WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

The Management of Chronic Conditions in Wales – An Update

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

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Report presented by the Auditor General for Wales to the National Assembly for Wales on 27 March 2014

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Summary

1   The impact of chronic conditions is growing in Wales. One-third of the adult population, an estimated 800,000 people, report having at least one chronic condition, such as diabetes, Chronic Obstructive Pulmonary Disease (COPD) or coronary heart disease (CHD).[1] The prevalence of chronic conditions increases with age and two-thirds of the population of Wales aged 65 or older report having at least one chronic condition while one-third have multiple chronic conditions. The burden of chronic conditions on the system is likely to increase in the future with people living longer and the number of people aged 65 and over projected to increase by around 181,000 or 32 per cent between 2010 and 2026.[2]

2   It is widely recognised that many parts of the Welsh health and social care system are under considerable pressure and 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)[3] identified the need for the radical redesign of health and social care services to create greater capacity in services outside the hospital setting. Both health and social care services continue to face rising levels of demand at a time of financial constraint. Health budgets are unlikely to rise to match the known cost and demand pressures for the foreseeable future, which points to an urgent need for service transformation and whole-system change. At the beginning of 2013-14, health boards had identified a net funding gap of £197 million,[4] which had reduced to £83.5 million at the end of January 2014. This reduction comes after the Welsh Government allocated an additional £150 million in October to meet new demands and pressures.

3   In 2005, the Welsh Government published **Designed for Life**, its 10-year vision for creating world-class health and social care in the 21st century. This document flagged the need to redesign services, including developing an integrated framework for chronic conditions. In 2007, the Welsh Government published its Chronic Conditions Management Model (Exhibit 1),[5] which signalled the need to rebalance services on a whole-system basis and to provide more care in community settings. The chronic conditions model identifies four levels of care appropriate to the complexity of a person's condition. Patients will flow between, or even straddle, the levels of care as their condition changes. Generally as care needs intensify, patients will move up the model.

1   National Public Health Service for Wales, **A profile of long-term and chronic conditions in Wales**, 2005

2   Welsh Government, **Local Authority Population Projections for Wales, 2011-based Variant Projections (SDR 165/2013)**, 2013

3   Welsh Assembly Government, **The Review of Health and Social Care in Wales, The Report of the Project Team advised by Derek Wanless**, 2003

4   Wales Audit Office, **Health Finances 2012-13 and beyond**, 2013

5   Welsh Government, **Designed to Improve Health and the Management of Chronic Conditions in Wales: An integrated model and framework for action**, 2007

Exhibit 1 - The Welsh Chronic Conditions Model

Pathways of Care and Self-care Continuum

Level 4 — Care is usually case managed with services and support coordinated and targeted at those individuals who have been actively identified as having highly complex conditions or care needs or who have been frequently hospitalised.

Level 3 — Services and support for individuals with more complicated health and social care needs whose everyday life is being impacted upon by their condition, or who may have had one or more hospital admission because of their condition. Services are typically community based or provided in peoples' own homes for example district nursing, reablement or pulmonary rehabilitation.

Level 2 — Services at the GP practice level to help individuals in the early stages of disease to delay progression and to support self care for example through structured education programmes or exercise referral schemes.

Level 1 — People typically care for themselves at home or in the community and may access services that promote health and well being, such as smoking cessation or weight management, to prevent or delay the onset of chronic conditions.

Source: Welsh Government Designed to Improve Health and the Management of Chronic Conditions in Wales: An integrated model and framework, 2007 and summarised by the Wales Audit Office

4   Between 2008 and 2011, the Welsh Government made £15 million of 'transitional' funding available to assist health communities improve the planning and integration of services for chronic conditions and to enable change. All health boards were required to undertake baseline service reviews to fully understand the local situation. The funding was intended to help strengthen community-based services and to manage the shift of appropriate services from hospital to community, as well as to develop integrated, clinically-led teams around clusters of GP practices. The transitional funding was also used to establish three national demonstrator sites to test aspects of the chronic conditions model at a local level and to accelerate learning across the NHS. Evidence from the demonstrator programme suggests that it had achieved its aims.[6]

5   In December 2008, the Auditor General published **The Management of Chronic Conditions by NHS Wales**.[7] The report concluded that too many patients with chronic conditions were treated in an unplanned way in acute hospitals, accounting for one in six of all emergency medical admissions and 17 per cent of bed days on acute medical wards. Services were fragmented and poorly coordinated, and service planning and development was insufficiently integrated.

6   A number of Welsh Government strategies and policies published since 2008, most notably **Setting the Direction**[8], as well the 2009 reconfiguration of the NHS, provided the building blocks to achieve the shift from hospital to community. **Setting the Direction**, the Welsh Government's framework for primary care and community-based services, provides a vision of integrated community services that will act as a bridge between primary care and hospital care. The vision is about changing from a reactive crisis management approach to a more proactive, coordinated and preventative approach to allow more people to be cared for closer to, or in, their own home.

7   During 2011 and 2012, local audit work was carried out at all health boards in Wales to look at efforts to improve chronic conditions management, as well as unscheduled care. People with chronic conditions tend to be frequent users of the unscheduled care system because when their conditions become worse, they often need to access services in an urgent and unplanned way. People with chronic conditions are twice as likely to be admitted to hospital as patients without such conditions. Improving self-care support and community services for chronic conditions has the potential to substantially reduce demand for unscheduled care services.

8   This report, which should be read in conjunction with our report on unscheduled care,[9] outlines the key conclusions drawn from our audit work, which sought to answer the question 'Are health boards improving the efficiency and effectiveness of their approach to improving the management of chronic conditions?' Details on our audit approach are provided in Appendix 1.

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6   National Leadership and Innovation Agency for Healthcare, **Final Report from the Chronic Conditions Management Demonstrators, Learning to Support Integrated Primary and Community Care across Wales**, November 2011

7   Wales Audit Office, **The management of chronic conditions by NHS Wales**, 2008

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

9   Wales Audit Office, **Unscheduled Care – An Update on Progress**, 2013

9   We concluded that progress has been made
     with the management of chronic conditions in
     Wales, and it is positive to note that hospital
     admissions for certain key conditions have
     reduced. However, there is more to do,
     most notably to secure further progress with
     shifting resources to the community sector
     and expanding access to community-based
     services for chronic conditions. We reached
     this conclusion because:

     a   Whilst NHS Wales has a clear vision for
         improving the management of chronic
         conditions, underpinning local plans have
         hitherto failed to set out how the care will
         be rebalanced towards the community;
         opportunities to address this are now
         presented by the development of an
         integrated three-year planning framework.

     b   Services for patients with chronic
         conditions have benefited from
         rationalisation; there is better support for
         self-care and related hospital admissions
         have reduced but progress is variable
         across Wales and scope for better
         coordination still exists.

     c   Information for planning and monitoring
         services for chronic conditions and
         community services is limited and boards
         rarely receive information on the shift of
         relevant resources to community settings.

Whilst NHS Wales has a clear vision for improving the management of chronic conditions, underpinning local plans have hitherto failed to set out how care will be rebalanced towards the community; opportunities to address this are now presented by the development of an integrated three-year planning framework

The vision for chronic conditions has been articulated through a large number of national strategies and delivery plans but until recently health boards have not had sufficiently clear plans to change their patterns of delivery

10   Meeting the needs of people with chronic
     conditions has been a priority for the NHS
     in Wales since the Welsh Government first
     signalled its intention in 2005 to develop an
     integrated framework for chronic conditions
     to reblance services from an overreliance on
     acute hospitals and towards greater use of
     primary and community services. In 2012,
     the Welsh Government has reaffirmed its
     vision for services based around primary
     and community care with a greater range of
     services available at all times.[10]

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10   Welsh Government, **Together for Health, A Five Year Vision for the NHS in Wales,** 2012

11   Our audit found that health boards have a clear vision for transforming chronic condition services reflecting the direction of travel outlined by the Welsh Government and underpinned by a better understanding of the health needs of their local populations. However, each health board's vision was not always supported by a detailed plan setting out the resources needed to deliver it. Most workforce plans, for example, have not adequately addressed the shift needed from hospital to primary and community settings and, other than information about GPs, information about the wider primary care workforce is poor. Opportunities to address this planning deficit have recently been presented by additional planning guidance from the Welsh Government, leading to the development of integrated three-year plans by health boards. At the time of preparing this report, the contents of health boards' three-year plans were being scrutinised by the Welsh Government.

Health boards have established groups to oversee the implementation of the chronic conditions model and Setting the Direction but the interrelationship with other strategic priorities is not always joined up

12   Our local audits found varying arrangements in place at health boards to oversee the implementation of the chronic conditions model and **Setting the Direction**. Accountability at the executive director level for transforming chronic conditions management services was typically well defined. However, individuals concerned hold wide and challenging portfolios, which may dilute executive leadership for chronic conditions management.

13   All health boards had established a multi-agency group to bring together key stakeholders and the high level of importance placed on these groups was reflected in their membership and lines of accountability to the board. In some health boards, these groups provided the mechanism to bring together disparate strategic planning and operational groups where there was a clear interrelationship with chronic conditions, such as unscheduled care. Where separate strategic or operational groups existed, our audit also found a lack of commonality in group membership with little oversight at the executive level and different reporting lines to the board.

Health boards are trying, with mixed success, to work in partnership with key stakeholders to redesign services

14   Changes to organisational structures are helping to bring clinical directors closer to the executive teams. Locality structures within health boards are also making it easier for primary care clinicians to take an active part in planning processes and improving the dialogue between hospital and primary care clinicians. In some health boards, however, efforts to engage clinicians have not been wholly effective. GP practices responding to our survey had mixed views about the extent to which they had been involved in the planning and redesign of services for chronic conditions.

15   We found that health boards were committed to building strong partnerships with local authorities to support service integration with examples of this commitment evident, for example through joint appointments between health boards and social services, and through specific programmes that aim to provide better coordinated care for specific cohorts of patients, such as the frail elderly.

Services for patients with chronic conditions have benefited from rationalisation; there is better support for self-care, and related hospital admissions have reduced, but progress is variable across Wales and scope for better coordination still exists

There have been positive steps to support service developments in primary care for patients with, or at risk of, chronic conditions

16 Our previous audit found only a handful of enhanced services[11] in place to support patients with, or at risk of, a chronic condition. Local enhanced services are now more common with one or more of these services in place across all health boards. Health boards are also working to agree ways that GPs and other primary care staff can access urgent advice from hospital consultants to better manage their patients in the community and thereby reduce the need to refer patients to A&E or outpatient departments. Whilst these are positive developments, our audits did identify scope to improve the range of support or information available to GPs to manage patients more effectively in the community and to avoid unnecessary hospital referrals or admissions.

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

17 Since our 2008 report, all health boards in Wales have implemented the national generic self-management education programme for people with a long-term condition, or those caring for someone with a long-term condition. These programmes aim to give individuals the confidence to look after their own health needs.

18 In 2009, the then Minister for Health and Social Services indicated that health boards should aim to get one per cent of the population with a chronic condition through these education programmes in the following three to four years. Just over 5,400 participants completed a programme between 2010 and 2013, which is short of the target set by the minister. The number of participants completing a course has increased but two-fifths of individuals registering for a course, either cancel, fail to attend or fail to complete it. The failure of participants to take up and complete a course is contributing to the non-achievement of the overall target of getting one per cent of the patients with chronic conditions through a patient education programme.

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11 GMS enhanced services are defined as those services other than essential services, additional services or out-of-hours services, where an element of such a service requires an enhanced level of service provision. There are three types of enhanced services. These are: directed enhanced services that are nationally directed and commissioned for the local population; national enhanced services that are commissioned to meet local needs using national specifications and benchmark pricing; and local enhanced services that meet local health needs with local payment arrangements.

Community-based services for chronic conditions are less fragmented and more timely but most services are still available weekdays only

19 Our 2008 report found that the pattern of community services for managing chronic conditions was fragmented and poorly coordinated. The NHS reforms in 2009 facilitated a review and rationalisation of the overall number of services to support patients with chronic conditions in the community and supported the introduction of more integrated services.

20 Our previous audit found that many of the chronic condition and intermediate care services had limited capacity with services operating waiting lists and the availability of services not matching demand. Our recent audit identified improvements and found that one in five services could see patients almost immediately once a referral had been received. However, just over half of the services were still available on weekdays only.

Health boards have made some positive steps in developing community-based services for the most vulnerable patients but there is scope for better coordination

21 Health professionals need to be able to identify those individuals at greatest risk of unplanned admissions in order to provide them with support. In 2008, we had been informed that PRISM, a risk stratification tool, would be tested and evaluated before wider implementation in 2009. The pilot took place in 2009, slightly later than planned and our most recent local audits found that PRISM had still not been rolled out widely. A formal independent evaluation is currently being carried out but is not expected to be completed for some time. According to NHS Wales Informatics Service (NWIS) estimates, 100 GP practices currently use PRISM but during our audit fieldwork we were told that delays in the roll-out meant some practices were losing interest.[12]

22 Risk stratification is key to effective service planning and the Welsh Government encourages the use of a range of risk stratification tools. Health boards, working with GP practices, have been developing and testing different approaches to identify individuals with complex health needs or those experiencing multiple admissions to support them in the community. However, there needs to be a mechanism for sharing and evaluating the relative success of these different approaches so that effective practice is spread more widely.

23 New measures in relation to risk stratification were also introduced into the 2013-14 Quality and Outcomes Framework, part of the General Medical Services (GMS) contract. General practices participating in the Quality and Outcomes Framework are required to produce a list of five per cent of their registered patients predicted to be at significant risk of an 'unscheduled care admission or an unplanned community-based alternative' and to identify those who would benefit from review and active management. Health boards will rely upon locality networks or clusters of GP practices to share the key themes to emerge from the risk stratification process. The information can be aggregated to inform service planning and to identify gaps in service provision, as well monitoring outcomes at a local, regional or national level. At the time of audit fieldwork, we were told that primary and community staff had concerns about the implications for information governance in relation to storing and sharing information obtained from risk stratification. Mechanisms

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12 **Reducing Emergency Risk, The Prism tool**

for sharing information, particularly at the level of an individual case, will therefore need to be agreed by health boards and their locality networks or GP clusters.

24 The chronic conditions model and **Setting the Direction** both advocate the need for integrated multidisciplinary teams that focus on coordinating community services for these individuals. At the time of our audit, 16 community resources teams had been established across five of the seven health boards. Each of these teams was at different stage of development but for the most part provided an umbrella for intermediate care services that operated individually. Since our recent audit, one health board has now established its community resource team.

25 The community resource teams have a range of approaches in place covering case management, rapid assessment and virtual wards[13]. However, health boards also provided, or were developing, other similar community services for the same groups of patients, namely the frail elderly, those with multiple chronic conditions, and those at risk of unplanned admissions. District nursing services also add to this complexity, providing similar care to the same groups of patients with some health boards reorganising district nursing services to increase capacity and to help facilitate the shift in service provision from hospital to community.

26 Collectively, this means that responsibility for identifying and coordinating services for patients is unclear, particularly for the most vulnerable patients. This risks efforts being duplicated across the different services. The Welsh Government's recent guidance[14] on integrated assessment does, however, aim to help drive better coordinated care for older people across the different sectors.

27 The chronic conditions model and framework envisioned a designated care coordinator working closely with GP practices and health and social care services to stratify practice populations, identify, plan and coordinate services to meet needs and to monitor patient progress. However, many of the care coordinator roles established with the transitional funding ceased when the funding stopped in 2011. The lack of a care coordinator may be a factor in the current duplication of services.

Hospital admissions for chronic conditions are reducing and health boards have begun to rebalance the workforce towards the community

28 Our previous audit work found that too many patients were being admitted to hospital as an emergency and that the role of community hospitals in helping to prevent acute admissions for chronic conditions was unclear. Over the last six years there has been a downward trend in the number of emergency admissions for CHD and COPD while emergency admissions for diabetes is relatively unchanged. Overall numbers of readmissions for these three conditions is also reducing.

29 Meanwhile, the average number of daily-staffed beds within community hospitals has also reduced over the last five years by 29 per cent with small reductions in numbers of acute hospital beds. The reductions in community hospitals is due to old and outdated facilities either being replaced or closed. This means that the greater reliance will be placed on community-based services to prevent or divert emergency admissions or to provide ongoing support when a patient is discharged from hospital.

13 The virtual ward uses similar daily routines to a hospital ward with patients receiving regular visits from health staff in their own homes, thereby providing interventions that avoid the need for a hospital admission or replacing a long stay on a hospital ward.

14 Welsh Government, **Integrated Assessment, Planning and Review Arrangements for Older People, Guidance for Professionals in supporting the Health, Care and Well-being of Older People**, December 2013

30 Health boards have begun to rebalance the workforce with small increases in numbers of nursing staff deployed in community services and small reductions in numbers working in acute hospitals. However, the increase in community nurses may not be keeping pace with the demographic shift and health boards need to review the availability of their community nurses to support an increasingly older population.

Information for planning and monitoring chronic services for conditions and community services is limited and boards rarely receive information on the shift of relevant resources to community settings

Progress in developing a national community information data set has been slow

31 Our 2008 report highlighted the paucity of financial information and activity data with which to plan services or evaluate exisiting ones and we recommended the development of more comprehensive community informaton. The Welsh Government reviewed the available information and found that data for chronic conditions and community services was often disparate, inconsistent and incomplete and that financial information was not fit for purpose.[15] Furthermore, to deliver integrated care services as set out in the chronic conditions model (and subsequently **Setting the Direction**), would require integration of information systems across organisations.

32 Our recent audit found little progress had been made to improve existing information about chronic conditions and community services. Unlike in England where providers of community services have been required to capture information about users in receipt of, or referred to, community services since April 2012, information systems to record community care episodes are inadequate or non-existent.

33 The NWIS has recently tendered for a Community Care Information Solution to support the information sharing required for an integrated health and social care system. However, this system will not be in place before April 2014 and health boards and local authorities will not be compelled to use it.

34 In order to achieve the priorities set out in the quality delivery plans underpinning **Together for Health**, NHS organisations will need a single information system to support efficient and effective patient care, and good-quality information to demonstrate progress against the delivery plan milestones and performance in relation to the outcomes of care.

Despite evidence of significant increases in budgets for community services, performance information presented to NHS boards is largely focused on hospital activity with limited information available to monitor the shift in balance of care towards community provision

35 Boards of NHS organisations receive limited information about the performance of community services. There is little, if any, reporting on demand for, or uptake of, community services, patient experience, service quality, patient outcomes, impact on demand elsewhere in the system, service costs or the overall shift in care from hospital to community.

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15 Welsh Government, **Community Health Information Requirements Project, Final Report**, 2009

36 At the time of our most recent audit, health boards were starting to develop data sets to help them monitor progress against their programmes of work in relation to **Setting the Direction** but these data sets remained overly focused on inpatient care. Even where information is available, like that for the patient education programmes, it is not used to provide a much-needed perspective on community service provision. The most recent NHS Wales Delivery Framework[16] sets out measures that are intended to provide a more integrated view of performance but measures to assess integration and partnership remain focused on hospital activity.

37 The combined budget for intermediate care and chronic conditions services in 2005-06 was £18.5 million and information from our most recent audit shows that budgets had nearly doubled to £34 million by 2011-12. However, gaps in financial and activity information still make it difficult to establish relative value for money of the different types of services.

38 With increasing pressure to deliver financial savings and little, if any, new money to fund service developments, NHS organisations will be reliant on shifting resources from one part of the system to another. Without robust and readily accessible information to support ongoing evaluation of services or measures of demand, the ability to present the case for releasing resources will be difficult.

Recommendations

Planning

1 NHS bodies have a clear vision for transforming chronic condition services but previously the vision has not always been supported by detailed plans setting out how the intended shift of resources from hospital to the community sector will be achieved. We recommend that health boards use the new integrated planning framework to:

a develop fully costed plans that identify the level of investment required to rebalance services towards the community;

b clearly set out how the intended shift of resources to the community sector will be achieved in practice, bringing together the various different policy and strategy requirements; and

c ensure interdependencies with other strategic and operational priorities, like unscheduled care, are adequately cross-referenced or reflected in a single integrated plan.

2 Local workforce plans need to be strengthened to reflect the required shift in service provision from acute to primary and community settings and increasing expectations around service integration for health and social care. We recommend that in developing their integrated three-year plans, health boards:

a map the capacity and capability of their current community workforce to inform workforce plans and to match resources to need;

16   Welsh Government, **NHS Wales Delivery Framework, 2013-2014 and Future Plans**, 2013

b work with the Welsh Government and local GP practices to agree mechanisms for collecting and sharing information on the wider primary care workforce in terms of numbers and skills and future workforce needs; and

c work with local government partners to identify the workforce number and skills needed to deliver integrated services.

Identifying patients at risk of unplanned admissions

3 Health boards, working with GP practices, have been developing new ways to identify individuals most at risk of an unplanned admission. PRISM is one such tool to help with this process but its evaluation and wider roll-out has not yet happened. It is important that there is a systematic approach to risk stratification across Wales and we recommend that the Welsh Government working with the NWIS and health boards:

a evaluate the relative success of the different approaches to risk stratification currently being used and agree a mechanism to share good practice;

b expedite the evaluation of PRISM; and

c agree an all-Wales set of requirements for information governance in relation to storing and sharing information obtained from risk stratification.

4 The 2013-14 GMS contract requires GPs to identify the proportion of their patients most at risk of an unplanned contact with services and who would benefit from review and active management. We recommend that:

a health boards work with clusters of GP practices to agree mechanisms for sharing anonymised information on the needs of patients identified as most at risk of an unplanned contact in order to identify gaps in service provision and strengthen service planning and monitoring; and

b health boards regularly publicise the range of community services available and how these can be accessed to help GPs actively manage patients with chronic conditions more effectively in the community and to avoid unnecessary hospital referrals or admissions and to facilitate timely hospital discharge.

Support for self-care and education programmes

5 The uptake and completion of programmes designed to educate patients and support self-care is still poor. We recommend that health boards:

a work to understand the reasons for non-attendance on patient education programmes in order to maximise uptake, to ensure courses are viable and improve the cost-effectiveness of the programme;

b actively promote education programmes for patients and support for self-care amongst the health and social care professionals in regular and frequent contact with patients and service users;

c continue to seek alternative ways to support patients to self-care by ensuring patient education and access to self-care information are an integral part of the services provided; and

d develop indicators to measure the impact of these programmes on individual patient experience and reported outcomes.

Coordinating services

6 Responsibility for identifying and coordinating services for patients at risk of unplanned admissions or those who would benefit from active case management is unclear given that many community services provide the same or similar services to these groups of patients. We recommend that health boards, working with GPs, should simplify, coordinate and direct resources towards those patients who would benefit most.

Information

7 Information systems to record community care episodes for individual patients, to share clinical records and care plans or to provide good-quality information for monitoring community services and performance in relation to outcomes of care are currently inadequate or non-existent. We recommend that the Welsh Government working with the NWIS:

a examines the feasibility of introducing a community care episode record, similar to the inpatient episode record; and

b completes the procurement of the Community Care Information Solution and ensures that the benefits of using this system are publicised across NHS Wales.

8 Boards of NHS bodies receive limited information about the performance of primary and community services across their organisation and where information is available it is not always brought together effectively to provide a much-needed perspective. In order to strengthen board reporting, we recommend that health boards:

a develop a more comprehensive approach to reporting performance to the board that brings together information on both primary and community care services, including information on the demand and uptake of services, the impact of services on patient outcomes and patient reported outcomes linked to the actions in the **Together for Health** delivery plans, patient experience, service quality and safety, services costs and the overall shift in care from hospital to primary and community care.

Part 1 – Whilst NHS Wales has a clear vision for improving the management of chronic conditions, underpinning local plans have hitherto failed to set out how care will be rebalanced towards the community; opportunities to address this are now presented by the development of an integrated three-year planning framework

1.1 Improvements in services for patients with chronic conditions are easier to achieve if there is clear national policy guidance and service standards that reflect recognised good practice. Individual NHS organisations then need to have the necessary plans and resources in place to implement policy imperatives. This section of the report looks at NHS in Wales' strategic approach and adequacy of plans to realise service transformation for chronic conditions management.

The vision for chronic conditions has been articulated through a large number of national strategies and delivery plans but until recently health boards have not had sufficiently clear plans to change their patterns of delivery

1.2 Meeting the needs of people with chronic conditions has been a priority for NHS Wales since the Welsh Government first signalled its intention to develop an integrated framework for chronic conditions in 2005. This is clearly evident from the number of strategies and plans published prior to and following our most recent audit (Exhibit 2 and Appendix 2). The chronic conditions model and framework advocates a proactive, planned and managed approach to chronic conditions and stresses the need to prevent or delay the onset of

chronic conditions and the role individuals play in their own care. **Setting the Direction** reinforces the need to rebalance the whole system of care away from an overreliance on acute hospitals and towards greater use of primary and community services.

1.3 The chronic conditions model and associated transitional funding and **Setting the Direction** were the key drivers in helping to redesign and rebalance services for patients with chronic conditions at the time of our most recent audit. Our audit found that health boards have a clear vision for transforming chronic condition services, which reflects the broad direction of travel as outlined in **Setting the Direction**. Each health board's vision for chronic condition services was underpinned by a better understanding of the health needs of their local populations due in part to the transitional funding provided by the Welsh Government to establish a baseline analysis of local needs.

1.4 However, each health board's vision was not always supported by a detailed plan setting out the resources needed to deliver it. For example, we found a mixed picture in relation to the extent to which workforce plans supported the vision. Rebalancing the care system will require increased capacity within community services and workforce plans that consider the number and type of staff in the community will be vital to success. Few workforce plans adequately reflected the need to shift staff from secondary to primary and community care.

1.5 One of the challenges to compiling a robust workforce plan is the need to reconcile workforce numbers with the necessary skills and competencies to deliver different models of care and more complex care in the community. We would expect current service and workforce planning to identify and help take forward new thinking in terms of role redesign. Our local audits found that health boards recognised the need to focus efforts around increasing capacity and skills within the community but few health boards had a good understanding of the capacity or capability of their community workforce making it difficult to target the training and development needed to support the shift in resources from hospital to primary and community care settings.

1.6 Our local audit work also identified that health boards have little information on the primary care workforce, other than GPs, with which to inform their workforce plans. Data from the latest GMS Census highlights succession planning challenges associated with the GP workforce. The census shows that nearly one-quarter of GPs are aged 55 or older but the average age of GPs leaving the workforce is 51 years. A considerable number of older GPs could retire in the next few years and would need to be replaced in order to sustain the policy drive to rebalance services towards the community. Also the number of GPs joining the workforce normally exceeds the number leaving but this trend was reversed in 2011-12 when the number leaving exceeded the number joining.

1.7 Information on the wider primary care workforce with which to inform workforce plans was limited with only one health board[17, 18] identifying the proportion of practice nurses that could potentially retire. Findings from a survey of members of the Royal College of Nursing conducted in 2009 suggest that practice nurses tend to be older than their hospital counterparts, with just over one-fifth of UK practice nurses aged 55 or older.[19]

1.8 Since the introduction of the new GMS contract in 2004, it is no longer mandatory for GP practices to supply data on practice staff. The policy drive to increase care provision in the community, however, means that health boards will need to expand their knowledge about the primary care workforce to address potential shortfalls in numbers and skills to meet the needs of an ageing population with complex health and care needs. Although GPs are independent contractors and not directly employed by the NHS in Wales, it is important that health boards work with local GPs to ensure its communities have an appropriate primary care workforce. In England, the Health and Social Care Act 2012 places a duty on all organisations that deliver care funded by the NHS to provide data on their current workforce and to share their anticipated future workforce needs. In the absence of such a statutory provision in Wales, health boards and the Welsh Government will need to work closely with general practices to ensure that the necessary workforce data is collected. Workforce information for social, independent and voluntary care sectors will also be needed to ensure that an appropriately trained and skilled workforce is in place to deliver integrated health and social care services.

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17   Cwm Taf University Health Board

18   Since our audit, Hywel Dda University Health Board has indicated that this information is becoming available through local audit work by the local medical committee.

19   J Ball and G Pike, **Practice nurses in 2009: results from the RCN annual employment surveys 2009 and 2003**, 2010

Exhibit 2 - National policy landscape in relation to chronic conditions

Source: Wales Audit Office

1.9   Since our audit fieldwork in 2011 and 2012, the Welsh Government has reaffirmed its vision for services based around primary and community care with a greater range of services available at all times. This vision is set out in **Together for Health** and health boards are expected to continue improving links across primary, community, hospital and social care, in line with **Setting the Direction**.

Together for Health, is underpinned by a series of national delivery plans in relation to both quality improvement and quality assurance. The series of delivery plans is designed around common themes and actions that mirror the generic chronic conditions model, namely prevention, early detection and treatment and support to help individuals or their carers to live with the disease or condition.

Timeline of Welsh Government health policy documents published February 2011 to December 2013.

1.10 During 2013 and the early part of 2014, health boards have been developing integrated medium-term (three-year) plans. These plans will be subject to scrutiny by the Welsh Government to ensure they adequately address the operational and financial challenges facing services. For chronic conditions management, the plans will need to set out how the intended shift of resources to the community sector will be achieved in practice, bringing together the various different policy and strategy requirements.

Health boards have established groups to oversee the implementation of the chronic conditions model and Setting the Direction but the interrelationships with other strategic priorities are not always joined up

1.11 If health boards are to deliver on their ambitions to rebalance services towards the community as described in the chronic conditions model and **Setting the Direction**, they must have effective arrangements in place for the coordination and oversight of national strategies and policies. Within these structures, there must be individual leaders who are well positioned and empowered to drive transformation. Our local audits found varying arrangements in place at health boards to oversee the implementation of the chronic conditions model and **Setting the Direction**. Whilst accountability at the executive director level for transforming chronic conditions management services was typically well defined, the individuals concerned hold wide and challenging portfolios and health boards need to guard against the risk that executive leadership for chronic conditions management becomes diluted.

1.12 All health boards had established a group to bring together key stakeholders from across the health board, primary care, local authorities and the third sector (Appendix 3). Health boards generally conferred a high level of importance on these groups, which was reflected in their membership and the lines of accountability to the board. Most groups include Independent Members (IMs), often as the group's chair. Lines of accountability to the boards of these organisations are either informal through the IMs on the groups or via formal reporting to a committee of the board.

1.13 In some health boards, these groups have provided the mechanism to bring together disparate strategic planning and operational groups to provide an overview of chronic conditions and other elements with a clear interrelationship, such as unscheduled care. Where separate strategic or operational groups exist for chronic conditions and unscheduled care, for example, it is important that there is some commonality in the group membership to provide coordinated oversight, particularly at the executive director level. However, this was not always the case and reporting lines to the board were not always the same.

Health boards are trying, with mixed success, to work in partnership with key stakeholders to redesign services

Health boards are committed to engaging clinicians and placing them at the centre of service redesign but in some health boards, efforts to engage clinicians have not been wholly effective

1.14 Effective engagement of clinical staff is a critical success factor in driving 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. Our local audits found that there is a clear vision for clinicians to be at the heart of service redesign and to be engaged fully to help deliver health boards'

strategic and financial savings plans. Changes to organisational structures are helping to bring clinical directors closer to the executive teams.

1.15 Some health boards have established or reinvigorated clinical forums as another way in which to engage their clinicians. These forums bring together clinical directors from both hospital and primary and community care sectors. Health boards have also been engaging clinicians in service reviews or developing clinical service strategies. Clinicians that we met as part of our recent audit told us that they felt engaged in these service reviews and the development of plans to modernise services. The process of reviewing services is said to be contributing to clinicians' understanding of the need for change and their role in the change process, such as helping to make the case for service change with the wider public. Clinicians also told us that they have a better understanding of the financial pressures facing their respective organisations. Equally, health boards recognise that not all clinical staff have a good understanding of the direction of travel, particularly where they have not been directly involved in service reviews or contributed to strategic planning. We found that health boards are working to improve channels of communication and providing support for clinical directors to engage with their staff and communicate the direction of travel more effectively.

1.16 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. Where locality structures are in place within health boards, these have made it easier for primary care clinicians to take an active part in planning processes with local clinical directors, who are in the main GPs, providing clinical leadership across clusters of practices. Having GPs in these lead roles is also helping to improve dialogue between GPs and hospital clinicians. However, there were mixed views about the extent to which primary care practitioners felt involved in the planning and redesign of services. Fewer than half (45 per cent) of the practices responding to our survey agreed or strongly agreed that the practice had been actively involved in work related to the planning and redesign of services for patients with chronic conditions.

Health boards are generally committed to building strong partnerships with local authorities to support service integration but the pace of progress is slow

1.17 Health boards in partnership with local government and the third sector will need to support people with chronic conditions to live in their own homes independently for as long as possible, avoiding unnecessary admissions to hospitals and long-term care. **Setting the Direction** argued for the coordination of services on the basis of locality networks. Most health boards have localities that are co-terminous with local authority boundaries, which should support effective partnership working. However, some health boards need to work in partnership with a large number of local authorities, which means that these health boards have to find effective ways of working together to coordinate and integrate service planning and delivery. Complex organisational structures within health boards can also be a barrier to effective partnership with local authorities. For example at Betsi Cadwaladr University Health Board, one local authority would have to build relationships with not only the health board, but up to four locality teams and multiple Clinical Programme Groups (CPGs).

1.18 The extent to which health boards had developed strong working relationships with local authority partners was variable. At a strategic level, there is generally good representation from local authorities on local strategic and operational groups responsible for implementing **Setting the Direction**. However, while some good practice is evident at an operational level (Box 1), the overall pace of progress with service integration is slow.

Box 1 – Examples of partnership working at an operational level between health boards and local authorities

Abertawe Bro Morgannwg University Health Board received funding from the local authority to support the Community Resource Team to carry out more rapid community assessments to reduce delayed transfers of care in the Swansea area and to extend the Community Resource Team to cover the A&E department at Morriston Hospital at night to prevent social admissions.

Aneurin Bevan University Health Board and the five local authorities began work on the Gwent Frailty Programme in 2007. The programme puts in place the infrastructure to deliver integrated health and social care services. In 2011, locality intermediate care and reablement teams were successfully integrated into six locality community resource teams to deliver all emergency social care, urgent medical assessment, rapid response nursing, reablement and falls management.

Cardiff and Vale University Health Board worked in partnership with the Vale of Glamorgan Council to establish a communications hub provided by a single integrated team. The hub provides a single point of contact for both service users and professionals to signpost them to a range of health and social care services, as well as take referrals and schedule appointments.

Cwm Taf University Health Board worked in collaboration with the Rhondda Cynon Taf County Borough Council (RCT CBC) to implement a 'single point of access' whereby ward staff at the Royal Glamorgan Hospital and Ysbyty Cwm Rhondda could make referrals direct to the council's Intermediate Care and Reablement Service without the need for a social service assessment. This single point of access has supported more timely discharge and saved bed days. Since our local audit work, the health board has rolled out the single point of access across all hospital sites in conjunction with both RCT CBC and Merthyr County Borough Council.

Hywel Dda University Health Board sees partnership working as a major driver of change and demonstrated its commitment by creating a post for a Director of Strategic Partnerships to support integration and improve partnership working. The health board has also entered into a formal Section 33 Agreement (National Health Service (Wales) Act 2006) with Carmarthenshire Local Authority to align community health and social care services although budgets are not pooled, which involves integrated and shared posts and integrated budget management arrangements aimed at reducing duplication. The agreement provides opportunity to pool budgets in future and put in place a single management structure.

Powys Teaching Health Board is working with Powys County Council to implement integrated IT systems for health and social care services. An IT manager was appointed jointly to take this work forward.

Part 2 – Services for patients with chronic conditions have benefited from rationalisation; there is better support for self-care, and related hospital admissions have reduced, but progress is variable and scope for better coordination still exists

2.1 Our previous audit work highlighted the fact that community services were often fragmented and poorly coordinated. 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. This section of the report discusses the progress that the NHS has made to coordinate the delivery of services for people with chronic conditions or those at risk of developing them.

There have been positive steps to support service developments in primary care for patients with, or at risk of, chronic conditions

2.2 Primary care is a key part of the health-care system in supporting people with chronic conditions. The first point of contact for most people in determining and managing their health needs is their GP. A large proportion of the work in primary care is in supporting patients with chronic conditions as well as their families and carers, and in particular supporting the frail elderly with complex care needs. In England, estimates suggest that people with chronic conditions use half of all GP appointments.[20]

2.3 In addition to the Quality and Outcomes Framework that incentivises GP practices to improve the quality of care relating to chronic conditions, as well as health promotion to delay disease progression, health boards can use the GMS contract to create capacity to care for patients in the right place through enhanced services. Practices can choose whether or not to provide enhanced services. Historically, the use of local enhanced services has been limited. Our previous audit found only a handful of local enhanced services in place to support patients with, or at risk of, chronic conditions, such as services for diabetes or smoking cessation. We found that across all health boards one or more local enhanced services are provided to support patients with, or at risk of, chronic conditions. Some health boards have extended the range of local enhanced services commissioned, for example to include heart disease and respiratory diseases, or support different ways of delivering services to prevent unplanned admissions (Box 2). In 2012-13, expenditure on these local enhanced services totalled £2.9 million compared to £263,000 in 2005-06, but current expenditure still accounts for less than one per cent of the total expenditure on the GMS contract.

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20 **Ten things you need to know about long term conditions**

2.4 Minimising avoidable admissions is only possible if GPs are aware of, and have access to, adequate support services such as rapid diagnostics, access to consultant advice and emergency clinics. If such services are not available, or are hard to access, GPs may be dissuaded from using them. Our local audits found that health boards are working to agree ways that GPs and other primary care staff can access advice from consultants within 24 to 48 hours to help manage requests for outpatient referrals or when seeking urgent advice, for example by secure e-mail.

2.5 The 2009 NHS reconfiguration and the subsequent publication of **Setting the Direction** have provided the impetus to bridge primary care and hospital care. Box 3 shows several examples of where health boards are working to bridge primary and hospital care for patients with diabetes.

2.6 In November 2011, we surveyed 498 GP practices (including branch practices) for their views about the range of support or services available to manage patients more effectively in the community. The overall response rate across Wales was poor with only 26 per cent of practices responding. The low response rate means that the survey results need to be treated with some caution. They can, nonetheless be used to illustrate particular issues. Survey responses indicated that there is scope to improve the range of support or information available to GPs to manage patients more effectively in the community and avoid unnecessary hospital referrals or admissions. GP practices located within

Aneurin Bevan University Health Board were generally more positive with higher proportions of practices agreeing or strongly agreeing that support or services were available across the community. Overall we found that:

a   32 per cent of practices agreed or strongly agreed that they had good access to telephone or e-mail advice from consultants (or other specialists) to help manage a patient's acute condition but this varied between health boards from none to 54 per cent;

b   34 per cent of practices agreed or strongly agreed that they had good access to rapid access clinics but this varied between health boards from 6 per cent to 50 per cent;

c   32 per cent of practices agreed or strongly agreed that they had good access to diagnostic services but this varied between health boards from 21 per cent to 44 per cent;

d   42 per cent of practices agreed or strongly agreed that they had enough information about the range of community services available to prevent avoidable admissions but this varied between health boards from 13 per cent to 59 per cent; and

e   36 per cent of practices agreed or strongly agreed that they could refer patients to a good range of community services to avoid emergency admissions or hospital attendances but this varied between health boards from none to 56 per cent.

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

2.7   Individuals in the early stages of chronic conditions may be able to delay disease progression by good management of their condition supported by education programmes that encourages and supports them to look after their own health and well-being. This '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 health-care services. Supporting individuals to look after their own health and care is a key part of the Welsh Government's policy in relation to chronic conditions[21] and is reinforced in the national suite of delivery plans that underpin **Together for Health**.

2.8   Our 2008 report on chronic conditions found that fewer than half of the community services for people with chronic conditions included aspects of patient education or support for self-care. By 2011, most (89 per cent) of the community-based services supporting patients with chronic conditions included patient education and support for self-care.

2.9   Since 2008, all health boards in Wales have implemented the national generic self-management education programme for people with long-term conditions and those caring for someone with a long-term condition. This evidence-based programme aims to give participants the confidence to look after their own health needs. Each course requires participants to attend for 2.5 hours per week for six weeks.

21   Welsh Government, **Improving Health and Well being in Wales, A Framework for Supported Self-care**, 2009

2.10 At the time of our 2008 report, we estimated that the NHS in Wales would need to provide 500 patient education courses annually in order to support just one per cent of the adult population with a chronic condition. In a ministerial letter to chief executives in 2009, the then Minister for Health and Social Services indicated that health boards should aim to get one per cent of the population (estimated to be 6,500 people) with a chronic condition through these courses over the following three to four years. Since April 2010, a total of 604 programmes have been provided across Wales with just over 5,400 participants completing a course. A further 1,000 people across Wales will need to complete a course in order to achieve this target.

2.11 In support of the ministerial guidance, a target was set in 2010 to increase throughput by 20 per cent and to increase the average number of participants completing the programme to 10 per course starting from the third quarter of 2010-11, until such time as the one per cent target is achieved. Across Wales, the required increase in throughput has been achieved. The number of participants completing a self-management education programme increased by 53 per cent between 2011 and 2013 with an average of 10 participants completing a course at most health boards (Exhibit 3).

Exhibit 3 – Change in throughput and average number of participants completing self-management education programmes between January and December 2011 to 2013

Health board	Numbers of participants completing the programme (throughput)[1,2]			Average number of people completing each course (throughput)		
	2011	2012	2013	2011	2012	2013
Abertawe Bro Morgannwg	249	297	311	9	8	10
Aneurin Bevan	252	311	440	9	10	10
Betsi Cadwaladr	307	374	290	7	9	9
Cardiff and Vale	135	230	359	9	10	10
Cwm Taf	72	79	123	7	7	7
Hywel Dda	128	161	304	9	9	10
Powys	50	55	0	10	11	NA
Wales	1,193	1,507	1,827	8	9	10

Notes:

1   Since April 2012, Betsi Cadwaladr has provided the Online Self-Management Programme for the whole of Wales, as well as the traditional face-to-face programmes. The figures presented in this table exclude participants completing the Online Self-Management Programme and may account for the apparent reduction in throughput for the face-to-face programmes. In Quarter 3 2013-14, 19 people registered to take part in the online course and 14 completed it. At the same time, 138 people registered to attend a face-to-face course and 63 people completed it.

2   The generic education programme for patients has not been supported by Powys Teaching Health Board since the end of 2012. Instead, the health board is developing and piloting its own programme called 'Invest in Yourself', which is health professional led.

Source: Wales Audit Office analysis of data derived from the Education Programme for Patients, Cymru all-Wales quarterly reports (these figures exclude disease-specific education programmes, such as X-PERT or DAPHNE)

2.12 In 2013, three-fifths (60 per cent) of individuals who registered to attend a course, took up a place and completed it compared with a higher proportion (64 per cent) in 2011. Although the number of participants completing a course is increasing, the percentage completion rate reduced with big variations between health boards (Exhibit 4). Since the end of 2011 the way in which completion rates are presented in the quarterly reports prepared by the Education Programme for Patients Cymru have changed. The numbers of people that register for a course but cancel or do not attend are excluded from the calculation. This means that the overall completion rate will appear much higher. Irrespective of how the completion rate is calculated, health boards need to understand the reasons for non-attendance in order to maximise uptake, to ensure courses are viable and to improve the cost-effectiveness of the programme. Moreover, the failure of participants to take up and complete a course is contributing to the non-achievement of the overall target of getting one per cent of the patients with chronic conditions through a patient education programme.

2.13 Education programmes for patients are led by individuals who have personal experience of either living with, or caring for, someone with a chronic condition. At the end of 2013, there were 82 tutors available to deliver the programmes and to support the quality assurance framework but the number of tutors available across each health board area varies considerably from seven tutors in Cwm Taf University Health Board to 20 tutors in Hywel Dda University Health Board. With a target to deliver education programmes to one per cent of the population with a chronic condition, the numbers of tutors is inadequate across some health boards. Health boards will need to recruit more voluntary tutors to deliver education programmes to achieve targets and ensure the quality of service.

Exhibit 4 – Completion rates for education programmes for patients between January and December 2011 to 2013

Health board	Completion rate (%)		
	2011	2012	2013
Abertawe Bro Morgannwg	85	74	76
Aneurin Bevan	61	70	64
Betsi Cadwaladr	44	51	54
Cardiff and Vale	59	55	56
Cwm Taf	55	47	47
Hywel Dda	79	69	62
Powys	70	69	0
Wales	64	60	60

Note:

1   The generic education programme for patients has not been supported by Powys Teaching Health Board since the end of 2012. Instead, the health board is developing and piloting its own programme called 'Invest in Yourself', which is health professional led.

Source: Wales Audit Office analysis of data derived from the Education Programme for Patients, Cymru all-Wales quarterly reports (these figures exclude disease-specific education programmes, such as X-PERT or DAPHNE)

2.14 Only four of the seven health boards were able to provide information on the cost of these education programmes for patients. The information provided shows that local budgets are relatively small. In 2011-12, the median budget was £50,000 (ranging from £49,000 to £124,000) with two-thirds of the budget supporting salary costs for the programme coordinators and administrator, with Whole-Time Equivalent (WTE) numbers of coordinators and administrators ranging from 0.5 to 2.6 (median WTE was 1.5). These are relatively small costs, which can have a significant impact in terms of reducing overall demand on health services by supporting patients to confidently manage their own health and condition.

2.15 The education programme for patients in Wales is one of local delivery with support from a small national team. The national team compiles information about the delivery of programmes, provides training and accreditation for tutors and programme coordinators and monitors compliance with the programme quality assurance framework. The national team works in collaboration with its counterpart[22] in England to develop other ways of providing self-management programmes. Across Wales, a number of other self-management programmes are being developed and tested between the national team and local health boards to facilitate a wider choice of interventions. These include:

a a three-hour taster session on the introduction to self-management;

b the COPD self-management for life programme at Hywel Dda University Health Board, which is a seven-week course; and

c a web-based generic self-management programme that individuals anywhere in Wales can access in their own homes.

2.16 In addition to the generic self-management programmes outlined above, health boards support a number of disease-specific education programmes, such as X-PERT and DAFNE for patients with Type II and Type 1 diabetes respectively. A number community-based services, such as cardiac and pulmonary rehabilitation services and exercise referral schemes, also incorporate a large element of patient education and support for self-care, as well as promoting healthy lifestyles, such as healthy eating, weight management, exercise and smoking cessation.

Community-based services for chronic conditions are less fragmented and more timely but most services are still available only on weekdays

2.17 Our 2008 report identified a large number of chronic condition and intermediate care services in the community but that these services were not effectively integrated and coordinated between the local health boards and NHS trusts. Following the NHS reforms in 2009, the overall number of services to support patients with chronic conditions or intermediate care needs in the community has been rationalised through integration. Three-fifths (58 per cent) of services are provided by health boards with the remainder provided by the voluntary sector (16 per cent), local authorities (5 per cent) or in collaboration with local authorities and/or the voluntary sector (21 per cent).

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22   Education Programme for Patients Community Interest Company

2.18 Our 2008 report found that around one-third of services operated waiting lists, with patients waiting on average 14 days for an assessment of their needs and access to services. Our recent audit found one in five (20 per cent) of the services that we mapped could see patients almost immediately while one in four services could see patients in less than one week. For a small proportion (9 per cent) of services, patients typically waited for more than six weeks for services to commence compared with 24 per cent we reported in 2008.

2.19 Our 2008 report found that the availability of chronic condition and intermediate care services did not match demand with three-fifths of services available weekdays only, that is, 9 am to 5 pm. Our most recent audit found increased availability across the whole week with a reduction in the proportion of services that operate on a weekday only. However, nearly half (49 per cent) of the services are still only available on a weekday with just one-fifth of services operating seven days a week during the day and into the evening. Those services operating longer hours were typically for palliative care and reablement, or those teams operating under the community resource team umbrella. The proportion of services operating 24 hours a day, seven days a week is unchanged from our previous report in 2008.

Health boards have made some positive steps in developing community-based services for the most vulnerable patients but there is scope for better coordination

Health boards are developing alternative ways to identify individuals at risk of unplanned admissions to support them in the community

2.20 For individuals whose condition impacts upon their everyday life or results in frequent hospital admissions, services at level three and four of the chronic conditions model are intended to support them in the community with active case management for those patients with the most complex care needs. In order to support individuals at greatest risk of unplanned admissions, health professionals need to be able to identify them.

2.21 At the time of our previous report on chronic conditions, the Welsh Government had commissioned the development of a risk stratification tool, the Predictive Risk Stratification Model (PRISM). PRISM is a computer-based system to stratify GP practice populations to identify an individual's percentage likelihood of an emergency admission in the coming year. Although very much a practice-based tool, risk stratification is an important part of local strategies for supporting patients with chronic conditions, for both understanding the health of the local population and 'case finding' those patients at risk of adverse outcomes in order to target preventative support.

2.22 In 2008, we were informed that PRISM would be tested and evaluated during the autumn of 2008, before wider implementation in 2009. The pilot took place, slightly later than planned, in 2009 with 25 GP practices piloting PRISM. At the same time as the pilot, a national technical service was established in preparation for making PRISM available to all Welsh GP practices from April 2010. The feedback from GP practices piloting the PRISM tool had indicated that GPs would like clear communications on their legal obligations with regards to the use of the tool, including who was responsible for the clinical care of the patient as a consequence of using the tool. GPs were concerned that the resources required to treat high-risk patients identified by PRISM might not be available.[23]

2.23 Our most recent local audits found that PRISM had still not been rolled out more widely. According to the NWIS estimates, 100 GP practices currently use PRISM but during our audit fieldwork we were told that delays in the roll-out meant some practices were losing interest.

2.24 A formal independent evaluation[24] of PRISM is currently underway but it is not expected to be complete for some time. If the evaluation finds that PRISM is effective, health boards, through their locality networks and GP clusters, may consider its take up or whether to continue with existing risk stratification arrangements.

2.25 Risk stratification is key to effective service planning and the Welsh Government encourages the use of a range of risk stratification tools that have been evaluated as clinically effective. At the time of our recent audit, health boards, working with GP practices, were developing and testing different approaches for identifying individuals with complex health needs or those experiencing multiple admissions. These approaches include:

a Focusing on those patients with chronic conditions and complex health-care needs who are hospitalised three of more times per year.

b Developing and testing criteria that can be extracted on GP information systems to identify those patients that would benefit from a district nursing assessment, advanced care planning or social care assessment and comparing these data with information on retrospective admissions to see if there is a match.

c Identifying patients while in hospital with a chronic condition and assessing their risk of readmission using the LACE[25] score – the higher the score the more intensive support that is needed on discharge; patients readmitted within 30 days are rescored and the new score compared with the previous score to assess concordance

d Establishing specialist nurse posts to work with general practices to identify frail elderly people in the community who are deemed to be at risk of unplanned admission or at risk of falling. Criteria include the frequency of attendance at emergency departments or out-of-hours services, individuals receiving high-cost health or social care packages or individuals receiving intensive district nurse support.

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23 National Leadership and Innovation Agency for Healthcare, **PRISM: Conclusions and Way Forward**

24 **Welcome to PRISMATIC**

25 Patients are scored based on inpatient Length of stay, Acuity of admission, Co-morbidities and number of Emergency attendances at A&E in the last six months.

2.26 However, there needs to be a mechanism for sharing and evaluating the relative success of these different approaches so that effective practice is spread more widely between locality networks between and within health boards.

2.27 New measures in relation to risk stratification were introduced into the 2013-14 GMS Quality and Outcomes Framework. A practice's participation in the Quality and Outcomes Framework is, however, voluntary. General practices participating in the Quality and Outcomes Framework are required to produce a list of five per cent of their registered patients predicted to be at significant risk of an 'unscheduled care admission or an unplanned community-based alternative, such as contact with out-of-hours services'. From this group of patients, the practice must identify a proportion that would most benefit from review and must ensure there is an active management plan in place.

2.28 Health boards will rely upon locality networks or clusters of GP practices to share the key themes to emerge from the risk stratification process. This information can be aggregated at a health board level to inform service planning and commissioning in order that gaps in service provision can be identified, ensure that community services are better targeted where need is greatest and to help monitor progress and outcomes at a local, regional or national level. At the time of audit fieldwork, we were told that primary and community staff had concerns about the implications for information governance in relation to storing and sharing information obtained from risk stratification. Mechanisms for sharing information, particularly at the level of an individual case, will therefore need to be agreed by health boards and their locality networks or GP clusters.

Community resource teams provide an umbrella for the various disparate services, although better integration and cohesion is still required in some areas

2.29 The chronic conditions model and **Setting the Direction** both advocate the need for integrated multidisciplinary teams that focus on coordinating community services across geographical localities for individuals with complex health and social care needs, including case management. These teams are expected to target care and support at individuals identified as at greatest risk of an unplanned hospital admission to maintain their independence in the community.

2.30 At the time of our most recent audit, five of the seven health boards had established community resource teams. Across these health boards some 16 such teams were in place generally on a locality basis. Most of the community resources teams are multidisciplinary with the exception of the all-nurse teams at one health board.[26] At the two health boards[27] where community resource teams had yet to be established, locality management teams were expected to take forward their design and implementation.

2.31 The community resources teams were at different stages of development, even within an individual health board area, but for the most part, provided an umbrella for the large number of disparate disease-specific and intermediate care services that were in place at the time of our 2008 report, such as rapid response, hospital at home, reablement and pulmonary rehabilitation. We found, however, that the services operating under the community resource team umbrella continued to function separately rather than as one integrated team. Service capacity was dependent upon the capacity of constituent

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26 Cardiff and Vale University Health Board

27 Betsi Cadwaladr University Health Board and Powys Teaching Health Board; since our audit, Powys Teaching Health Board has established a community resource team comprising multidisciplinary community services for falls, COPD, Parkinson's disease, cardiac services and neurology clinics.

services, half of the teams did not have a single patient record for use by all disciplines and the constituent services were available at different times and different days of the week.

2.32 The amount of time a patient may have to wait to receive support from the community resource team is dependent upon their clinical needs. Some patients may be seen immediately, within one to two hours, while for some elements of the service, such as reablement, patients may wait up to six weeks. Only four of the community resource teams were able to indicate how many patients could be supported by the team at any one time. For the other teams, there was a lack of clarity with one service manager reporting that 'the service is unable to refuse enquiries and a formula for working out the exact capacity does not exist'.

2.33 Our previous audit found that case management for individuals with complex care needs had not been widely developed, and case management schemes were available weekdays only. Our most recent audit found that four of the seven generic chronic conditions teams that provided case management were still in place with three of the teams operating within locality boundaries. The other three teams have been absorbed into community resource teams providing case management for patients frequently admitted to hospital or those with complex health-care needs.

2.34 The lines of accountability for identifying and coordinating services for patients with chronic conditions, or complex health-care needs, and for case management are unclear and there appears to be duplication of effort. The chronic conditions model and framework envisioned a designated care coordinator working closely with GP practices and health and social care services to stratify practice populations, identify, plan and coordinate services to meet needs and to monitor patient progress. Transitional funding was used to establish a number of care coordinator roles across health boards but when funding ceased in 2011, many of these roles disappeared. The lack of a care coordinator may be a factor in the current duplication of services.

2.35 As well as chronic condition teams providing case management, new models of care are being developed to provide anticipatory care, rapid multidisciplinary assessment and diagnosis in the community and support for the most vulnerable patients to be cared for at home. At the time of our audit, virtual wards were being developed by two health boards[28] to provide multidisciplinary case management in the community.[29] The virtual ward uses similar daily routines to a hospital ward. Patients receive regular visits from health staff in their own homes, thereby providing interventions that avoid the need for a hospital admission or replacing a long stay on a hospital ward.

2.36 In addition to the community resource teams, the chronic condition nurse teams and the development of virtual wards, some health boards provide acute or rapid response services. Information provided by health boards as part of our service mapping indicates that these services and teams are targeting the same groups of patients, namely the frail elderly, those with multiple chronic conditions and those at risk of unplanned admissions, and provide many of the same types of care.

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28 Cwm Taf University Health Board and Hywel Dda University Health Board

29 Since our audit, Powys Teaching Health Board has established a virtual ward with daily virtual ward rounds with a GP, district nurse and practice-based social worker while multidisciplinary team meetings, including age care consultants, take place weekly.

2.37 District nursing services also add to this complexity, providing similar care to the same groups of patients with some health boards reorganising district nursing services to increase capacity and to help facilitate the shift in service provision from hospital to community. We know from our pilot audit work on district nursing at one health board that teams are not always aware of the other health-care services that their patients may be receiving, such as from the community resource team.

2.38 GP practices play a central role in managing patients with chronic conditions and the practice list provides the basis for coordinating services and continuity of care. GP practices participating in the Quality and Outcomes Framework are expected to ensure an active management plan is in place for those patients identified as most at risk of an unplanned admission, or an unscheduled care contact.

2.39 The Programme for Government[30] sets out the Welsh Government's commitment to ensuring people with long-term conditions have an individual care plan that is proportionate to their needs. The Welsh Government's recent guidance on integrated assessment for older people requires health and local government, working with their partners, to ensure they have integrated well-being, assessment, care and support planning and review arrangements. The aim is to help drive better coordinated care across the different sectors. For those aged under 65, a framework for agreeing individual care is being developed. This work may go some way to ensuring the various interventions by service providers set out above are better coordinated.

Hospital admissions for chronic conditions are reducing and health boards have begun to rebalance the workforce towards the community

Reliance on the acute sector in relation to chronic conditions is reducing but lengths of stay for COPD remain above target

2.40 One of the key aims of the Chronic Conditions Management Model and framework was to reduce the number of avoidable emergency admissions and readmissions due to chronic conditions, and to reduce lengths to 5.7 days or less for these three conditions. Achieving this will help acute hospitals use their resources more appropriately, and support a more efficient 'flow' of patients through the hospital, including through A&E departments.

2.41 Our previous audit work found that too many patients with a chronic condition were being admitted to hospital as an emergency. Since April 2007, NHS bodies have been expected to achieve reductions in admissions for three specific conditions. These are: COPD, CHD and diabetes. Over the last five years, there has generally been a downward trend in the number of emergency admissions for CHD and COPD (Exhibit 5). Emergency admissions for CHD and COPD reduced by eight per cent and four per cent respectively. However, there has been little change in the overall number of emergency admissions for diabetes, which show small fluctuations year on year. Meanwhile, the NHS Wales Chief Executive's annual report[31] for 2012-13 indicates that the number of emergency readmissions for COPD, CHD and diabetes are also reducing.

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30 **The Programme for Government**

31 **NHS Wales Chief Executive's Annual Report 2012/13**

Exhibit 5 – Trend in the number of emergency admissions for the three chronic conditions studied for Welsh health board residents between 2007-08 and 2012-13
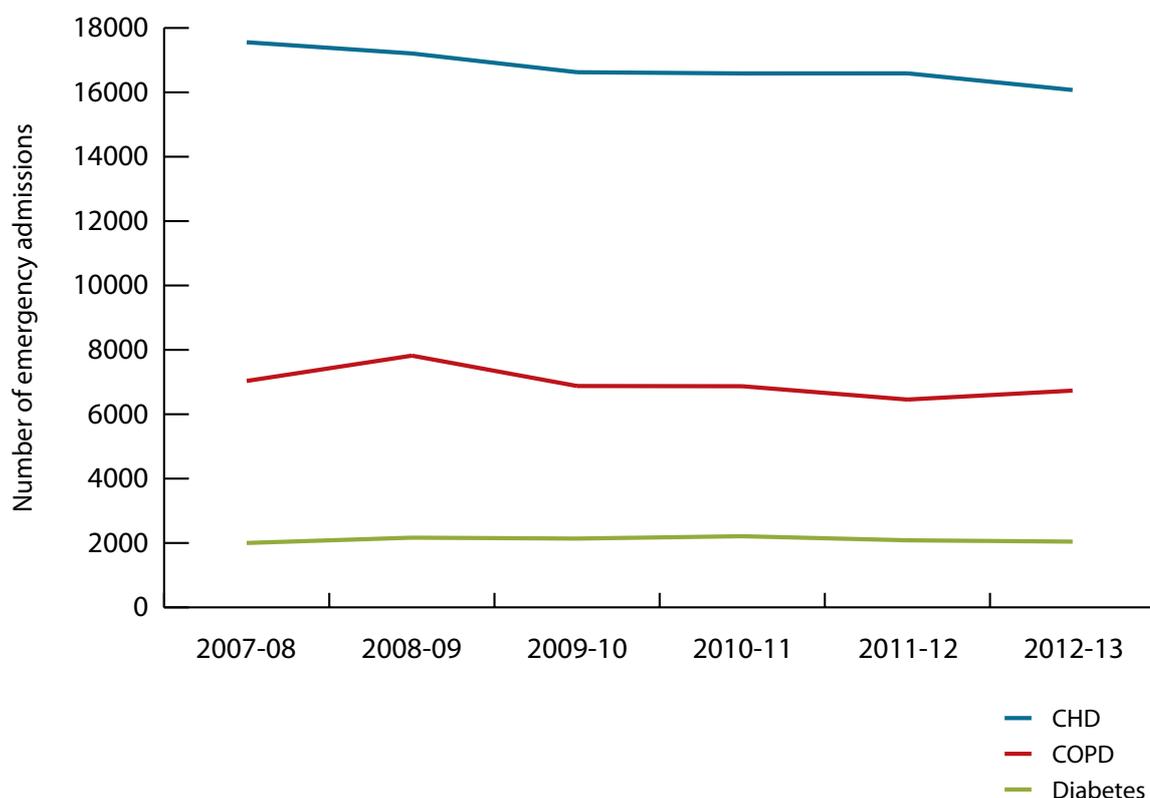
Source: Wales Audit Office analysis of data derived from the Patient Episode Database for Wales and provided by NHS Wales Informatics Service. Hospital activity data are split by health board of residence, HRG 3.5 and financial year.

2.42 Between 2007-08 and 2011-12, the number of occupied bed days for COPD, CHD and diabetes admissions reduced year on year by 22 per cent, 27 per cent and 12 per cent respectively. In 2012-13, the number of occupied bed days increased for all three conditions but remained well below the totals for 2007-08. The reduction in occupied bed days means that average lengths of stay, irrespective of age or complications or comorbidities, have also reduced year on year for each condition until 2012-13 (Exhibit 6).

The role of community hospitals in chronic conditions management is becoming clearer

2.43 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. For the purposes of this review, community hospitals are seen as part of the wider provision of community services.

Exhibit 6 – Trend in average lengths of stay for the three chronic conditions studied for Welsh health board residents between 2007-08 and 2012-13

Source: Wales Audit Office analysis of data derived from the Patient Episode Database for Wales and provided by NHS Wales Informatics Service. Hospital activity data are split by health board of residence, HRG 3.5 and financial year.
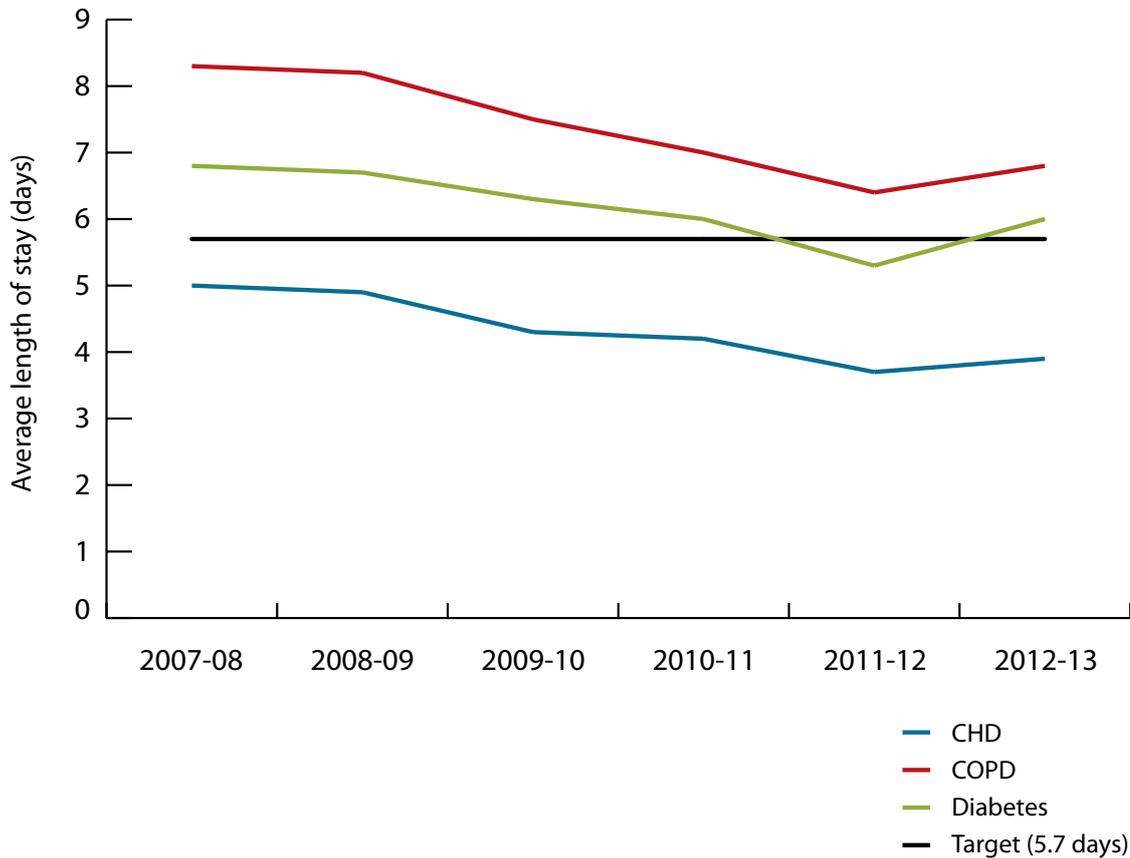
2.44 Our recent audit work identified differences in the role of community hospitals. Health boards were working to develop community hospitals as the focal point for providing rapid access to diagnostic and assessment services and appropriate rehabilitation to support independence rather than preventing acute admissions through step-up beds. Our audits also identified examples of health boards actively relocating services from acute to community hospitals or establishing new community-based services for chronic conditions in community hospitals.

2.45 The network of community hospitals across Wales has changed since our previous audit with some old and outdated facilities either being replaced or closed. Data published by the Welsh Government show that the average number of daily-staffed beds within community hospitals, including those for mental health services, reduced by 29 per cent from 5,212 in 2007-08 to 3,711 in 2012-13. At the same time, the average number of daily-staffed beds within acute hospitals reduced by five per cent from 8,092 to 7,728 (Exhibit 7). General medicine is one of the specialities

where the impact of reductions was greatest. The average number of daily-staffed beds in general medicine reduced by 26 per cent from 2,841 to 2,106 across both acute and community hospitals. General medicine beds are typically used for patients being admitted as an emergency with an exacerbation of a chronic condition.

Exhibit 7 – Trends in the number of acute and community hospital beds across health boards

	Acute hospital beds	Community hospital beds
2007-08	8,092	5,212
2008-09	8,128	4,927
2009-10	8,149	4,590
2010-11	7,818	4,272
2011-12	7,739	4,021
2012-13	7,728	3,711

Source: Wales Audit Office analysis of data derived **from Stats Wales**

2.46 The extent to which these reductions in staffed beds are part of a planned shift in care from hospital to community setting is not always clear when reviewing health boards' plans. Cwm Taf University Health Board's three-year delivery plan, for example, does make it clear that the shift of activity from hospital to community will enable a further reduction in the community hospital bed-stock in the first half of 2013-14. As a more general point, the reduction in both acute and community hospital beds will mean that greater reliance will be placed on community-based services to prevent or divert admissions or to provide ongoing support on discharge from hospital.

Health boards have begun to rebalance the workforce towards the community but more needs to be done to keep pace with the demographic shift

2.47 In order to transform services and support the shift from hospital to community settings, the NHS in Wales also has to work to redevelop and rebalance its workforce. The overall WTE number of nursing staff (both registered and unregistered) deployed across community services increased by seven per cent, or 229 nurses between 2009 and 2012 (Exhibit 8). At the same time there was a one per cent reduction in the numbers of nursing staff working on acute, elderly and general wards.

2.48 To support the rebalancing of the workforce, the Welsh Government's NHS annual operating framework for 2010-11 required a 10 per cent increase in the proportion of staff providing services in the community between 2010 and 2013.[32, 33] By 2012, there was a five per cent increase across Wales with one health board – Aneurin Bevan University Health Board – exceeding this target. Others were working towards the target but in two

32 Nursing staff are used to illustrate the shift in resources as these staff accounted for 42 per cent of the directly employed staff working in Welsh health boards in 2012. The next largest category of staff is Administration and Estates, which makes up 18 per cent of the directly employed health board workforce.

33 Unregistered nursing staff make up 15 per cent of the nursing workforce deployed across community services; this figure has remained relatively constant over this time.

Exhibit 8 – Trend in WTE number of nursing staff (all grades) deployed in community services across health boards at 30 September

Health boards	2009[1]	2010	2011	2012	Per cent change between 2010 and 2012[2]
Abertawe Bro Morgannwg	627.5	603.0	560.8	584.1	-3%
Aneurin Bevan	700.8	765.7	841.3	871.1	14%
Betsi Cadwaladr	564.3	608.4	636.0	636.0	5%
Cardiff and Vale	432.3	449.1	455.2	459.2	2%
Cwm Taf	426.3	395.9	398.0	391.7	-1%
Hywel Dda	285.0	289.8	300.6	311.0	7%
Powys	167.7	170.6	176.2	179.3	5%
Total	**3,203.9**	**3,282.5**	**3,368.1**	**3,432.4**	5%

Notes

1 The seven health boards were established in 2009.

2 Health boards are required to increase the proportion of staff providing services in the community by 10 per cent between 2010 and 2013.

Source: Wales Audit Office analysis of data derived **from Stats Wales**

health boards – Abertawe Bro Morgannwg and Cwm Taf University Health Boards – there was a reduction in number of community nurses.

2.49 On 1 April 2011, a small number of community nursing staff were transferred from Abertawe Bro Morgannwg to Cardiff and Vale as part of an agreed change to the provision of services in the western Vale. This transfer of staff contributed to some of the reduction in numbers between 2010 and 2011 at Abertawe

Bro Morgannwg and the corresponding increase at Cardiff and Vale. In addition, a number of grant-funded schemes, such as Sure Start and the Joint Working Special Grant, led to the employment of nursing staff at Abertawe Bro Morgannwg. When funding ceased, some roles were withdrawn, which may also account for the reduction in numbers of community nursing staff.

2.50 Nursing staff directly employed in community services account for less than a fifth (18 per cent) of the nursing workforce working in the community and acute, elderly and general wards. These are some notable differences (Exhibit 9). One in three nursing staff work in community services at Powys Teaching Health Board, which reflects the nature of the organisation but higher proportions of nursing staff work in community services at Aneurin Bevan and Cwm Taf University Health Boards, 25 per cent and 23 per cent respectively, compared with 13 per cent at Cardiff and Vale University Health Board.

Exhibit 9 – Percentage of directly employed nursing staff working in community services in 2012
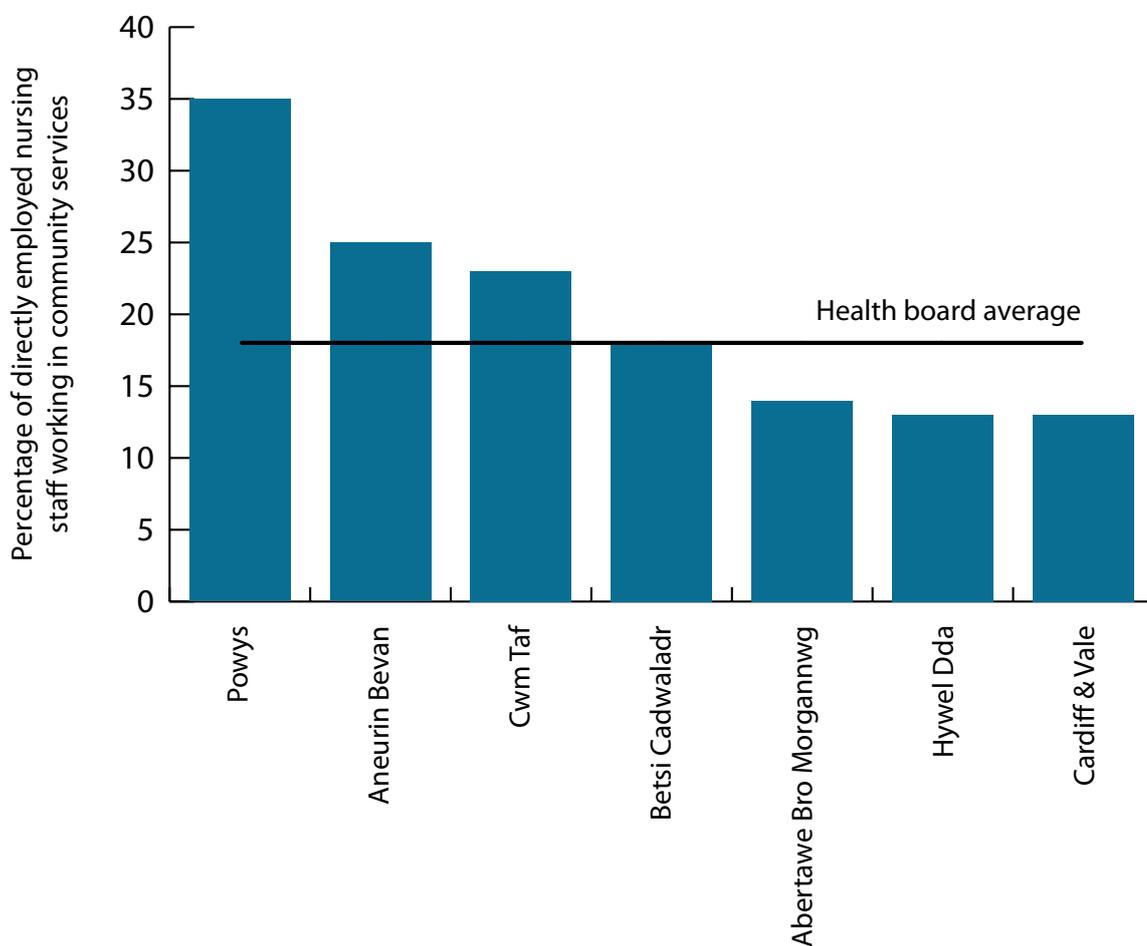
Source: Wales Audit Office analysis of data derived **from Stats Wales**

2.51 Although the WTE number of nursing staff deployed across community services has generally increased, the number of community nursing staff available to support older patients varies between health boards and may be insufficient. In 2012, there were, on average, 6.1 WTE nursing staff per 1,000 people aged 65 or older across Wales, ranging from 3.8 at Hywel Dda University Health Board to 8.5 WTE staff at Aneurin Bevan University Health Board (Exhibit 10). Given the number of older people is forecast to grow, we would expect health boards to review the availability of resources in the community to support an increasingly older population of patients.

Exhibit 10 – WTE numbers of community nursing staff per 1,000 people aged 65 or older in 2012
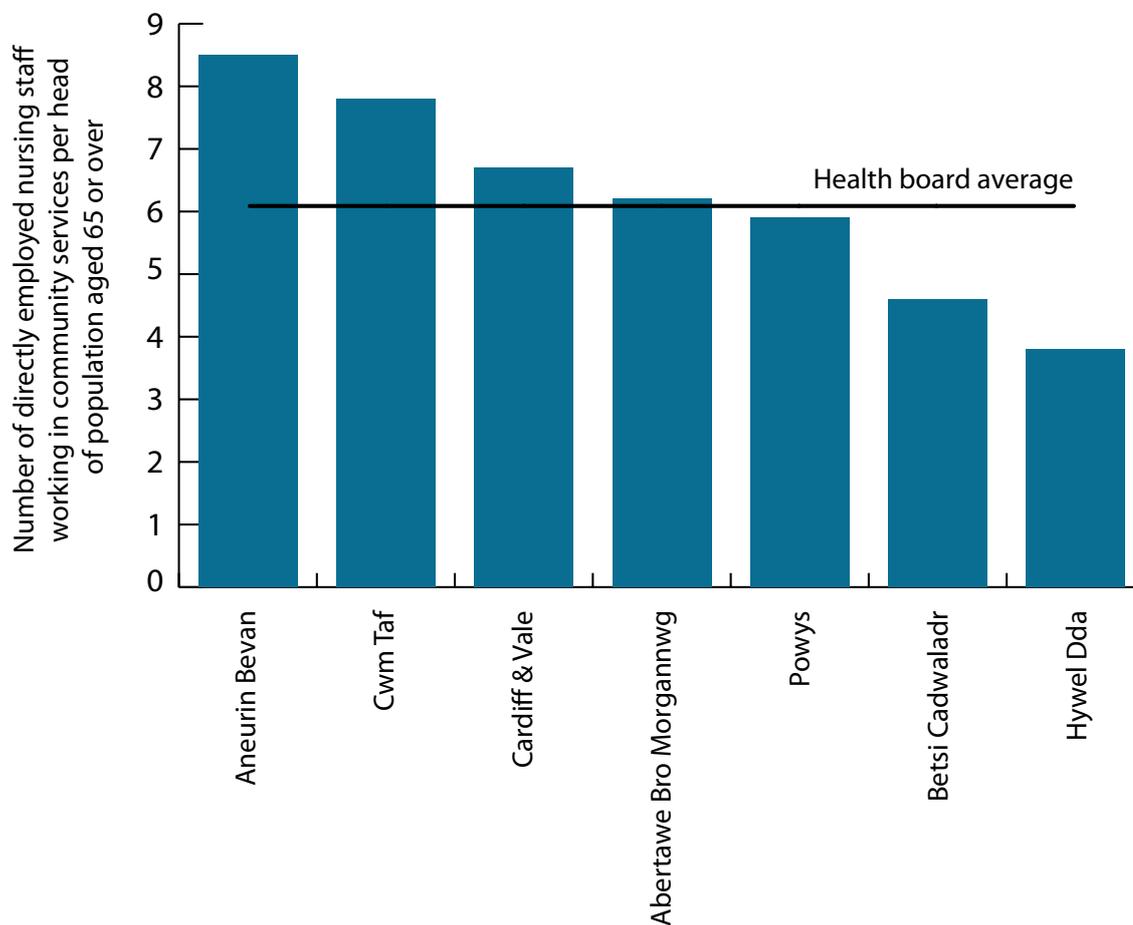
Source: Wales Audit Office analysis of data derived **from Stats Wales**

Part 3 – Information for planning and monitoring chronic condition and community services is limited and Boards rarely receive information on the shift of relevant resources to community settings

3.1   If health boards are to deliver on their ambitions for transforming services for chronic conditions and rebalance care as set out in **Setting the Direction**, they must have arrangements to support effective monitoring, as well as the information to monitor progress. This section of the report looks at the availability of information to monitor service delivery and patient outcomes.

Progress in developing a national community information data set has been slow

3.2   Information is crucial for the planning and delivery of effective services, as well as monitoring service provision and patient outcomes. Our previous report highlighted the paucity of financial information and activity data, which undermined NHS Wales' ability to evaluate existing services, to plan new ones or to support the shift of resources from hospital to community settings. In 2008, we recommended the development of more comprehensive community information to support the transition of services and resources from hospital to community settings.

3.3   At that time, the Welsh Government had established a project to review the information available to support the chronic conditions model, to identify key information requirements relating to chronic conditions and to strengthen other related community information. The project found that patient-

level data to support delivery of care was necessary but the data for chronic conditions and community services was often disparate, inconsistent and incomplete and financial information related to chronic conditions and community services more broadly was not fit for purpose. Furthermore, integrated care advocated by the chronic conditions model (and subsequently **Setting the Direction**) would require integration of information across organisations. The project made a number of recommendations, including making better use of existing data, making better links across different information programmes, such as PRISM, and agreeing and developing common standards and definitions for community information.

3.4   Our most recent local audits found little evidence that progress had been made to improve existing information about chronic condition and community services more broadly. Nor has there been improvement in monitoring and benchmarking at a local level or the use of information to inform service developments. Information systems to record community care episodes are inadequate or non-existent. Where systems exist, the information is high level and relates to numbers of patients cared for by the service. Since April 2012, providers of community services in England have been required to capture information about any patient in receipt of, or referred to, community services. This Community Information Data Set[34] provides national definitions for the

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34   Information Standards Board for Health and Social Care, Community Information Data Set, 2011

data required to generate consistent person-based data, which can be used to manage the delivery of community health services and monitor performance at a local level. The type of data captured includes patient demographics, care contacts and activities. It is anticipated that the Community Information Data Set in England will be aggregated at a national level by 2014 to enable comparative data across providers, as well as enable monitoring of progress against policy objectives.

3.5 Since we completed our local audits, the NWIS has tendered for a Community Care Information Solution to support the information-sharing requirements that underpin the delivery of an integrated health and social care system. However, the system will not be in place until April 2014 at the earliest and NHS organisations and local authorities will not have to implement the system if they feel it does not meet their requirements.

3.6 In order to achieve the priorities set out in the quality delivery plans underpinning **Together for Health**, NHS organisations will need a single information system to support efficient and effective patient care, and good-quality information to demonstrate progress against the delivery plan milestones and performance in relation to the outcomes of care. The quality delivery plans set out specific priorities to ensure the IT infrastructure supports effective sharing of clinical records and care plans, as well as decisions made about an individual's care. The Diabetes Delivery Plan[35], for example, signals the introduction of an integrated diabetes patient management system where information from primary care and hospital and community services would

be routinely added. This patient management system would ensure timely access to clinical information to ensure efficient and effective care for patients, as well as planning and delivery of services and performance monitoring. The use of single information systems is seen by the Welsh Government as an indicator of highly-performing integrated care partnerships in its consultation on integrated health and social care[36]. However, in progressing disease-specific delivery plans, NHS Wales must ensure that it does not end up with a number of stand-alone information systems that do not 'talk' to each other or make information sharing more difficult.

Despite evidence of significant increases in budgets for community services, performance information presented to NHS boards is largely focused on hospital activity with limited information available to monitor the shift to community service provision

Performance information is largely focused on hospital activity

3.7 Boards of NHS bodies currently receive limited information about the performance of community services across their organisation. There is little, if any, reporting on demand for or uptake of community services, patient experience, service quality, patient outcomes, impact on demand elsewhere in the system, services costs or the overall shift in care from hospital to community.

35 Welsh Government, **Together for Health – A Diabetes Delivery Plan A Delivery Plan up to 2016 for NHS Wales and its partners,** 2013
36 Welsh Government, **Framework for Delivering Integrated Health and Social Care For Older People with Complex Needs, Consultation Document**, July to October 2013

3.8 Information received by the boards of NHS bodies is largely focused on acute hospital services. Five quality domains to provide a more integrated view of NHS performance have been set out in the latest delivery framework[37] but measures to assess integration and partnership are still very much focused on hospital activity, namely reducing emergency admissions and readmissions for a basket of chronic conditions. Health boards are currently developing a core information data set for primary care but this data set does not include information on community services.

3.9 At the time of our local audits, groups responsible for taking forward the chronic conditions agenda and implementing **Setting the Direction** at each health board were starting to develop data sets to monitor progress against their own programmes of work and more widely in relation to the impact of new service developments. Some of the groups were adopting a maturity matrix to track progress in relation to the high-impact changes for community services or in shifting resources from hospital to community services. However, the data sets were overly focused on inpatient care. Even where information was available, it was not always used to provide a perspective on community service provision, such as the information provided on the education programme for patients.

3.10 The lack of performance information presents significant challenges to making planning decisions or getting assurance that community services are safe and of high quality and meet patients' needs. There is no consistent mechanism for assessing service provision in the community, much of which is invisible as it is delivered in patients' homes.

3.11 The national suite of delivery plans underpinning **Together for Health** clearly set out the population outcomes expected, as well as outcomes for individuals receiving care alongside expected performance levels by NHS services, both in the community and within hospitals, for a number of specific chronic conditions, as well as more generic service areas. To track progress in improving health and health care and to monitor performance, the Welsh Government is developing a comprehensive framework of population outcome indicators and performance measures. Health boards will be required to regularly publish progress against these individual delivery plans and overall performance against a range of measures, including outcomes of care, for the public and their boards. Meanwhile, the Welsh Government will also produce annual reports[38] summarising progress against each of these delivery plans providing a clear line of sight between policy imperatives and local implementation.

Health board budgets for chronic condition services have increased significantly but it is unclear whether the additional funding has helped to shift the balance of care

3.12 As part of the arrangements for receiving transitional funding, health boards reported annually to the Welsh Government on the progress made against their funding proposals, for example, in relocating care from hospital to community or establishing care coordination. In the first full year of funding, the Welsh Government commissioned an independent review of the progress reports provided by health boards. The review concluded that health boards were making progress against their proposed service developments with lots of activity, much of it

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37   Welsh Government, **Delivery Framework, 2013-2014 and Future Plans**, 2013
38   The Welsh Government published the first **annual report on stroke services in 2013**

focused on building good foundations for joint working and service delivery. Weaknesses in monitoring arrangements meant that health boards could not always report on the impact of funding on outcomes. At that time, health boards highlighted the long timescales needed to make whole-system changes and the long lead-in times for service developments.

3.13 Information provided by health boards for our most recent audit (and distinct from the transitional funding and GMS funding) shows that three-fifths of chronic condition and intermediate care services were funded from health boards' revenue allocations while the remainder were funded with initiative monies from the Welsh Government (7 per cent), or jointly funded with local authority partners (19 per cent) or the third sector (12 per cent). Funding for chronic condition and intermediate care services has increased over the last six years. In our 2008 report, we noted that 70 per cent of the services for chronic conditions and intermediate care were able to provide budgetary information. Our most recent audit found that a higher proportion (80 per cent) of services were able to provide budgetary information.

3.14 The combined budget for intermediate care and chronic conditions services in 2005-06 was £18.5 million and information from our most recent audit shows that budgets had increased significantly to £33.4 million by 2011-12 (Exhibit 11). However, gaps in both financial and activity information still makes it difficult to establish the relative value for money of the different types of services. Where budgetary information was unavailable, we applied the median value to those services giving an estimate of an additional £4 million to fund chronic condition and intermediate care services.

3.15 Our previous audit found that few services had been comprehensively evaluated and where service evaluations had been carried out, these were predominantly about patient satisfaction or admissions avoided with few evaluated for cost effectiveness. Our latest audit found more than four-fifths of services had been evaluated with most of these services evaluated across a range of measures. Where services had not been evaluated, the most commonly cited reason for this was the relative newness of the service.

Exhibit 11 – 2011-12 budgets for chronic condition and intermediate care services

Type of service	Median health board budget	Total budget across Wales
Education programmes for patients	£50,000	£223,000
Community resource teams	£118,000	£13,768,000
Chronic condition and intermediate care services	£125,000	£19,412,000
Total		**£33,403,000**

Source: Wales Audit Office analysis of service mapping information provided by health boards

3.16 There is very little emphasis on measuring how effective health boards are at actively getting patients out of the hospital setting and towards highly-organised community services closer to home rather than simply reporting numbers of delayed transfers of care. There is little statistical evidence of the impact of community resource teams in helping to prevent avoidable admissions. With increasing pressure to deliver financial savings and little, if any, new money to fund service developments, NHS bodies will be reliant on shifting resources from one part of the system to another. Without robust and readily accessible information to support ongoing evaluation of services or measures of demand, the ability to present the case for releasing resources will be difficult.

Appendix 1 – Audit approach

We carried out our audit work between November 2011 and March 2012 and upon completion we reported the detailed findings to each NHS health board. Our audit sought to answer the question: 'Building on the potential benefits of NHS reorganisation, are health boards taking a well-planned and proactive approach that is improving the management of chronic conditions?' In particular:

a   Is there a clear strategic approach?

b   Is the approach to chronic conditions management having a positive impact?

c   Is there an effective system in place to monitor and evaluate service delivery for chronic conditions?

The audit methodology included the following activities:

a   Analysis of data sources, such as the Patient Episode Data for Wales and the Education Programme for Patients.

b   Mapping primary and community services for individuals with, or at risk of, chronic conditions; these services were either provided by, or commissioned by, NHS health boards.

c   A questionnaire survey of general practice, which also supported our audit work on the unscheduled care system.

d   Reviewing health board's strategic documents and operational plans.

e   Conducting semi-structured interviews with key individuals within the health board and with stakeholder groups in the wider community, such as executive directors responsible for primary and community services, non-executive directors responsible/championing **Setting the Direction**, operational leads for chronic conditions, locality managers and locality clinical directors and directors of social services.

A more detailed breakdown of some of these activities is given below.

Service mapping

We undertook a data collection exercise in winter 2011-12 to gather information on the range of generic or disease-specific services that health boards provided or commissioned to support individuals with chronic conditions or those who were frail and at risk of avoidable hospital admissions. Health boards were asked to complete a pro forma for these individual services. The pro forma was broadly similar to the pro forma used during our 2006 audit.

The aim was to map the range of generic or disease-specific services and compare the findings with the information collected during our 2006 audit. The types of information sought included the primary purpose of the service, the availability and accessibility of services, use of referral and management protocols, information on budgets and costs and whether services were provided in collaboration with others, such as local authorities or the third sector, the number of patient referrals, the numbers and types of staff providing the service and whether services had been evaluated. A total of 131 forms were returned of which nine related to district nursing services and were excluded from the analysis.

Questionnaire survey of general practice

In November 2011, we e-mailed a questionnaire survey to general practice managers at 498 GP practices (including several branch practices) across Wales. Practice managers were asked to complete the survey on behalf of the practice. The overall response rate across Wales was poor with only 26 per cent of practices responding. While unlikely to be representative of all general practices in Wales, we have used the responses to highlight a number of issues. The survey sought the following information from practices:

a   whether practices sought the views of their patients in relation to ease of access to services or how access could be improved;

b   whether practices had analysed demand for their services or assessed the barriers to better access;

c   whether practices had good information on their patients who attended A&E departments or out-of-hours services;

d   whether the practice was involved in helping the local health board redesign services for chronic conditions or unscheduled care; and

e   whether the practice has access to specialist advice or expertise to manage patients more effectively in the community to prevent unnecessary trips to hospital.

Appendix 2 – Welsh Government strategies and delivery plans related to chronic conditions management

Year	Strategies and delivery plans
2005	**Designed for Life, Creating World Class Health and Social Care for Wales in the 21st Century** This 10-year strategy recognised the likely impact of chronic conditions with the Welsh Government actively promoting a change of emphasis from treating patients with chronic conditions in hospital to preventing conditions arising and where possible, providing services in, or close to, individuals' homes and with individuals helped to become 'expert patients'. This document flagged subsequent publications, such as the service development and commissioning directives and chronic conditions model and framework.
2007	**Designed for People with Chronic Conditions – Service Development and Commissioning Directives: Arthritis and Chronic Musculoskeletal Conditions** This document focuses on the key areas that underpin the commissioning and organisation of services for individuals with arthritis and chronic musculoskeletal conditions. The key areas are: • Health promotion and prevention (reducing the risks) • Assessment and diagnosis • Treatment and management • Facilitating and managing independence
2007	**Designed to Improve Health and the Management of Chronic Conditions in Wales – An Integrated Model and Framework for Action** This document sets out the Welsh Government's model for a proactive and planned approach to the management of chronic conditions. The model is based on providing integrated services to meet population needs, across four or levels of care: • Ill-health prevention and health promotion • Population management • High-risk management • Complex case management It set out a number of strategic actions necessary to implement the model.

Year	Strategies and delivery plans
2007	**Designed for People with Chronic Conditions – Service Development and Commissioning Directives: Chronic Respiratory Conditions** This document focuses on the key areas to underpin the commissioning and organisation of services for individuals with chronic respiratory conditions. The key areas or pathway of care are: • Health promotion and prevention (reducing the risks) • Diagnosis, treatment and management • Facilitating and managing independence
2008	**Designed to Improve Health and the Management of Chronic Conditions in Wales – Service Improvement Plan 2008-2011** This service improvement plan supported the implementation of the chronic conditions model and framework. It identified a number of short, medium and long-term actions to improve service delivery, as well as the need to develop common baseline indicators, a risk stratification tool, a review of workforce needs and a research and evaluation framework. It also set out a maturity matrix of 25 elements across five domains to reflect the complex interactions impacting directly on the management of chronic conditions. The domains include: vision, priorities and partnership; local model and resources; foundations for change; agents for delivery; and monitoring and evaluation. Health boards assessed their progress against the 25 elements on one of three levels: (i) initial development; (ii) progress in development; and (iii) delivery of integrated mainstream services as between 2008-09 and 2010-11 as part of the Welsh Government's annual performance management framework for the NHS.
2008	**Designed for People with Chronic Conditions – Service Development and Commissioning Directives: Chronic Malignant Pain** The document focuses on key areas to underpin the commissioning and organisation of services for individuals with chronic non-malignant pain. The key areas are: • Health promotion and prevention (reducing the risks) • Assessment and diagnosis • Treatment and management • Facilitating and managing independence
2008	**Designed for the Management of Adults with Diabetes Mellitus across Wales: Consensus Guidelines To Support Implementation of the Diabetes National Service Framework for Wales Quality Requirements** This document sets out the consensus guidelines for the 12 standards of the national service framework for diabetes. The guidelines conform to guidance issued by the National Institute for Health and Care Excellence.

Year	Strategies and delivery plans
2009	**Designed for People with Chronic Conditions – Service Development and Commissioning Directives: Epilepsy** This document focuses on key areas to underpin the commissioning and organisation of services for individuals with epilepsy. The key areas are: • Health promotion and prevention (reducing the risks) • Assessment and diagnosis • Treatment and management • Facilitating and managing independence
2009	**The Cardiac Disease National Service Framework for Wales** This document supersedes the 2001 Coronary Heart Disease National Service Framework for Wales and provides an up-to-date basis for planning and developing services for the prevention and treatment of cardiac disease. The framework sets out seven standards that cover the following: • Promoting healthy hearts • Managing risk factors for cardiovascular disease • Managing the care of patients with coronary heart disease • Managing the care of patients with chronic heart failure • Managing the care of patients with arrhythmias and families of young victims of cardiac arrest • Providing cardiac rehabilitation • Managing the care of adults with congenital heart disease
2009	**Improving Health and Wellbeing in Wales, A Framework for Supported Self Care** The framework describes a continuum of self-care starting with healthy living, self-care of minor ailments with or without the support of professionals, like GPs or pharmacists, to more formal help in managing complex health problems. There are four key elements of self-care support covering this continuum. These are information and signposting, skills training for patients and professionals, support networks and assistive technologies to help self-monitoring, like telehealth.
2009	**Rural Health Plan** This document identifies the need to create ways in which primary and community services are provided in rural areas that are flexible and responsive to needs. It identifies three key themes: access to services, the need and opportunities for closer service integration and community cohesion and engagement.

Year	Strategies and delivery plans
2009	**Strategy for Lymphoedema in Wales** The strategy outlines a vision for lymphoedema services in Wales to improve well-being, to minimise risks associated with lymphoedema, to ensure patients can access the right services and to help them to maximise independence. Like the service development commissioning directives for other chronic conditions, this strategy sets out a number of key actions related to the following: • Assessment, diagnosis and classification of lymphoedema • Management of lymphoedema • Facilitating and managing patient independence • Education (of health-care professionals) • Audit and research (in the NHS)
2010	**Setting the Direction, Primary and Community Services Strategic Delivery Programme** This document sets out a strategic delivery programme for primary and community services in NHS Wales. Setting the Direction argues for a need to rebalance the whole system of care away from an overreliance on acute hospitals and towards greater use of primary and community services and an increased focus on preventative approaches. The framework is predicated on the development of locality networks to provide the platform for the planning and coordination of community services to populations of between 30,000 and 50,000 patients and supported by clusters of GP practices working collaboratively to meet local needs. The concept of localities is one where the boundaries are agreed by health and social care sectors and are meaningful in terms of geography, patient flows or natural communities. It highlights the need for the delivery of integrated community services that provide a proactive coordinated approach to patient care rather than reactive crisis management.
2011	**High Impact Service Changes – Delivering High Quality, Cost-effective Care in the Community** This document identifies six key areas to support service redesign and high-quality services for chronic conditions in the community. These are: • Early intervention and diagnosis • Localised evidence-based care pathways for conditions such as heart failure or COPD • Individual management plans so patients receive care in the community tailored to their needs • Risk stratification • Timely access to specialist advice and expertise or services • Prompt hospital care if needed and timely discharge These high-impact changes reinforce the key themes and elements of the chronic conditions model, as well as the chronic conditions development and commissioning directives.

Year	Strategies and delivery plans
2012	**Together for Health, A Five Year Vision for the NHS in Wales** This document reaffirms the Welsh Government's vision for services based around primary and community care with a greater range of services available at all times. More information about services and health issues will be available by telephone or online. Health boards are expected to continue improving links across primary, community, hospital and social care, in line with **Setting the Direction**.
2012	**Achieving Excellence – The Quality Delivery Plan for the NHS in Wales, 2012-2016** This plan sets out the Welsh Government's ambition for achieving consistent excellence in Welsh health care by 2016. This means providing services that are safe, effective, accessible, affordable and sustainable and meet the needs of local people. The plan sets out 11 actions to drive quality improvement and provide a system of quality assurance. This plan is underpinned by a number of delivery plans setting out what it means for the delivery of excellence and the outcomes expected for the following: • Cancer care • Cardiac care • Diabetes care • Stroke care • Mental health care • Primary and community care • Unscheduled care • End of life care
2012	**Together for Health – Stroke Delivery Plan, A Delivery Plan for NHS Wales and its Partners** This plan provides a framework for action by NHS organisations working with partners to set out what delivering excellence means for stroke services. The aim is to achieve the following: • To prevent stroke • To detect stroke quickly • To deliver fast and effective care • To support life after stroke Health boards, together with their partners, will produce and publish a detailed local stroke delivery plan to identify, monitor and evaluate action needed by when and by whom. Health boards are expected to report progress against milestones in these delivery plans and publish these reports on their websites quarterly. Health boards will also publish clear, concise information about local stroke services based on formal progress against the delivery plans, performance measures and feedback from people about the services they receive. The Welsh Government will also produce an annual all-Wales report on the effectiveness of NHS stroke services in Wales. It published its first report in October 2013.

Year	Strategies and delivery plans
2013	**Together for Health – Delivering End of Life Care, A Delivery Plan up to 2016 for NHS Wales and its Partners** This plan sets out the Welsh Government's expectations of the NHS in Wales in delivering high-quality end of life care. It provides a framework for action for NHS organisations working with partners. The aim is to achieve the following: • To support living and dying well • To detect and identify patients early • To deliver fast and effective care • To reduce the distress of terminal illness for patients and their families • To improve information • To target research Health boards, together with their partners, should have produced and published a local delivery plan by September 2013. Health boards are expected to report formal progress against the delivery plans, including milestones, and performance measures at least annually from March 2014. The Welsh Government will produce an annual all-Wales report from March 2014.
2013	**Together for Health – A Heart Disease Delivery Plan, A Delivery Plan up to 2016 for NHS Wales and its Partners** This plan provides a framework for action by NHS organisations working with partners to set out what delivering excellence means for services for patients with a broad range of heart conditions. The aim of this plan is to achieve the following: • To promote healthy hearts • To detect heart disease quickly • To provide fast and effective care • To support people living with heart disease • To improve information • To target research Health boards, together with their partners, should have produced and published a detailed local heart disease delivery plan by December 2013. Health boards will report at least annually against milestones in these delivery plans and NHS performance measures starting by March 2014. From March 2014, the Welsh Government will produce an annual all-Wales report on the effectiveness of NHS heart disease services annually.
2013	**Delivering Local Health Care, Accelerating the Pace of Change** This document is intended to be a three-year plan to strengthen local health-care services in relation to **Setting the Direction** and **Together for Health**. The plan sets out a range of specified actions to improve health and well-being, access to local care and coordinated care for frail, older people. The intention is to achieve these actions through effective locality networks and integrated health and social care.

Year	Strategies and delivery plans
2013	**A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs** This consultation document sets out the Welsh Government's expectation that health and social care services will be more effectively integrated to ensure individuals receive services that are coordinated around their needs and take into account their views. The framework also makes clear the need for robust governance arrangements when delegating responsibilities, sharing resources and monitoring quality and outcomes. Consultation closed on 31 October 2013.
2013	**Together for Health – A Diabetes Delivery Plan, A Delivery Plan up to 2016 for NHS Wales and its Partners** This plan provides a framework for action by NHS organisations working with partners to set out to deliver high-quality diabetes services. This plan supports the continuing delivery of service standards established in the Diabetes National Service Framework published in 2003. The plan aims to achieve the following: • To ensure children and young people with diabetes have the best start in life • To prevent diabetes • To detect diabetes quickly • To deliver fast and effective treatment and care • To support people living with diabetes • To improve information • To target research Health boards, together with their partners, will review current local delivery of diabetes services against the expectations set out in this plan. Health boards are expected to report twice a year in April and September against the milestones in the plan and to publish progress on their websites and to produce an annual formal report from March 2014 on progress. The Welsh Government will produce an annual all-Wales report on the effectiveness of NHS diabetes services starting from October 2014.

Year	Strategies and delivery plans
2013	**Together for Health – A Respiratory Delivery Plan, A Delivery Plan up to 2016 for NHS Wales and its Partners** This consultation document is a framework for action by NHS organisations working with partners to set out what delivering excellence means for respiratory services. Like the other delivery plans that support **Together for Health**, the aims of the plan are grouped under the following themes: • Preventing poor respiratory health • Detecting respiratory disease quickly • Delivering fast and effective care • Supporting people living with respiratory disease • Improving information • Targeting research Health boards will be expected to implement the delivery plan and review and update plans at least annually in the first instance then twice yearly after September 2014. Health boards will also be expected to report formal progress against the delivery plans and performance measures annually from 2014. The Welsh Government will produce an annual all-Wales report on the effectiveness of NHS respiratory services in Wales from November 2014. Consultation on this delivery plan closed in January 2014.
2013	**Together for Health – A Neurological Conditions Delivery Plan, A Delivery Plan up to 2016 for NHS Wales and its Partners** This consultation document is a framework for action by NHS organisations working with partners to set out what delivering excellence means for services for neurological conditions. Like the other delivery plans that support **Together for Health**, the aims of the plan are grouped under the following themes: • Raising awareness of neurological conditions • Timely diagnosis of neurological conditions • Fast and effective care • Living with a neurological condition • Improving Information • Targeting research Health boards will be expected to develop a local delivery plan by June 2014, implement the delivery plan, and review and update it by March 2015. Health boards will also be expected to report formal progress against the delivery plans and performance measures annually from September 2014. The Welsh Government will produce an annual all-Wales report on the effectiveness of NHS neuroscience services in Wales following publication of health board reports in September 2014. Consultation on this delivery plan closed in January 2014.

Appendix 3 – Health boards' arrangements for oversight in relation to implementing the chronic conditions model and Setting the Direction

Health board	Arrangements for oversight
Abertawe Bro Morgannwg University Heath Board	The health board's Primary and Community Services Implementation Board is a multidisciplinary, multi-agency strategic group responsible for driving the implementation of **Setting the Direction**. This group is chaired by one of the health board's IMs, who in turn, reports to the board. The Primary and Community Services Implementation Board is supported by an operational group, the Primary Care Development Group, which is comprised of professional staff from the health board and GPs. Its role is to develop the detailed service specifications and policy frameworks for implementing **Setting the Direction** and the high-impact service changes for chronic conditions management and unscheduled care.
Aneurin Bevan University Health Board	The health board established a Primary Care and Community Services Board (PCCSB) to provide the governance structures in relation to chronic conditions management. A Primary and Community Care Service Development Group oversees and coordinates the activities of a number of subgroups developing care pathways for COPD, diabetes, epilepsy, stroke, falls, case management for patients admitted frequently to hospital and the neighbourhood care networks. There is a clear interface with other groups, such as the Unscheduled Care Transformation Board with the chairs of the groups and the executive leads for chronic conditions and unscheduled care on both boards.
Betsi Cadwaladr University Health Board	The health board is structured around CPGs with chronic conditions management services primarily managed through the Primary, Community and Specialist Medicine CPG. At the time of our audit, the health board had established a Primary and Community Services Implementation Board, a multi-agency forum to oversee improvements to the planning and delivery of primary and community-based services. The board is chaired by the vice chair of the health board and membership comprises representation from the third sector, directors of social services from the local authorities, the Executive Director for Primary, Community and Mental Health Services and the Chief of Staff for the Primary, Community and Specialist Medicine CPG, as well as corporate staff responsible for strategy and planning. Since our audit work, this group has been renamed to the Community Services Partnership Forum to reflect the fact that 'implementation' is not part of the group's remit.

Health board	Arrangements for oversight
Cardiff and Vale University Health Board	Until 2011, chronic conditions management was the responsibility of the Director of Primary, Community and Mental Health Services but when this post was restructured responsibility for chronic conditions management and **Setting the Direction** passed to the Director of Public Health. The health board implemented a transformational change programme in 2012-13 to focus attention on the five key areas, namely transforming unscheduled care services, providing care closer to peoples' homes, supporting frail, older people, providing timely access to planned care and improving mental health and well-being. Chronic conditions management sits predominantly within the **Setting the Direction** theme but many patients with chronic conditions are frail, older people, and when unmanaged, patients are likely to access unscheduled care services. In March 2012, a group – the **Setting the Direction** Programme Board – was established to act as a mechanism to provide momentum and focus to implement the framework outlined in **Setting the Direction**. The **Setting the Direction** Programme Board meets bimonthly and replaces the Chronic Conditions Management Board, which had overseen the use of the transitional funding and the demonstrator projects. However, there is no formal mechanism to bring together the different boards providing oversight of the transformational programme. Executive directors leading the various boards do not sit on the other boards and reporting lines to the board are not via the same committee.
Cwm Taf University Health Board	The health board established the **Setting the Direction** Assurance Collaborative (the Collaborative), which is a multi-agency forum to oversee the implementation of the organisations' plans to improve primary and community-based services. The membership comprises representatives from the third sector, both directors of social services from the two local authorities and a number of staff who are drawn from across the health board, including four executive directors with responsibility for primary and community services, planning, public health and operational delivery, as well as finance and HR managers, and clinical directors for localities (of whom several are GPs) and a number of acute services. The Collaborative brings together a number of different but interrelated working groups, such as chronic conditions and unscheduled care, to align respective work programmes more effectively. Although not a formal committee of the board, the Collaborative provides assurance to the board, through the group's chair, who is the health board's vice chair, and the minutes of meetings, that plans are being progressed.

Health board	Arrangements for oversight
Hywel Dda University Health Board	At the time of our audit, the health board had a well-established Community and Chronic Conditions Management Board (CCCMB). The CCCMB is responsible for reviewing progress and promoting the delivery of the relevant national and organisational strategies and plans in relation to community services and chronic conditions management. The CCCMB met bimonthly and was chaired by the Director of Therapies and Health Science, who is the lead for chronic conditions. Membership comprises the Medical Director, the Director of Nursing and the Director of Strategic Partnerships, as well as GPs, representatives from the three partner local authorities and the third sector. The group provides assurance to the board via one of its governance committees. There were clear interrelationships between chronic conditions management and unscheduled care but the CCCMB terms of reference do not identify a key relationship with the health board's unscheduled care clinical programme board. Since our audit, the health board has worked to align the chronic conditions and unscheduled care within the Unscheduled Care Collaborative Boards.
Powys Teaching Health Board	The health board established a **Setting the Direction** Board to take forward chronic conditions management. There is representation from a wide range of stakeholders. The group is chaired by the Director of Public Health and Planning, who is the Executive Director responsible for driving improvements in services for chronic conditions management. In addition to the **Setting the Direction** Board, there are number of condition-specific forums which meet on a regular basis. However, not all of these groups work in an integrated way with the **Setting the Direction** Board, with some groups, such as the stroke steering group, reporting directly to the board.