to the planning and redesign of services for chronic conditions, all practices in Powys perceived to be actively involved in planning and redesigning CCM services (compared with 45 per cent of practices across Wales).
  - Only one practice believes the data on emergency admissions introduced as part of the QOF framework are helpful (38 per cent across Wales); similarly, only one practice believes the data are used by the practice (44 per cent across Wales), only one practice believes the data will lead to changes in the way practices provide services (25 per cent across Wales), and one practice believes that the data will lead



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to improvements in patient care: this is mirrored across practices in Wales.

Views expressed on how to improve the quality of the data include:

- concerns expressed about the quality of the data;
  - modern practices are able to produce more accurate and legible search results than those provided and most have had to do so to validate and correct the provided data;
  - if hospitals give us the information on their criteria for evaluating the emergency admissions we could possibly edit our records to correspond the data; and
  - the most useful lesson learnt from the admissions data provided is the need for the practice to improve recording (read coding) of emergency admissions to build up an accurate and in-depth picture for analysis on an ongoing basis so trends can be identified and lessons learnt.
- One practice has undertaken work itself or had work undertaken by the Health Board, or to identify patients who are repeatedly attending the emergency department or other unscheduled care service in the hospital.
  - Six practices are routinely notified when their patients access the emergency department, but only one indicated that they are informed of the frequency of access.
  - In respect of support, practices are given to help avoid emergency admissions, hospital attendances and A&E attendances:
    - only two practices perceived that they have good access to either telephone or e-mail advice from consultants (or other specialists) to help manage a patient's acute condition and avoid an emergency admission/hospital attendance or A&E attendance when appropriate (compared with 32 per cent across Wales);
    - only one perceived that they have good access to 'rapid access clinics' or 'hot clinics' to help avoid emergency admissions/hospital attendances and A&E attendances when appropriate (compared with 34 per cent across Wales);
    - two practices perceived that they had good access to diagnostic services to help avoid emergency admissions/hospital attendances and A&E attendances when appropriate (compared with 32 per cent across Wales);
    - two practices perceived that they can refer patients to a good range of community services to avoid emergency admissions/hospital attendances and A&E attendances when appropriate (compared with 36 per cent across Wales); and
    - two practices agreed that they had enough information about the range of community services available to prevent avoidable admissions (compared with 42 per cent across Wales).



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