Public Accounts Committee

Meeting Venue:
Committee Room 4

Meeting date:
16 January 2014

Meeting time:
09:00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:

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Committee Clerk
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Agenda

1 Introductions, apologies and substitutions

2 Unscheduled Care: Evidence Session (09:00-10:15) (Pages 1 - 10)
PAC(4)-01-14 (paper 1)

Dr Andrew Goodall - Aneurin Bevan Health Board

3 Unscheduled Care: Evidence Session (10:15-11:30)
Dr Chris Jones – Cwm Taf Health Board

4 Caldicot and Wentlooge Levels Internal Drainage Board: Consideration of Welsh Government Response (11:30 - 11:35) (Pages 11 - 21)
PAC(4)-01-14 (paper 2)

5 Papers to note (11:35) (Pages 22 - 23)

Governance Arrangements at Betsi Cadwaladr University Health Board: Letter from David Sissling (9 December 2013) (Pages 24 - 29)

Unscheduled Care: Letter from Cwm Taf Health Board (20 November 2013) (Pages 30 - 69)

Unscheduled Care: Letter from Aneurin Bevan Health Board (12 December 2013)

(Pages 70 - 99)

Unscheduled Care: Letter from Betsi Cadwaladr University Health Board (11 December 2013) (Pages 100 - 101)

National Framework for Continuing NHS Healthcare: Letter from the Minister for Health and Social Services (13 December 2013) (Pages 102 - 129)

6 Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business: (11:35)

Items 7, 8, 9 & 10

(Break 11:35 - 11:45)

7 Unscheduled Care: Consideration of evidence (11:45 - 12:05)

8 Penmon Fish Farm: Briefing from the Wales Audit Office (12:05-12:20)

9 Health Finances 2012-13 and Beyond: Consideration of draft report (12:20 - 12:50)

10 Memorandum for the Accounting Officer of the Office of Public Services Ombudsman for Wales (12:50-13:00) (Pages 130 - 137)

PAC(4)-01-14(paper 3)

GIG CYMRU NHS WALES
Bwrdd Iechyd Aneurin Bevan Health Board

Our ref: AG/CG/loe Direct Line: 01633 435958 11 November 2013

Claire Griffiths
Deputy Clerk
Chamber and Committee Service
National Assembly for Wales

Dear Claire

Re: Inquiry into Unscheduled care

I am writing further to your invitation for me to attend the PAC on Tuesday 19th November 2013. I am responding in recognition of both my roles – the first as one of the two lead Chief Executives allocated to unscheduled care and also as Chief Executive of Aneurin Bevan Health Board. I hope it will help the Committee if I am able to respond in relation to my experience of both of these.

As far as the WAO report on unscheduled care is concerned, I received this as a fair assessment of demands, expectations and progress in an unscheduled care system that clearly remains under pressure, is not in a static position notably in respect of demand and is trying to ensure actions are taking place across the whole of the unscheduled care system and not just the hospital environment. The national report clearly has to aggregate up experiences, performance and commentary above any individual Health Board, so I am grateful that I have also had the opportunity locally to receive our local report and assessment from the WAO in Aneurin Bevan Health Board.
Delivering improvements and performance in unscheduled care remains the responsibility of individual Health Boards in providing services for their local population from primary care through to specialist hospital treatment, but as would be expected this involves working closely with the Welsh Ambulance Service NHS Trust specifically and local partners and stakeholders.

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I can advise that in developing our national work programme for unscheduled care during 2013 that we have been able to anticipate most areas highlighted by the WAO within the national work programme for Unscheduled Care which represents key actions facilitated by Chief Executives in support of improvements in emergency system performance. This means we acknowledge the areas for improvement and recommendations set out by the WAO and have set out ourselves to work on these areas to impact on performance and services. In particular we have sought to learn from the specific and exceptional pressures we experienced in the last Winter period and have set out enhanced Winter planning arrangements for the months ahead of us, under the supervision of Welsh Government colleagues.

We are working in a system of increasing demand, driven by demographic changes and average age of admission through A&E rising above 80. The system and demands placed upon it are not static, and the WAO assessment does acknowledge this in setting the context for the report. At appendix 1 I have attached as an example the increase in A&E activity locally in Aneurin Bevan Health Board over the last few years and a trend in ambulance attendances – in particular there has been an increased presentation of patients needing to be seen through our majors flow. This means we are having to adapt very quickly an A&E model that traditionally has focussed on accidents, injuries and traumatic injury (e.g. road traffic accidents) into one having to respond to vulnerable people (mainly older people) and attendances from societal issues such as alcohol. We still need to ensure A&E can deal with the former, but there have to be alternative services and different ways of managing demand for the latter. This requires a different attitude and approach to the way we commission and develop services locally and we are having to review our service provision quite fundamentally from avoidable hospital admissions, better pathways focused on primary care services, different staffing models that respond to recruitment difficulties, alternative emergency care services and better public education of options.

The NHS of course has the major role and responsibility for organising the unscheduled care system – but it is a system that cuts across other areas of provision (e.g. primary care) and other public services (e.g. social services). The WAO report is correct that for us to keep ahead of the increases of demand that are currently impacting on the performance of the system, we need all parts of this system to manage patients in the appropriate environment, with the action of last resort being A&E. As an example, we have developed a primary care approach called "A is for Access" within Aneurin Bevan Health Board which jointly with the Community Health Council and Local Medical Committee, assesses and targets primary care waiting times and have seen progress and improvement on this in a short period of time. We are also fortunate to have good local relations with local government with may examples of joint teams and initiatives in place and have benefitted from a very strong and shared approach to our Winter plans for 2013-14.

We will need to ensure that such joint actions across GPs, social services and hospital and community services are driven forward. We need all to be working effectively and together, not just the hospital system.

Targets aside, we need to focus on the patient experience throughout. I think the WAO report validly shows this as an area for improvement and Health Boards in Wales openly report pressures, progress and performance in respect of the current system targets from 4 hour waits to ambulance turnaround. This includes working with the public and patients on the choices they have for alternative and other more appropriate services, particularly where the system even when under the greatest pressure is consistently offering access and turnaround for the majority within the 4 hour target. There is more that we can do nationally and locally on both understanding patient experience and public education and why choices to attend are being made. Reporting more broadly on issues affecting is a normal part of my own Health Board's public reporting and our reports do try to set out performance, balanced with patient surveys on their experience and measures of staff views. Using all three together allows us to understand better the most effective actions to deliver consistent services. As an example I have attached at Appendix 2 a simple assessment on patient experience we have been using in Aneurin Bevan Health Board that gives a different perspective from performance. We will continue to use these and further experiences we receive from surveys our CHC undertakes, in particular to try to understand patient choices for attendance.

There are significant workforce pressures in A&E Departments and out of hours services. Some of these are driven by shortages and changes occurring around doctors in training and a view of the need to provide better supervision and more specialist training. These issues have been well rehearsed and promoted by doctors themselves in service discussions around Wales, including in great detail and with open information available through the South Wales programme. There are some sites struggling to attract staff at all levels, raising service concerns about sustaining local services safely at all sites. Such safety issues have to be highlighted and cannot be left without action to simply fail.

At the same time, there are positive opportunities for unscheduled care workforce in developing advanced nurse practitioner roles as highly experienced roles that discharge traditional doctor roles and can be recruited to more easily. There is a general concern however that some staff - doctors and nursing staff – are starting to choose different NHS careers away from A&E, not least due to the specific workload, patients' expectations and high pace environment that is being experienced across the whole of the UK. Creating sustainable and safe unscheduled care services will require decisions to be made on specialist centres, that will in future be able to attract and retain senior and experienced clinical staff. Given vacancies across the UK, and similar pressures on services, they have many choices about where to work.

We are liaising with our colleagues in England, Scotland and Northern Ireland and we know that the pressures and challenges are no different for them. This was particularly true of demand and experience over this last Winter.

We will be using these links as a matter of routine for further improvement and best practice through the national work programme and the National Collaborative we have established to help us focus on patient flow draws on experienced and advice inside and outside Wales.

I cannot overstate how much time, attention and resources we deploy to such a serious area, in order to provide safe and responsive services for unscheduled care. Despite detailed work on planning, when the system pressures are not static, there can be a significant impact from significant peaks in demand which require us to make local decisions for accommodating patients and bringing our contingency plans into action. As an example, some of the patterns of admission and attendance have changed over these recent years, with increasingly more activity shifting to evenings and overnight against a trend of activity more traditionally in more normal hours. This has been seen in Welsh Ambulance Service activity as well as in the hospital setting.

At the same time, traditional solutions on this not least more beds, does not provide us with a sustainable response. We have shown locally in Aneurin Bevan Health Board and across Wales that by commissioning more beds, without underpinning these with other system changes, the beds simply fill up. By getting our unscheduled care services in balance for the demand placed upon it and the capacity needed, whether in hospital or across pathways in other settings, gives us all the flexibility to get our elective services delivering, our primary care system to manage its own increasing demands and to push forward better community-based integrated services. Whilst we are in the middle of these pressures, staff are often focusing on the immediate operational issues rather than having the time to change the system. Our role on the national programme is to create to flexibility for organisations and staff to pause and focus on options to create a different way of working and delivering unscheduled care activities. Our staff remain the key to resolving this with their own views on actions that will work and make a difference.

For completeness, I have attached a summary of progress and alignment of the national work programme with the WAO report (attached at Appendix 2) which I have used within the Unscheduled Care Programme. This will complement the accountability of individual Health Boards and WAST to deliver local plans and improvements. The national work programme will remain an active and dynamic work programme and I am keen to ensure that we take advantage of all analysis, assessments and experiences that continue to focus on improving care for patients within our unscheduled care services.
I am very happy to respond to these and other areas highlighted by the WAO report during the Committee inquiry.

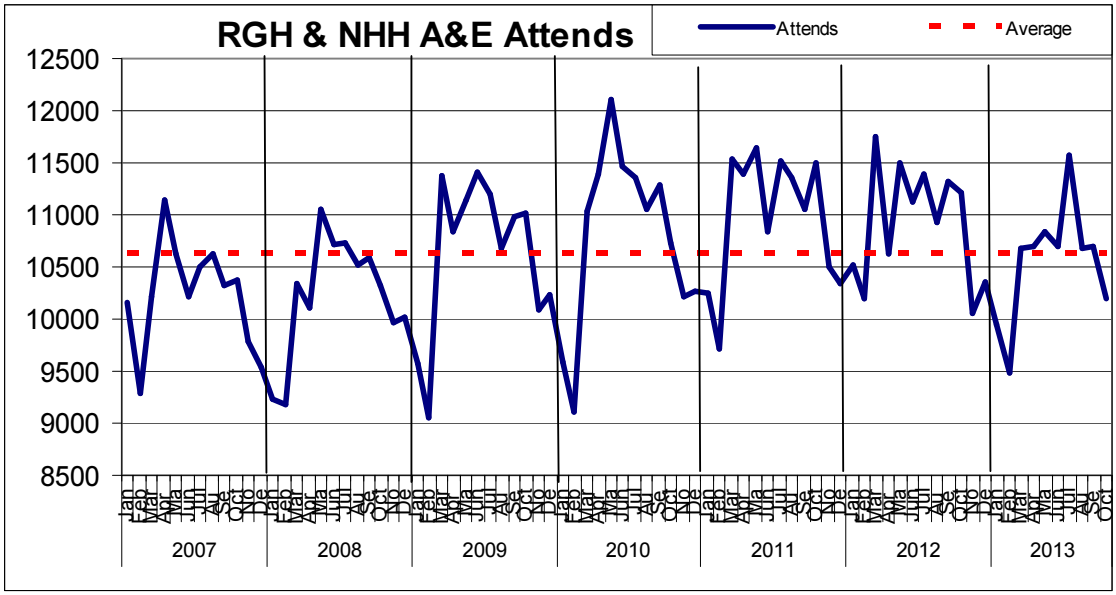
Given the opportunity to respond to the WAO themes, I will be accompanied by Judith Paget, Chief Operating Officer and Deputy Chief Executive, Aneurin Bevan Health Board, to support the session.

Yours sincerely

Dr Andrew Goodall
Prif Weithredwr/ Chief Executive

Enc

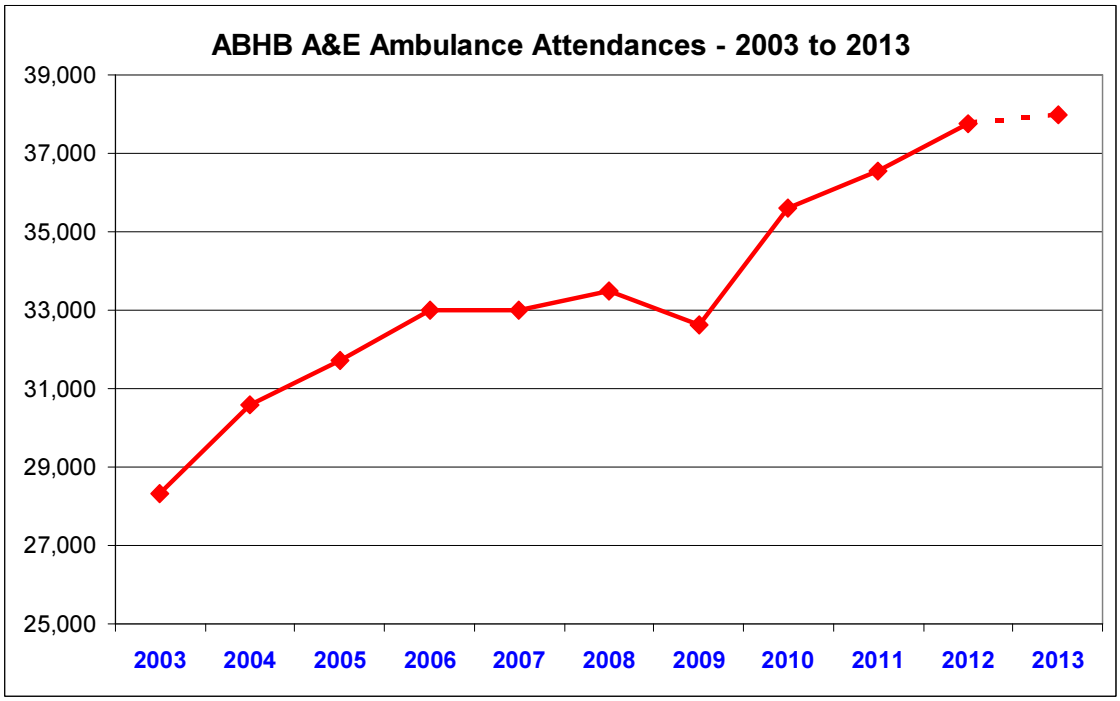
Appendix 1- Year on Year **–** RGH & NHH A&E Attendances



Source: Symphony

To October the ED attendances are 4789 down on the same period last year, a 4.6% reduction.

Appendix 1a - ABHB Ambulance Conveyance Volume Projection 2013



Source: Symphony

The ED Ambulance attendances to October are 176 up on the same period last year, a 0.6% increase.

Appendix 2-ED patient satisfaction scores September/October 2013

	Categories		Excellent	Good	Fair	Poor
1.	How was the welcome you received on admission?		72%	28%		
2.	How would you rate staff attitude towards you?		78%	22%		
3.	How would you rate the cleanliness of the ward?		56%	39%	6%	
4.	How would you rate the standard of the food?		55%	45%		
5.	How would you rate the overall standard of care given by: -	Nursing Staff	83%	17%		
		Medical Staff	82%	18%		
		Other Staff	81%	19%		
7.	Were you satisfied with the care you received?				94% satisfied	
8.	Was staff accessible to answer your questions?	**Nursing Staff**	100% yes			
		Medical Staff	100% yes			

Source: ED Department

Improved rating for staff attitude, cleanliness & food over previous period.

Appendix 3

Wales Audit Office Recommendations and national contribution of USCI Programme

1. Address the current safety issues within the hospital emergency departments
a. Medical and nurse directors to carry out joint urgent reviews to understand safety implications in EDs. Reviews to identify the extent of issues and produce specific action plans.
The USC programme will support the development of analyses of real time data and target areas affecting patient flow, many of which are under detailed consideration within Local Health Boards. The measurement and Information workstream and the National Collaborative for Patient Flow will provide all Wales support.

2. Drive delivery of USC vision
a. Progress on USC plans to be reported to WG and New National Programme b. New USC programme to ensure that the 10 high impact steps to transform USC are addressed.
The USC Steering Board will ensure that the overarching work programme addresses the 10 high impact steps and assesses improvement. Detailed programme plans are being worked up and will be based on the development of products. The programme schedule now includes a mechanism for mapping all products to the WAO recommendations as well as the 10 High Impact steps which informed the initial work programme that has informed actions and planning during 2013.

3. Improve understanding of demand, performance, patient experience and outcomes
a. LHBs and WAST to implement the new framework for patient experience to ensure that they ask about USC across the whole system and not just in ED b. USC indicators used by LHBs to include: patient experience and outcomes, primary care access, performance of OOHs, ambulance services and local NHSDW performance, 4 hr and 12 hour waiting time performance, instances of corridor nursing and overnight stays in ED, performance of community- based USC services and measures related to patient flow, including responsiveness of impatient specialist teams c. WG and LHBs to ensure the national Emergency Data Set is completed consistently to understand demand d. LHBs to improve clinical coding e. PHW to provide LHBs and WAST with support to strengthen local demand analysis
The USC Steering Board recognises the central role of the National Service User Experience Group and its leadership in this area. Patient experience has been identified within the new programme as a cross-cutting theme and all workstreams will be expected to demonstrate how plans and products have built in the patient experience from the outset. This will be tested through separate programme assurance activities and reported to the new Steering Board on a regular basis. In addition, the Measurement and Information Worksteam will work with Welsh Government to agree a revised data set. Work commissioned from Public Health Wales will support local and national analysis.

4. Communicate with the public and improve understanding of the need for change
a. WG to decide on revisions to Choose Well b. WG to decide strategic direction for NHSDW and the model for 111. 111 to have timeline to implementation in 2015, supporting electronic systems to gather information on casemix and volume, and a communication campaign c. WG to develop national definitions of USC services and facilities, to improve public understanding
The USC programme includes an Out of Hours Workstream that will work with Welsh Government on the 111 service and promotion of *Choose Well* as appropriate. A targeted communications strategy will developed over time.

5. Addressing critical skills with unscheduled care skills and workforce
a. WG to share good practice in the use of Emergency Care Practitioners (ECP) b. LHBs to monitor use of ECPs and include in workforce plans c. WAST to deliver transformation in the skill base of its staff d. Consider and address the root causes of recruitment and retention problems in ED and primary care OOHs services e. LHBs to consider revising staffing models for USC to include paramedics and nurses with extended decision making skills. f. LHBs to consider whether physicians and GPs can be used in EDs to ease recruitment problems g. LHBs to reassess skill base of staff in EDs to ensure competence in addressing the needs of older people
The USC Programme will link into unscheduled care skills and workforce issues through the Review of the Ambulance Service Programme Plan. The Workforce agenda will be prioritised by NHS Workforce and OD Directors, noting most of this work is being undertaken locally or through collaboration across Health Boards, and the NHS Workforce Education and Development Service, with progress reported to the USC Steering Board. Learning around new models of care and alternative settings will be facilitated by the national programme.

6. Optimise the capacity for USC that exists within general practice
a. LHBs should work with GPs to agree and monitor local standards for access to urgent primary care b. LHBs to encourage general practices to implement access arrangements that reflect good practice c. LHBs to strengthen the support, guidance and information given to GPs to avoid emergency admissions d. LHBs to request that GPs provide them with data on their capacity and demand for seeing patients within the practice.
The USC Programme is supporting this through the Measurement and Information Workstream which will be developing a range of common metrics. A dedicated Out of Hours Workstream will also be looking to support the service in this area. A clinical reference group is part of the programme structure and has a role to engage GPs in taking this agenda forward**.**

7. Unblock issues with flow in the acute hospital and improve integrated working between health and social care
a. LHBs to generate more shared ownership of the pressures and patient flow issues by improving links between staff in EDs, Clinical Decision Units and inpatient ward teams b. WG to lead a specific programme of work to support better integration of health and social care to ensure timely discharge of patients.
The USC Programme has established a National Collaborative for patient flow which is supporting individual LHBs by providing external support, expertise and training as required. The Integrated Care Workstream is examining aspects of integration between Health and Social Care which require support.

In conclusion, the national USC Programme is working alongside the activities to reconfigure hospital services and other groups which are operating at the national level. It continues to have a role to lead and support actions and interventions which will improve delivery locally and will complement the LHBs and WAST individual responsibilities to improve their unscheduled care system performance.

Alun Davies AC / AM
Y Gweinidog Cyfoeth Naturiol a Bwyd
Minister for Natural Resources and Food

Llywodraeth Cymru
Welsh Government

Eich cyf/Your ref
Ein cyf/Our ref

Darren Millar
Chair, Public Accounts Committee

11 December 2013

Dear Darren,

Internal Drainage Boards – Response to PAC Report

I thank the Committee for the report. As you will be aware, I have recently announced my intention to transfer the functions, assets and staff of the three Internal Drainage Boards (IDB) which are wholly or mainly in Wales to Natural Resources Wales. This will provide entirely new Governance arrangements for these functions, to a standard consistent with that which we would all expect from public bodies. It will also address the issues raised in relation to interrelationships between bodies.

I attach a response to each of the individual recommendations at Annex 1. However as a general comment, I am not persuaded that issuing further guidance – either to Internal Drainage Boards or other bodies – is a solution in itself. As you will see from the response to recommendation 1, clear guidance on accountability and audit arrangements was in place for the Caldicot and Wentlooge Levels Internal Drainage Boards, and had been given statutory force through a National Assembly regulation. Moreover detailed implementation guidance is, and was, available to Association of Drainage Authority members on their website, including templates for governance and other documents. Caldicot and Wentlooge Internal Drainage Board are active members of the association.

The real issue underlying this is individual behaviour, compounded by the lack of checks and balances that are available in a larger body. Ultimately we expect all those serving the public to act with integrity, and sadly, but rarely, this expectation is not always met.

Finally, I would like to draw the Committee's attention to the fact that the National Assembly recently rejected my Legislative Consent Motion (NDM5259) on the Local Audit and Accountability Bill. I understand and agree with the desire of the National Assembly and the Committee to ensure that these cross border IDBs are subject to the Welsh audit regime.

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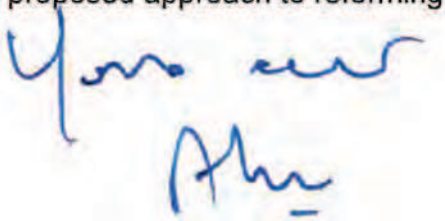
This, and many of the other recommendations in this report, will be addressed by the transfer of IDB functions to Natural Resources Wales.

As set out in my written statement I intend to make this change from April 2015, and I attach an outline timetable for the order. The Committee should however note that in light of the National Assembly's decision to reject the Legislative Consent Motion, there is no contingency for ensuring an audit regime for the two cross border IDBs should we be unable to give effect to the change by April 2015. I therefore trust that the Committee will support the proposed approach to reforming IDB and the timetable for change.



Alun Davies AC / AM
Y Gweinidog Cyfoeth Naturiol a Bwyd
Minister for Natural Resources and Food

SF-AD-4121-13 Annex 1

Response to the Public Accounts Committee

Caldicot and Wentlooge Internal Drainage Board

General

I thank the Committee for their report. As they will be aware, I have recently announced my intention to transfer to Natural Resources Wales the functions, assets and staff of the three Internal Drainage Boards which are wholly or mainly in Wales. This will provide entirely new governance arrangements for these functions, to a standard consistent with that which we would all expect from public bodies. It will also address the issues raised in relation to interrelationships between bodies.

I have addressed the individual recommendations within this context (see below).

Recommendation 1. We recommend that the Welsh Government publish clear guidance regarding the accountability of Internal Drainage Boards operating wholly or mainly in Wales.

Accept in principle.

I agree that such guidance is necessary, and is already in place.

For the Caldicot and Wentlooge Levels Board, the "Governance and Accountability in Internal Drainage Boards in England: A Practitioners Guide 2006" is provided for in the Accounts and Audit (Wales) Regulations 2005, which were approved by the National Assembly. This is clear on what constitutes proper practice and has a statutory basis. Further detailed guidance on what constitutes proper practice, including example documentation is available to members on the Association of Drainage Authorities website. Caldicot and Wentlooge Levels Internal Drainage Board is an active member of the Association of Drainage Authorities and since the Wales Audit Office report they have taken steps to work toward these standards.

Under present arrangements, accountability is to the individual Board of the Internal Drainage Board, whose members are appointed by landowners and local authorities as set out in legislation. Welsh Government does not have direct powers in this regard, other than powers to legislate to change the arrangements. As above we have stated our intention to use these powers and the new arrangements will provide an appropriate and robust governance framework.

Recommendation 2. We recommend that the Welsh Government set out a clear framework for joint working between Internal Drainage Boards, and other organisations accountable to Welsh Government including local authorities and Natural Resources Wales, for flood risk management. This framework should include details of roles and responsibilities of each organisation.

Accept

As above, roles and responsibilities are set out in existing legislation, and will be superseded by transfer to Natural Resources Wales. I will be establishing a joint Natural Resources Wales / Internal Drainage Board working group to oversee the transition.

Recommendation 3. We recommend that the Welsh Government review the governance arrangements of Internal Drainage Boards operating wholly or mainly within Wales, and that a system of monitoring of governance arrangements, including procurement processes and financial management, be introduced to ensure that they are transparent and consistent with best practice elsewhere in the public sector and have appropriate documents and plans in place.

Accept

I have announced my intention to use the powers given to Welsh Ministers in the Public Bodies Act 2011 to transfer to Natural Resources Wales the functions of all three Internal Drainage Boards wholly or mainly in Wales. This includes the two cross border Internal Drainage Boards, whose audit arrangements are currently within the jurisdiction of the United Kingdom Government. For the two cross border bodies the transfer will need the consent of the Secretary of State.

These transfers will replace the existing governance, financial controls and audit arrangements with those that apply to Natural Resources Wales. I believe that this will address these matters fully.

In the interim these are matters for the Internal Drainage Board itself. In that regard I have been advised that the Caldicot and Wentlooge Levels Board has been working to improve matters and that progress has been made.

Recommendation 4. We recommend that the Welsh Government works with Internal Drainage Boards operating wholly or mainly in Wales and other small public bodies to ensure that there are clear lines of accountability for their public facing activities, including maintenance of web sites. (Page 20)

Accept in principle

Lines of accountability for Internal Drainage Boards are set out in section 1 and schedules 1 and 2 of the Land Drainage Act 1991. Officers of the Internal Drainage Boards are accountable to their Board, who comprise a mixture of members appointed by charging authorities (Local authorities in practice), and members elected by those in the chargeable area.

While this arrangement has clearly been unsatisfactory, I have no powers to change this for Internal Drainage Boards without bringing forward legislation, and I have announced my intention to do so.

With regard to 'other small bodies' the Welsh Government, having discussed this with the Wales Audit Office, defines these principally, as being the 735 town and community councils in Wales. The clear line of accountability for these bodies is, primarily, the democratic process and their interaction and relationship with their principal councils in Wales.

In February 2013 the Welsh Government made hypothecated grant allocations totalling £1.125m available to the principal councils. This included £375,000 for the town and community councils to establish and develop websites. The grant award letters to the 22 principal councils made it clear that this funding was to be used solely by town and community councils for improvements in their publications and to develop their accessibility on the internet. The award letter set a target of 31 March 2014 for this to be completed.

This position was further underpinned by the provisions of the Local Government (Democracy) (Wales) Bill. This became law on 30 July 2013 and Section 55 requires town and community councils to establish a website and to include specific information relating to councils contact information, details of council members, minutes of meetings and audited statements of account.

Recommendation 5. We recommend that the Welsh Government re-issues guidance on Governance, citing the problems experienced at Caldicot and Wentlooge Levels Internal Drainage as an illustration of what can go wrong. (Page 21)

Accept

The Welsh Government and Welsh Audit Office issued guidance on good governance to community and town councils. In addition, One Voice Wales, the representative organisation for community and town councils in Wales, and the Society of Local Council Clerks have jointly issued their own guidance to councils. All this guidance is available on the internet. We will work with these organisations to ensure councils are reminded of the guidance available together with the conclusions of the report on the Internal Drainage Board.

Recommendation 6. We recommend that the Welsh Government work with Natural Resources Wales, the Association of Drainage Authorities and other appropriate bodies to review the size, composition and

functioning of Internal Drainage Boards operating wholly or mainly in Wales, and Boards for other small public bodies. (Page 25)

Accept

I have looked at this matter for Internal Drainage Boards, and concluded that new arrangements would provide a better approach in the future. This is covered by my written statement of 12 November.

With regard to town and community councils, responsibility for their review rests with the Local Democracy and Boundary Commission for Wales, working in conjunction with the 22 principal councils.

It is possible that the forthcoming report from the Commission on Public Service Governance and Delivery will impact on the size composition of town and community councils. The Welsh Government will give careful consideration to the Commission's report, conclusions and recommendations.

Recommendation 7. We recommend that Internal Drainage Boards should be mindful of the other commitments of Board Members (particularly Appointed Members from Local Authorities) when setting agendas and timetabling meetings to ensure improved attendance. (Page 25)

This recommendation is for the Internal Drainage Boards to take forward.

Recommendation 8. We recommend that in developing systems for monitoring the governance of Drainage Boards and other small public bodies, consideration is given to mechanisms for monitoring the performance of appointed board members, particularly those from local authorities. (Page 25)

Partially Accepted

For Internal Drainage Board functions, this will be addressed by the transfer of functions to Natural Resources Wales. In the interim, as I have previously stated, the Caldicot and Wentlooge Levels Internal Drainage Board has issued new Rules of Procedure/Standing Orders which follow the guidelines produced by the Association of Drainage Authorities.

For appointments to other small public bodies, responsibility for ensuring performance is monitored rests with the appointing authority. Where this lies with Welsh Ministers and comes within the remit of the Commissioner for Public Appointments Code of Practice, this requires that the Welsh Government ensures that regular, effective and transparent performance assessment processes are in place. The Code also stipulates that no member of a public body can be reappointed unless the individual has performed satisfactorily during the current term of appointment.

Recommendation 9. We recommend that consideration should be given to improving communication channels between Appointed Board Members and the local authority they represent. This should include guidance to Appointed Board Members on the escalation of concerns about governance arrangements and a reporting mechanism to enable details of the Boards activities to be scrutinised. (Page 25)

This recommendation is for the appropriate local authorities to take forward.

Recommendation 10. We recommend that the Welsh Government work closely with public bodies to ensure that the remuneration of senior staff is fully transparent and that consideration of proposals for increasing the pay of senior managers is within the Wales Audit Office guidance on good governance. (Page 30)

Partially Accepted

Chief Executive pay in Local Government is subject to external independent scrutiny by the Independent Remuneration Panel, following the Democracy Act 2013. Additionally, elected members have had their salaries set by the Independent Remuneration Panel since the 2011 Local Government Measure.

Where Welsh Ministers are responsible for the pay arrangements of senior staff of Welsh Government Sponsored Bodies and NHS managers, arrangements are in place to ensure that the remuneration is fully transparent and any increases are in accordance with good governance principles.

Recommendation 11. We recommend that the Welsh Government uses this episode to illustrate the need for all public bodies to be mindful of the importance of being able to demonstrably justify public expenditure, with decisions on use of public money supported by clear business cases and measurable outcomes. (Page 31)

Accepted

The Welsh Government is currently updating "Managing Welsh Public Money" which sets out the main principles for dealing with resources used by public sector organisations in Wales. This will be made available to public sector organisations throughout Wales in early spring 2014 when complete.

Recommendation 12. We recommend that the Welsh Government, in collaboration with Natural Resources Wales, works closely with Internal Drainage Boards operating wholly or mainly in Wales to ensure that a robust, effective and monitored induction and training programme is in place for new Members, and that all existing Members complete regular

performance management plans and are regularly encouraged to review their training *needs. (Page 32)*

Accepted

The transfer of functions, assets and staff to Natural Resources Wales will address this recommendation from April 2015.

In the short term this is a matter for the Internal Drainage Boards [and local authorities in relation to their appointed members]. Although Natural Resources Wales can provide direction to Internal Drainage Boards on operational matters, these are limited to works being carried out. Neither I, nor Natural Resources Wales therefore have appropriate powers to make these changes without legislating, and in relation to the cross-border Internal Drainage Boards this can only be done jointly with the Secretary of State.

Recommendation 13. We recommend that the Welsh Government considers whether there is a need to review the provision of training to Board Members on small public bodies in Wales, including bodies such as Community Councils. (Page 33)

Accepted

A report into the role, functions and future potential of community and town councils in Wales in 2003 found that very few councillors and clerks undertook training. Following this, the Welsh Government established a National Training Advisory Group (now under the chair of One Voice Wales) which developed a National Training Strategy for community and town councils in Wales. Funding from the Welsh Government has supported the development of the training programmes and have been taken up by a significant proportion of such councils.

Recommendation 14. We recommend that the Wales Audit Office appear before the Public Accounts Committee with the results of the review of its auditing methodology and proposals on how it intends to make improvements in the future. (Page 36)

This is a matter for the Wales Audit Office.

Recommendation 15. We recommend that the Welsh Government seeks to bring the audit arrangements for the Lower Wye and Powysland Internal Drainage Boards in line with those currently in place for the Caldicot and Wentlooge Levels Internal Drainage Board. (Page 36)

Accepted

The Public Bodies Act 2011 makes specific provision for Welsh Ministers to transfer Internal Drainage Boards 'wholly or mainly in Wales' to another Welsh body, and Welsh Government has announced its intention to use these powers to transfer them to Natural Resources Wales. This will bring the functions within the Welsh audit regime.

As set out in my written statement I intend to make this change from April 2015, and I attach an outline timetable for legislation which I trust the Committee will support. The National Assembly has rejected the Legislative Consent Motion which would have enabled the UK Government to allow the two cross border bodies to continue within the England regime, pending such a transfer.

The cross-border nature of these bodies means there is no simple alternative way in which the auditing arrangements for the cross border IDB could be brought under the Welsh regime. While we could consider legislation under section 108 of the Government of Wales Act (2006), it is by no means clear that all the functions exercised by these bodies are exercised in relation to Wales. An act to transfer these audit functions could therefore be subject to a competence challenge from the United Kingdom Government

Even if feasible this would be time consuming and ultimately nugatory work, given our intention to transfer the functions to Natural Resources Wales.

Recommendation 16. We recommend that the Minister for Natural Resources and Food makes a statement on the possible transfer of the functions of existing Internal Drainage Boards to Natural Resources Wales (NRW) as soon as possible. (Page 38)

Accept

I have made this statement, a copy of which is attached to this response. As above the outline timetable for these changes is also attached.

WRITTEN STATEMENT
BY
THE WELSH GOVERNMENT

TITLE **Future arrangements for Internal Drainage Boards in Wales**

DATE **12 November 2013**

BY **Alun Davies AM, Minister for Natural Resources and Food**

I have decided to transfer the functions, assets and staff of the Powysland, Lower Wye and Caldicot and Wentlooge Levels Internal Drainage Boards (IDB) to Natural Resources Wales.

This will improve opportunities for a more integrated approach to the management of our natural resources in the Internal Drainage Districts, remove duplication of organisational arrangements and improve resilience and value for money. By bringing this expenditure within the framework for audit and accountability we established for Natural Resources Wales, we will secure a long term solution to the many issues raised in relation to Caldicot and Wentlooge Levels IDB by the Wales Audit Office and the Public Accounts Committee.

I will be discussing the cross border issues for Powysland and Lower Wye with the Secretary of State for Defra.

I have asked officials to begin work to prepare the necessary orders and undertake due diligence on the pension arrangements and assets currently linked to the IDB, with a view to making this change in April, 2015.

Draft Legislative Timetable

At this stage this is very much a provisional timetable, but currently, key dates are expected to be –

Draft Instrument prepared 30 April 2014

Draft Order and Explanatory Memorandum circulated to interested parties for comment 1 May to 1 August 2014

Lay Draft SI 16 September 2014

Table the motion 10 February 2015

Plenary date 17 February 2015

Agenda Item 5

Public Accounts Committee

Meeting Venue:	Committee Room 3 – Senedd
Meeting date:	Tuesday, 10 December 2013
Meeting time:	09:00 – 11:02

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_400000_10_12_2013&t=0&l=en

Concise Minutes:

Assembly Members:	Darren Millar (Chair) Mohammad Asghar (Oscar) AM Mike Hedges Julie Morgan Jenny Rathbone Aled Roberts Jocelyn Davies Sandy Mewies
Witnesses:	Baroness Finlay of Llandaff Dr Mark Poulden, College of Emergency Medicine Veronica Snow, Powys Teaching Health Board
Committee Staff:	Fay Buckle (Clerk) Claire Griffiths (Deputy Clerk)

TRANSCRIPT
View the meeting transcript.

1 Introductions, apologies and substitutions

1.1 The Chair welcomed the Members to Committee.

2 Unscheduled Care: Evidence Session

2.1 The Committee questioned Mr Mark Poulden, Welsh Chair of the College of Emergency Medicine, on Unscheduled Care

3 Unscheduled Care: Evidence Session

3.1 The Committee questioned Baroness Finlay and Veronica Snow on Unscheduled Care.

4 Papers to note

4.1 The papers were noted.

4.1 Health Finances 2012-13 and Beyond: Letter from David Sissling (27 November 2013)

4.1 The papers were noted.

4.2 Unscheduled Care: Additional information from the BMA

4.3 Help to Buy – Wales shared equity scheme: Letter from Minister for Housing and Regeneration dated 4 December 2013

5 Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business:

5.1 The motion was agreed.

6 Unscheduled Care: Consideration of Evidence Received

6.1 The Committee discussed the evidence received on Unscheduled Care.

7 Ways of working: Consideration of proposals for new ways of working

7.1 Due to time constraints, the Committee was unable to discuss the paper. The Chair proposed that Committees holds an additional meeting on 14 January to consider the paper.

Yr Adran Iechyd a Gwasanaethau Cymdeithasol
Cyfarwyddwr Cyffredinol • Prif Weithredwr, GIG Cymru

Department for Health and Social Services
Director General • Chief Executive, NHS Wales

Llywodraeth Cymru
Welsh Government

Mr Darren Millar AM
Chair
Public Accounts Committee
National Assembly for Wales
Cardiff Bay
Cardiff
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Our Ref: DS/JJ/TLT

9 December 2013

Dear Darren

PAC INQUIRY INTO GOVERNANCE ISSUES AT BETSI CADWALADR UNIVERSITY HEALTH BOARD

Last week you advised me the Public Accounts Committee report into Governance issues at Betsi Cadwaladr University Health Board would be published in the near future. It is some months since we gave evidence so I thought you might welcome an update on the actions we have taken in the intervening period.

1. Quality and Safety Issues

Welsh Government Oversight
We have further strengthened the Quality and Safety Management systems within Welsh Government. We have put in place a group chaired by the Deputy Chief Medical Officer which meets regularly to oversee information and intelligence about the performance of NHS organisations. This enables interaction and if necessary escalation with Health Boards and Trusts.

Transparency
We are taking steps to ensure appropriate information is in the public domain. We have launched a website providing information on local health boards, hospitals and GPs, http://mylocalhealthservice.wales.gov.uk. This currently includes mortality and HCAI data as well as information on patient experience. This initiative will continue to be developed.

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Quality Reporting
All Health Boards and Trusts have published an Annual Quality statement. These are comprehensive and set out the organisation's approach in areas such as audit, patient experience and complaints A process of peer review is currently being progressed and a learning event will be held early in the New Year.

Mortality
There has been considerable progress across Wales to strengthen the process of reviewing mortality and mortality data. This includes undertaking case note reviews of all deaths in hospitals. The aim is to ensure a consistent approach is taken across Wales. We are paying particular attention to the work of Betsi Cadwaladr University Health Board in this area. They are reviewing relevant matters across their 3 District General Hospitals and undertaking necessary case note reviews. A major area of focus is any HCAI related deaths.

Health Care Acquired Infections (HCAIs)
This is a priority for attention across the Welsh NHS. It is a Tier 1 priority and we are taking action to share and adopt best practice. It is the focus for an All-Wales meeting on 11 December involving all Executive Teams. With reference to BCUHB we naturally remain concerned about levels of *Clostridium difficile* and other HCAIs across the Health Board. However there is evidence that the Board are now receiving timely, comprehensive information on the extent of infection and making progress with their 'Infection Prevention Improvement Action Plan'.

BCU have agreed a new structure for their infection prevention and control (IPC) team. This includes an agreement with the Royal College of Pathologists on a new IPC doctor post which will be directly accountable to the Executive Nurse lead for HCAI and an assistant director of nursing with extensive experience in IPC (who is already in post). When in place the team will provide the leadership, and have the capacity and capability to further strengthen systems and processes. There is emerging evidence of improved case ascertainment, outbreak management and proactive systems for root cause analysis of all deaths where C diff appears on the death certificate.

The Health Board has re-established local site specific IPC and decontamination groups and work is underway to develop and strengthen Board wide policies and procedures. This work includes:

- recent publication of an antimicrobial prescribing policy and guidelines;
- developing a more robust multidisciplinary education and training programme – for primary as well as secondary care;
- a communications strategy;
- appropriate interaction with local residential and nursing homes.

The Board is proactively engaging with the Community Health Council which has recently completed its 'Bugwatch' survey – the results of which has been shared with the Board and will be published.

2. Joint Work with Welsh Government, HIW and WAO on Escalation Procedures.

Work is well advanced through a task and finish group which has met regularly since August. The purpose is to agree protocols for the systematic and timely sharing of information, and ensuring appropriate intervention arrangements. The Project Board has considered:

- Escalation and Intervention arrangements elsewhere within Wales and the UK
- The powers and duties of Welsh Government, HIW and WAO as set out in legislation
- What information and intelligence should be shared routinely

This has informed proposals which we will be tested with stakeholders, leading to new arrangements being finalised early next year. These include

- WG, HIW and WAO to meet twice a year to share information and when required between these times when concerns arise
- A system with trigger points leading to various stages / levels of intervention
- Clarity about the range of intervention actions which should be taken.

3. Board Training and Development

As you know from the evidence session I consider effective Board development to be of critical importance. We need to ensure we have the right blend of consistent national activity and bespoke local arrangements to ensure non-executive Board members fully understand their roles and responsibilities and the Board functions effectively. In October I wrote out to all Chairs and Chief Executives restating the importance of Board development and advising them of the support available through Academi Wales. I am attaching of copy of my letter which sets this out in more detail.

4. Financial Position

We described a number of improvements we were taking forward in relation to budget and financial management arrangements at our Committee appearance in July. We are progressing these together with those recommended in the recent WAO NHS Finances report. We are already sharing the lessons from both reports with LHBs and Trusts. We will continue to monitor and seek assurances on all developments including improvements in local budgetary control and financial management arrangements.

An important development received approval this week. This is the new financial flexibility arrangements provided under the NHS Finances (Wales) bill. As already recognised by the Committee and the AGW these developments, linked to service planning improvements will substantially help to alleviate the over reliance on

unsustainable short term financial solutions. These new arrangements will apply from 2014/15.

The development will provide greater clarity on the requirements going forward for all LHBs and Trusts. Each organisation is currently finalising a 3 year Integrated Plan which will be submitted in January 2014. These Plans will bring together service, workforce and financial considerations into one robust Plan.

5. Disseminating the Report

I circulated the WAO/HIW Report to all Boards and Trusts and asked them to provide formal assurance that their internal governance arrangements were appropriate. All organisations have now done this.

I hope that the information above provides some further reassurance that we have been taking forward a range of actions we discussed with Committee in July. I look forward to receiving the Committee's final report and we will respond in more detail at that point.

Yours sincerely

David Sissling

ENC.

Yr Adran Iechyd a Gwasanaethau Cymdeithasol
Cyfarwyddwr Cyffredinol • Prif Weithredwr, GIG Cymru

Department for Health and Social Services
Director General • Chief Executive, NHS Wales

Llywodraeth Cymru
Welsh Government

Chairs – NHS Local Health Boards
Chairs – NHS Trusts

Our Ref: DS/JC/TLT

22 October 2013

Dear Colleague

Board Level Development Support

Effective Board development is of critical importance. We need to ensure we have the right blend of consistent national activity and bespoke local arrangements. The latter is, of course, for you to define and secure. The purpose of this letter is to advise you of the national support which is available through Academi Wales. Following recent discussions I am writing to advise you of Board level support available through Academi Wales.

- Two at the Top – New Chief Executive and Chair pairings to use this support in their first year, existing Chief Executives and Chairs to access when needs arise;
- Board Development Series – all Health Boards and Trusts should undertake the two parts of the programme over the next 2 years;
- The Good Governance Guide for NHS Wales Boards – to be used by all Board Members on an on-going basis;
- Governance Master class Series – Chairs to identify appropriate Board members to attend the series, learning to be shared with Boards on return to organisation;
- Bespoke Development – all Health Boards and Trusts to discuss other development support with Academi Wales as needs arise.

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I think it would be helpful if you could share a summary of your planned Board development activity for 2014. I would appreciate this by **end of December 2013**.

Yours sincerely

David Sissling

cc. Chief Executives – Local Health Boards/Trusts
Board Secretaries – Local Health Boards/Trusts
Directors of Workforce and OD – Local Health Boards/Trusts
Bernard Galton, Director General, Welsh Government
Jo Carruthers, Deputy Director Financial and Corporate Services, Welsh Government
Julie Rogers, DHSS, Welsh Government

GIG CYMRU NHS WALES
Bwrdd Iechyd Cwm Taf Health Board

Your ref/eich cyf:
Our ref/ein cyf: AJW/KMG/KAD
Date/Dyddiad: 20th November 2013
Tel/ffôn: 01443 744803
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Dept/adran: Chair & Chief Executive

Mr Darren Millar AM
Chair
Public Accounts Committee
National Assembly for Wales
Cardiff Bay
Cardiff CF99 2NA

Dear Mr Millar

RE: Wales Audit Office Report - 'Unscheduled Care – An Update on Progress' September 2013

Thank you for your letter of the 8th November 2013 concerning the above report and the short inquiry into the subject that will be undertaken by the Public Accounts Committee.

Please find attached Cwm Taf Health Board's action plan in relation to the recommendations from the above Wales Audit Office report which I hope you will find helpful.

In respect of inappropriate referrals, there has been no comprehensive audits undertaken locally, however significant work has been progressed in conjunction with the Welsh Ambulance Services NHS Trust to reduce hospital conveyance rates and provide an alternative to hospital attendance. This work has included the development of condition specific pathways with direct links to community based services, and the introduction of additional support to care homes to prevent inappropriate conveyance to hospital and inappropriate admissions.

The initial evaluation of the "Phone First!" for minor injuries project in the Rhondda area also appears to illustrate that the initiative has been successful in ensuring patients access other services as an alternative to the accident and emergency department. The evaluation report considered by the Health Board in September 2013 is attached for your information and you will note that we are now working to roll out the "Phone First!" approach for minor injuries across Cwm Taf.

Contd/…

The above are two examples of the many work streams in progress across the Health Board in relation to unscheduled care services. If you require any additional information please do not hesitate to contact Kath McGrath, Assistant Director of Operations (Unscheduled Care) on 01443 744800.

Yours sincerely

Mrs Allison Williams
Chief Executive/Prif Weithredydd

CWM TAF HEALTH BOARD
WALES AUDIT OFFICE REPORT – UNSCHEDULED CARE RECOMMENDATIONS (SEPTEMBER 2013)

RECOMMENDATION		PLAN	EXAMPLES OF GOOD PRACTICE / WHERE SIGNIFICANT IMPROVEMENT HAS BEEN ACHIEVED
1a	To supplement existing quality assurance and risk management practices, Health Board medical directors and directors of nursing should carry out joint, urgent reviews to make sure they fully understand the safety implications for patients in their Emergency departments. The reviews should identify the extent of safety issues, and produce specific action plans that seek to reinforce what is acceptable and what is not acceptable practice.	Staffing establishments have been reviewed within each emergency department, and minimum staffing numbers agreed. Any gaps in rotas are covered by flexible bank and agency staff to maintain the minimum safe staffing levels. Acute care physician appointments have been made with further appointments planned. New roles have been developed to support and maximise the potential of all staff. Each emergency department now has a fully staffed therapy assessment team working within the emergency department and clinical decision unit. Daily local conference calls are held to ensure the departments are well supported and that there is always a senior manager on site. Patient records are reviewed regularly to ensure all appropriate care is provided. All 12 hour waits are incident reported and reviewed.	Development of advanced emergency practitioner role – provides senior clinical nursing support within the department reducing the need for agency staff. Increased impact in turn around at the front door due to increased acute care physician input.

RECOMMENDATION		PLAN	EXAMPLES OF GOOD PRACTICE / WHERE SIGNIFICANT IMPROVEMENT HAS BEEN ACHIEVED
2a	Health Boards' progress in delivering their unscheduled care plans should be reported robustly and regularly to their board meetings, to the Welsh Government and within the new national programme.	The Health Board's unscheduled care plan was submitted to the WG in September, and presented to the Health Board executive board in September, updates on progress are reported via the monthly operational board meetings, and also at finance and performance and quality and delivery committee meetings. The Health Board is also developing a specific unscheduled care dashboard to further support Board level performance reporting. The Health Board provided a presentation at the September national programme event and Health Board representatives will attend all events planned.	
2b	Those charged with developing the new unscheduled care programme should ensure the programme specifically addresses the issues presented in this report and in the *Ten High Impact Steps to Transform Unscheduled Care (USC)*.	The Unscheduled Care plan seeks to specifically address the issues highlighted in the *Ten High Impact Steps to Transforming Unscheduled Care*.	
3a	As a matter of urgency, Health Boards and the ambulance service should implement the new national framework for patient experience and ensure that they are routinely asking patients about their experiences of unscheduled care, across the whole	Recent patient surveys have been undertaken in each emergency department and will continue to be undertaken on a regular basis to inform the departments' progress and further action. Informal visits are also undertaken by	

RECOMMENDATION		PLAN	EXAMPLES OF GOOD PRACTICE / WHERE SIGNIFICANT IMPROVEMENT HAS BEEN ACHIEVED
	system and not just in the emergency department.	independent board members. The Health Board has also commenced work with the Public Health Wales Improvement Team around patient flow based on 1000 lives work.	
3b	Unscheduled care indicators used by each Health Board and reported to their board members should include a much wider suite of measures that cover, as a minimum, patient experience and outcomes, primary care access, performance of out-of-hours primary care, ambulance service and local NHS Direct Wales performance, 4-hour and 12-hour waiting time performance in emergency departments, instances of corridor nursing and overnight stays in the emergency department, performance of community-based unscheduled care services and measures related to patient flow, including responsiveness of inpatient specialist teams in responding to referrals and requests to review patients from the emergency department.	A suite of indicators has been developed to cover all aspects of patient flow, from primary care, out of hours service through community and intermediate care, acute and community hospital settings and these will be reported on a monthly basis via the operational board. Tier 1 targets are reported daily to the senior management team. Ward based measures are being developed and will be reported weekly to all ward areas capturing anticipated date of discharge compliance, length of stay, discharge pre-noon etc.	A suite of indicators covering primary, community, intermediate and acute care have been developed and will be implemented during October these will be utilised monthly to inform progress. A further ward based suite of data is being developed to enhance staff involvement at all levels in the patient flow improvement cycle.
3c	The Welsh Government should work with Health Boards to ensure the national Emergency Department Data	The Health Board continues to work closely with the DSU to ensure all data sets are robustly and consistently applied.	

	RECOMMENDATION	PLAN	EXAMPLES OF GOOD PRACTICE / WHERE SIGNIFICANT IMPROVEMENT HAS BEEN ACHIEVED
	Set (EDDS) is completed consistently and comparably across all units and that the data are used effectively to understand demand.	The EDDS data quality indicators are also regularly reported across the organisation as part of the integrated performance dashboard.	
3d	In line with new standards issued by the Welsh Government, Health Boards should make it a priority to significantly improve their clinical coding performance.	In order to improve upon the timeliness and quality of clinical coding within Cwm Taf, the following actions have been implemented: • The improved working relationship between the coding department and the Assistant Medical Director with the remit for Quality and Governance and strong links with the clinical audit department. • The introduction from November 2012 of daily minimum coding targets. These are set in line with the agreed standard of 30 episodes daily and are monitored on a weekly basis to ensure that the minimum standard is maintained • We have standardised the working practices in the two coding departments and in so doing we have seen a significant improvement in efficiencies in the coding process. • We have recruited into the two vacant positions in PCH, they took up their posts in December 2012. This recruitment round included the appointment of a coding supervisor and both new appointments have coding experience.	

RECOMMENDATION		PLAN	EXAMPLES OF GOOD PRACTICE / WHERE SIGNIFICANT IMPROVEMENT HAS BEEN ACHIEVED
		• We produce weekly reports on both the achievement of coding against the targets and data quality that is fed back to all members of the team • Recruitment of two trainee clinical coders at RGH – posts commenced in July 2013. • There is still a level of overtime being undertaken to support the removal of the backlog however this is now under review. • Monthly case note audit to ensure quality of coding is maintained. • Clinical coding performance is reported as part of the dashboard at executive board, finance and performance committee and public board level.	
3e	Public Health Wales should build on its recent analysis of unscheduled care demand by providing health boards and the ambulance trust with support to strengthen local demand analysis. This support should aim to strengthen local organisations' abilities to predict and pre-empt peaks in demand, across all unscheduled care services and not just the emergency department.	The Health Board has undertaken a point prevalence study led by public health to inform the work of the unscheduled care group and this has informed further work on specific pathways. The point prevalence work will be repeated on a quarterly basis. Further work on the Health Board's revised escalation triggers and long length of stay will provide early indications of blockages across the system, enabling early identification of issues and targeted action. The revised escalation triggers provide a Health Board wide predictor tool as opposed to just the emergency department triggers.	Point prevalence work has informed further work of unscheduled care programme. The newly revised Health Board escalation triggers provide early prediction of delays across the pathway of care to pre-empt blockages at an early stage. Escalation is closely linked to the local authorities and WAST providing a whole system approach.

RECOMMENDATION		PLAN	EXAMPLES OF GOOD PRACTICE / WHERE SIGNIFICANT IMPROVEMENT HAS BEEN ACHIEVED
4a	If the Welsh Government decides to continue with the *Choose Well C*ampaign, it should: • Ensure the campaign complies with the National Social Marketing Centre's good practice principles. In particular, the campaign should set clear, measurable targets and should be robustly evaluated. • Consider whether *Choose Well* would benefit from using the *Mindspace*18 methodology to optimise the approach of changing public behaviours.	In advance of 111 Cwm Taf Health Board has implemented a "Phone First!" minor injuries service, this has had a positive impact in the Rhondda area and will be rolled out to all areas of the Health Board over the coming months. This service has resulted in a reduction in footfall at the Royal Glamorgan Hospital and has directed patients to other services – including pharmacies, self-help, and primary care services as an alternative to the emergency department. Patients are also re-directed from the main emergency departments to the two Health Board minor injury units and a varied communication campaign is being developed to encourage patients to use these services more frequently.	The "Phone First!" minor injuries service in Ysbyty Cwm Rhondda has evaluated and this has shown a reduced foot fall at the major emergency department, redirection of patients also occurs on a daily basis from the main emergency departments to both minor injury services. The Health Board is in the process of enhancing communication with the public to encourage re-direction to the minor injury services via a multi-faceted approach.
4b	The Welsh Government should take the following actions in relation to the 111 service: • as part of the decision-making process about the future of the 111 call service, come to a clear decision about the strategic direction of NHS Direct Wales; • develop a model for 111 that avoids all of the issues experienced in the English 111 service pilots; produce a detailed timeline setting out clear milestones that must be achieved	The Health Board in advance of the 111 development has implemented phone first minor injuries service, this is now being further enhanced with a multi faceted communication campaign and roll out.	As above. National OOH Forum has a desire to develop the integrated Phone First , Single Point of Access and OOHs service across Wales.

RECOMMENDATION		PLAN	EXAMPLES OF GOOD PRACTICE / WHERE SIGNIFICANT IMPROVEMENT HAS BEEN ACHIEVED
	before the final implementation of 111 in 2015; • ensure that the 111 service has supporting electronic systems to gather information on call case mix and volume to help contribute to a better understanding of unscheduled care demand and patients' urgent care needs; and • use the public communication campaign that will be needed to launch the new 111 service as an opportunity to communicate clearly and widely to the public about how best to access unscheduled care services.		
4c	The Welsh Ambulance Services NHS Trust should, as a matter of urgency, deliver transformation in the skill base of its staff so they have significantly stronger skills in assessing and referring patients.	The Health Board has worked with the WAST to develop pathways for specific conditions to reduce the number of conveyances. This has greatly enhanced the patient pathway and reduced conveyance rates, utilising community services as an alternative to admissions. Work continues to divert ambulances appropriately to the Health Board minor injury services. More detailed work is being undertaken to support nursing and residential homes in the localities, this work has commenced in the two largest homes with the aim to reduce unnecessary attendances.	The Health Board has commenced work with the two largest nursing / residential homes, alongside the WAST to reduce attendances and utilise community services as an alternative to conveyance to hospital.

RECOMMENDATION		PLAN	EXAMPLES OF GOOD PRACTICE / WHERE SIGNIFICANT IMPROVEMENT HAS BEEN ACHIEVED
5a	The Welsh Government should facilitate a Wales-wide exercise to share good practice, from Wales and further afield, in the use of Emergency Nurse Practitioners (ENPs).	Emergency nurse practitioners are based in and run both minor injury departments. ENPs also provide cover in both emergency departments. Training of new staff continues. The development of the advanced emergency practitioners further enhances the skills of senior nursing staff and enables a senior clinical role within the departments.	The ENP role within Cwm Taf is well embedded and has been further enhanced by the introduction of the advanced emergency practitioner role. This role has been developed and supports senior clinical nursing and paramedic staff to extend their emergency skills and work at a higher level within the department.
5b	Health boards should monitor their use of ENPs to ensure they are not routinely drawn into core nursing roles and they should ensure that ENP roles are fully considered in their workforce plans for unscheduled care.	ENPs have a separate rota to ensure they are not routinely drawn into the core nursing numbers within the departments. This rota spans minor injuries services as well as the emergency departments.	
5c	The Welsh Ambulance Services NHS Trust should, as a matter of urgency, deliver transformation in the skill base of its staff so they have significantly stronger skills in assessing and referring patients.		
5d	The Welsh Government should work with representative bodies and its counterparts across the United Kingdom to identify and address the root causes of recruitment and	Within Cwm Taf Health Board there have been developments to start to address some of the shortfalls in medical staff. The development of the advanced emergency practitioner role is the first in Wales and has demonstrated some	Within Cwm Taf Health Board there have been developments to start to address some of the shortfalls in medical staff working with colleagues to

	RECOMMENDATION	PLAN	EXAMPLES OF GOOD PRACTICE / WHERE SIGNIFICANT IMPROVEMENT HAS BEEN ACHIEVED
	retention problems in the emergency department and primary care out-of-hours services.	success in its early stages. Recruitment campaigns continue across the Health Board to ensure appropriate levels of staff at all times. Longer term locum posts as opposed to add hoc agency are used where at all possible. South Wales Programme is also looking at service redesign to develop more sustainable unscheduled care services across South Wales.	develop innovative opportunities for training. The development of the advanced emergency practitioner role is the first in Wales and has demonstrated some success ion its early stages.
5e	Based on local circumstances, health boards should consider revising their staffing models for unscheduled care services to include paramedics and nurses with extended decision-making skills. Health boards should also consider whether physicians and GPs can be used effectively in emergency departments to ease the recruitment and retention problems relating to middle-grade and consultant emergency medicine staff.	As above the development of the advanced emergency practitioner role has enabled both nurses and paramedics the opportunity to extend their clinical skills and work at a more advanced level within the emergency department. This innovative role will continue to be developed across the service. The introduction of increased numbers of acute care physicians has provided early senior clinical decision making, reducing the numbers of admissions and increasing the numbers of patients with a short (<48 hour) length of stay. It is the Health Boards intention to further enhance this workforce and redesign services to align the acute care physician with care of the elderly services. A review of out of hours services has been undertaken and alignment of GP service	The Out of Hours model is currently being redesigned. The aim of the new model is to integrate A&E and GP Out of Hours and will involve a multidisciplinary team working together (not alongside) each other to provide 'emergency' services. New pathway for acute exacerbation of COPD patients is being developed utilising the skills of APPs and referral to GP for follow-up therefore avoiding an acute admission.

RECOMMENDATION		PLAN	EXAMPLES OF GOOD PRACTICE / WHERE SIGNIFICANT IMPROVEMENT HAS BEEN ACHIEVED
		(especially out of hours) with the emergency departments is one of the proposed ways forward.	
5f	Given the increase in emergency department attendances from older patients, Health Boards should reassess the skill base of their staff for meeting the needs of older people.	Alongside the above changes to medical staffing, nursing and therapy staffing has been enhanced to meet the needs of the increase in elderly attendances. Therapy staff are closely linked to the reablement and local authority services providing important links to community based services.	
5g	Health boards should assess the levels and causes of stress within emergency department staff, with a view to protecting and supporting the workforce.	A specific staff survey has been undertaken in one of the two emergency departments and face to face interviews have been undertaken by the organisational development team, this is planned for the second of the two areas in the next month. Dedicated work to address some of the issues raised has been successful and close monitoring of staff sickness and absence continues to ensure early support during times of high activity. The OD team has worked closely with the emergency department team to identify areas of potential "stress".	
6a	Work with GPs to agree local standards for access to urgent primary care; and once agreed the extent to which these standards are achieved should be routinely monitored.	The Health Board has established an access group for general practice, which is reviewing opening hours, and access to urgent primary care. This group will set and monitor standards through practice visits and patient experience surveys.	Activity in out of hours is assessed regularly at the Access Improvement group and correlated against access in hours

RECOMMENDATION		PLAN	EXAMPLES OF GOOD PRACTICE / WHERE SIGNIFICANT IMPROVEMENT HAS BEEN ACHIEVED
		A new model for out of hours services is being considered which will align general practitioners with the emergency departments.	Development of new out of hours model has commenced. In the early stages of design.
6b	Strongly encourage general practices to implement access arrangements that reflect good practice. In doing so, Health Boards should highlight the benefits that these good practices can bring to patients as well as to those working in general practice.	As above	New Access LES has been developed which will encourage practices to assess demand and need and to produce 3 year implementation plans. Implementation of DNA policy
6c	Strengthen the support, guidance and information they give to GPs in order to avoid inappropriate emergency admissions.	The Health Board primary care services work alongside the locality services and are fully involved in the development of at home services, reablement and district nursing services. Home IV services have provided an alternative to long stay admissions, and collaborative work with nursing and residential homes is proving successful.	Q&A service has been developed for Cardiology, ENT, Paediatric, and Respiratory Specialities and enables GPs to email queries to the consultant regarding specific patients prior to referral.
6d	Request that GPs provide them with data on their capacity and demand for seeing patients within the practice. Health boards should work with primary care providers to ensure these data are analysed and used to improve services.	This work is being undertaken by the access group for primary care and reports via the operational board on a monthly basis. Feedback is provided to General Practices via the locality cluster groups by the relevant locality clinical director.	GP Demand and activity in-hours is now being submitted to the Health Board on a weekly basis. In July & August the out of hours service saw a drop in demand of approximately 1000 patients as a result of a slight

RECOMMENDATION		PLAN	EXAMPLES OF GOOD PRACTICE / WHERE SIGNIFICANT IMPROVEMENT HAS BEEN ACHIEVED
		General practices have access to Myrddin data related to emergency department attendances.	change in the 'front end' messaging system. Ongoing monitoring is continuing to take place.
7a	Health boards should facilitate improved teamwork and mutual support between key staff groups involved in unscheduled care. This work should focus, in particular, on generating more shared ownership of the pressures and patient flow issues that exist in emergency departments by improving the links between staff in emergency departments, Clinical Decision Units (CDUs) and inpatient ward teams.	All possible opportunities to improve team work across the range of Health Board services is utilised to ensure staff at all levels and across all areas understand that the pressures in the emergency department are a symptom of the whole system. Clinical director meetings have a standard item on patient flow. The revised escalation policy looks at levels of escalation across the service not just the emergency department. Ward areas including the community hospitals will have a suite of indicators that will relate to their individual patient flow improvement. The Health Board has reconfigured its nursing structure to focus on site based senior nurse presence this has resulted in the development of twice daily hospital wide bed meetings, engaging all areas of the site. This has resulted in shared ownership of the pressure and focus on a system wide solution.	The Health Board has reconfigured its nursing structure to focus on site based senior nurse presence this has resulted in the development of twice daily hospital wide bed meetings, engaging all areas of the site. This has resulted in shared ownership of the pressure and focus on a system wide solution.
7b	The Welsh Government's Department of Health and Social Services should lead a specific programme of work to support better integration of health and social care with the aim of	The Health Board has forged improved relationships with social services. Work is ongoing to improve implementation of the choice protocol, both local authorities are align to the Health Board escalation plans and	Task and finish group has been established to take forward the implementation of the new Integrated Assessment. This group comprises health and

RECOMMENDATION		PLAN	EXAMPLES OF GOOD PRACTICE / WHERE SIGNIFICANT IMPROVEMENT HAS BEEN ACHIEVED
	ensuring the timely discharge of patients that are ready to be discharged from hospital. This programme should use the forthcoming Social Services and Well-being (Wales) Bill as a key driver for change but it should not wait for the bill to be enacted.	respond positively to high levels of activity. Joint working in relation to reablement and other community services continues.	local authority leads and is supported by the project manager for integration.

MEETING	Health Board
DATE	4 September 2013
RESPONSIBLE DIRECTOR	Chief Operating Officer
STANDARD FOR HEALTH SERVICES REFERENCE	Safe and Clinically Effective Care (7) Care Planning and provision (8)

TITLE OF REPORT

"Phone First!" – Minor Injuries Service – Evaluation Report

SITUATION / PURPOSE OF REPORT

This report provides the Board with information following the evaluation of the Phone First! Minor Injuries Service at Ysbyty Cwm Rhondda and seeks support to roll out the approach to Ysbyty Cwm Cynon and across the Cwm Taf area.

BACKGROUND / INTRODUCTION

Board members will be aware that the Minor Injuries Unit at Ysbyty Cwm Rhondda was temporarily closed in October 2011 in order to ensure that the Health Board had the right level of support available to the A&E department at the Royal Glamorgan Hospital whilst we recruited additional staff.

The Health Board was faced with a serious shortage of doctors at the Royal Glamorgan Hospital's A&E department, threatening the viability of the unit and we chose to transfer the emergency nurse practitioners working in the Minor Injuries Unit to improve safety and patient care at the Royal Glamorgan Hospital. This was the most appropriate short-term solution and at the time of the closure, we made the commitment to patients that it would only be a temporary measure. This temporary closure provided an opportunity to remodel the service and attempt to minimise inappropriate attendances by sign posting patients to the most appropriate setting.

During the temporary closure we worked with the staff at both departments to develop a new and innovative Phone First! service model to ensure sustainable services into the future and to ensure that we are getting the **right patient to the right place for the right care by the right clinician in the most timely manner**.

On Monday 14 May 2012, the Minor Injury Treatment Centre at Ysbyty Cwm Rhondda became operational on the Phone First! pilot basis and evaluation of the pilot project started from day one. This report illustrates the results of the evaluation and demonstrates that the pilot project has been well received by the public and staff involved. It highlights a number of areas where further work is required and also sets out a proposal to expand the pilot project to other sites within Cwm Taf.

The service provided by the Minor Injury Treatment Centre compliments and supports the GP LES scheme and the Choose Well campaign that was recently re-launched by the Welsh Government.

THE EVALUATION

As stated above, the Phone First! pilot project has been evaluated since it was established and an interim evaluation report was considered by the Board at its October 2012 meeting. This report builds on the initial evaluation and provides an analysis of a number of aspects up to 31 December 2012. The evaluation report included as **Appendix 1** sets out the following: -

- Contacts with Phone First! and the outcome of the initial patient triage;
- Activity at the Minor Injuries Treatment Centre at Ysbyty Cwm Rhondda;
- Activity at the Minor Injuries Unit at Ysbyty Cwm Cynon;
- Analysis of patient safety incidents and concerns;
- Staffing profile and financial analysis;
- Possible impact on the accident & emergency departments at the Royal Glamorgan Hospital and Prince Charles Hospital;
- Activity and costs associated with the GP Local Enhanced Services in the Rhondda area;
- Patient satisfaction survey outcomes;
- Equality impact assessment and risks;
- Communications activity and future plans.

ASSESSMENT OF GOVERNANCE AND RISK ISSUES

The new approach has been well received by the local population and the Community Health Council with very few negative comments received to date. The new approach is seen as an innovative and sustainable way to ensure that we continue to provide safe and effective services to the population and get the right patient to the right place for the right care by the right clinicians in the most timely manner.

One area of concern relates to the ability of NHS Direct Wales to agree that it will accept responsibility for the anticipated additional activity. To date there has been no cost to the Health Board for the service provided

by NHS Direct Wales but this position is not felt to be sustainable. Contact has been made with the Welsh Ambulance Services NHS Trust to discuss the proposals for expanding the Phone First! service but it has not proved possible to meet and agree the best approach to suit both parties.

The Health Board could consider the possibility that the triage is done in-house by the Nurse Practitioners but this option would need to be considered further and costed to ensure that it was a viable option that would work across the whole of the Health Board.

CONCLUSION AND NEXT STEPS

The initial evaluation has been very positive about the impact of the Phone First! approach and the Health Board needs to now consider the roll out of the approach across the Cwm Taf area. This would involve: -

- expanding the Phone First! approach across the YCC minor injuries unit;
- considering the use of the approach to manage minor injury patients who present at both A&E departments;
- changing the opening times at the MITC to align with the times of highest demand;
- reviewing the availability of support service such as the plaster rooms and radiology departments;
- consider the provision of an in-house telephone triage service

RECOMMENDATION

The Board is therefore asked to: -

- Note the evaluation of the Phone First! Minor Injuries Service at Ysbyty Cwm Rhondda;

- Note that the evaluation report and the next steps were discussed with the Community Health Council at its meeting in July 2013;

- Support the expansion of the Phone First! approach to the YCC minor injuries unit;

- Support the establishment of a Task & Finish Group to consider the use of the approach to manage minor injury patients who present at both A&E departments.

APPENDIX 1

PHONE FIRST! – MINOR INJURIES SERVICE EVALUATION REPORT

PHONE FIRST!

At the heart of the new minor injuries treatment service is a new concept – Phone First! - instead of simply turning up at the Minor Injuries Unit, patients now phone ahead on a dedicated number. Patients are then assessed by staff experienced in telephone triage and directed to the most appropriate service for their injury. This telephone triage service is provided by NHS Direct Wales and is undertaken by Emergency Nurse Practitioners (ENP).

Those patients suitable to be treated at the Minor Injuries Treatment Centre are then given an appointment time – this means they are not waiting to be seen but can attend at a convenient time for them during the week-day opening hours.

Patients who can appropriately and safely look after their condition themselves are given self-care advice. In some instances where patients would be better seen at a GP practice under the Local Enhanced Service Scheme, the relevant practice is contacted and the patient is referred.

It might also be appropriate to re-direct the patient to their nearest A&E department and, in a small number of cases, an emergency ambulance has been required.

The new Phone First! system means that only those patients who are suitable to be seen by the Minor Injuries Treatment Centre are directed there for treatment at a time which is convenient for them. In the past there had been incidences when genuine emergencies and patients who needed A&E treatment had instead come to the minor injuries unit.

During the period 14 May 2012 to 31 December 2012, the Phone First! minor injuries treatment service received 3,695 calls - an average of 109 calls a week. Of these:

- 1,404 (38%) were given an appointment to attend the Minor Injuries Treatment Centre at Ysbyty Cwm Rhondda to receive treatment from an emergency nurse practitioner;

- 824 (22%) were re-directed to A&E for urgent treatment;

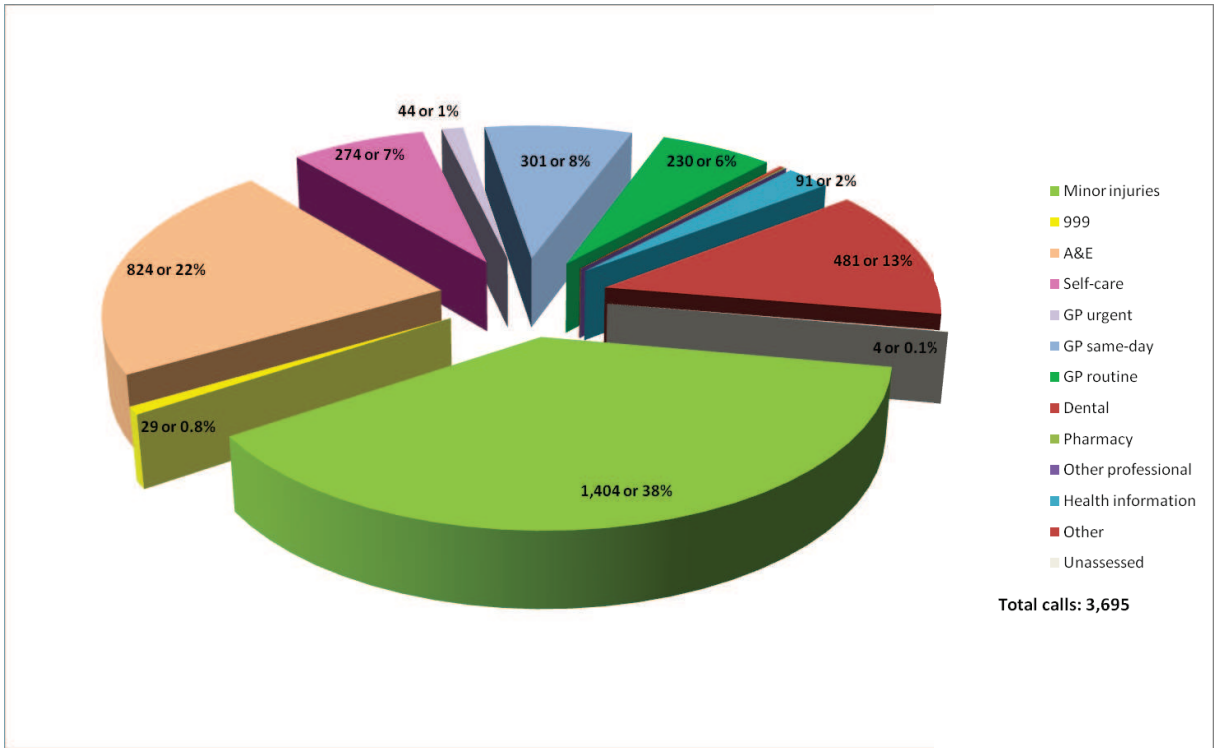
- 575 (15%) were referred to their GP for care. 44 people needed urgent GP care; 301 were suitable for same-day GP care and the remaining 230 needed routine GP care;

- 589 (16%) were referred to other sources of help, including their dentists, to their local pharmacy or another professional, such as a midwife, social worker or police officer, or they were given health information during the call;

- 274 (7%) were given advice about self-care;

- 29 (0.8%) were triaged as having a serious illness or injury which needed a 999 emergency ambulance response.

In summary, five out of 10 calls to Phone First! continue to be safely triaged away from the minor injuries service or A&E department to more appropriate sources of care thereby ensuring patients were seen by the right person, at the right time, in the right place.



Some initial teething problems were experienced including problems with the phone lines, Bank Holiday messaging, the percentage of abandoned calls and arrangements for the receipt of faxes. These problems have been largely addressed and business continuity plans have now being finalised to ensure that the service can be maintained in the event of phone line failure.

MINOR INJURIES TREATMENT CENTRE AT YSBYTY CWM RHONDDA

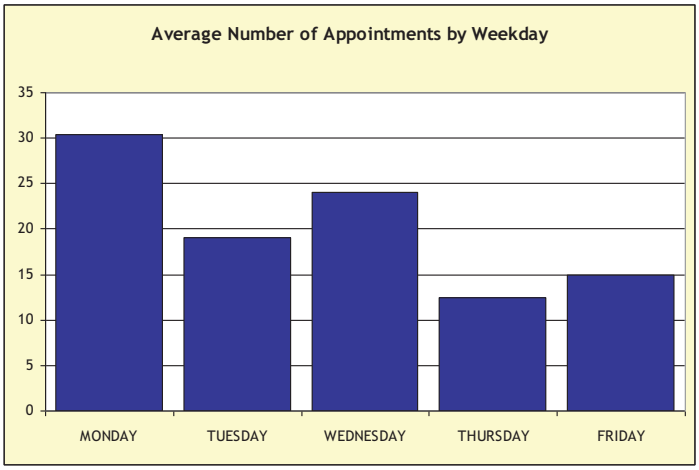
The Minor Injuries Treatment Centre (MITC) at Ysbyty Cwm Rhondda is open Monday to Friday between 9am and 5pm and has been operational since 14 May 2012. As mentioned above, since that date Phone First! has

referred 1,404 (38%) patients for an appointment to attend the MITC and 94% of these appointments have been kept by the patients.

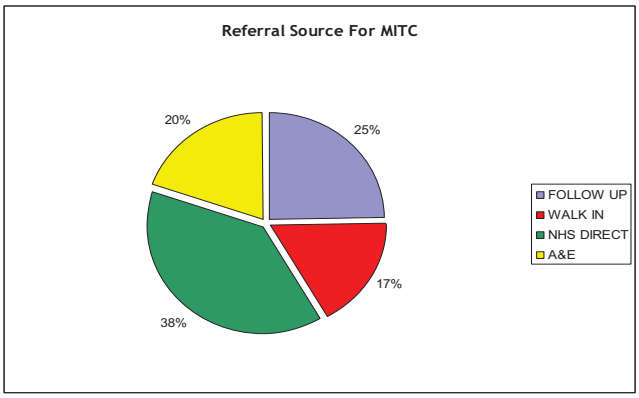
Patients attend the MITC with a wide range of injuries including animal, insect and human bites, needlestick injuries, broken bones, limb injuries, burns, facial injuries, foreign bodies in eye, ear, nose and skin, head injuries, eye injuries, genital trauma, wounds, and wound infections.

In addition to the patients referred via Phone First!, the MITC will see patients with follow up appointments, walk in patients and referrals from the A&E department at the Royal Glamorgan Hospital.

The total number of patients seen during the period is 6,047 and the average number of appointments has risen from 95 per week during the initial evaluation period to 101 per week and as before, the busiest day is Monday – see chart.



As before, the most common source of referral to the Minor Injuries Treatment Centre is NHS Direct Wales, although this has fallen from 50% during the initial evaluation period to 38%. The largest increase has been in the number of referrals from the A&E department at the Royal Glamorgan Hospital which have risen from 8% to 20%.



The number of walk-in patients continues to be an issue and the staff within the MITC will see an individual on the first occasion and then provide advice on how to appropriately access the service in the future. Further work needs to be undertaken to address this matter and to audit whether walk in patients are attending more than once.

The area covered by Phone First! has been expanded to include the Pontypridd and Llantrisant areas and a percentage of those attending live outside of the Rhondda Valleys - patients from Blackmill, Ogmore Valley, Cowbridge and Pentyrch have accessed the service.

Patients with a minor injury who attend the A&E department at the Royal Glamorgan Hospital are being redirected to the MITC when appropriate. Continued efforts need to be made to ensure that all appropriate patients are referred to the MITC by the A&E department and the Head of Nursing is working with the staff at both units to take this forward. The messaging within the A&E department has been strengthened to ensure that all patients know the most appropriate and timely pathway available.

From the evaluation above it is clear that the MITC is busiest on a Monday and Wednesday with lower numbers attending on Thursday and Friday. An average of 20 patients a day are seen in the MITC and it is accepted that there is capacity to see additional patients within the unit. The maximum number that could be seen within the unit is a day is 44 patients. This issue is considered further as part of the proposals to roll out the Phone First! concept across the Cwm Taf area.

MINOR INJURIES UNIT AT YSBYTY CWM CYNON

The Minor Injuries Unit at Ysbyty Cwm Cynon provides a walk-in service to the population of the Cynon Valley and Merthyr Tydfil. The service is open Monday to Friday between 9am and 5pm. Between May and 31 December 2012 the unit treated 5,288 patients – 4,109 new patients and 1,179 follow up patients.

No further analysis of the activity within the unit has been undertaken to date, although it should be noted that a comparison in respect of the cost of the service compared to the Phone First! approach is included later in the report.

PATIENT SAFETY INCIDENTS AND CONCERNS

The evaluation considered the reported patient safety incidents at the MITC at YCR and YCC during the period of the review. It was noted that nine incidents had been reported in respect of YCR and one in respect of YCC during the period and the details for each incident are set out below.

Ysbyty Cwm Rhondda

Incident 1 – Communication

Details - Patient referred to the MITC from NHS Direct Wales with chest pain and upper back pain and had been seen by her GP the previous day. The patient had been triaged fully at NHS Direct Wales and the disposition had stated A&E immediately. This advice had been over-ridden by the call handler and had also been discussed with the shift lead. The patient had been informed to make her way to MITC.

Outcome – On receipt of the fax from NHSD the receptionist at the MITC called NHS Direct Wales and informed it MITC did not take life-threatening emergencies. The receptionist spoke with the shift lead and was informed the patient had become verbally distressed and abusive, stating that she lived near the MITC and could attend immediately and didn't want to attend A&E. The ENP at the MITC then called NHS Direct Wales and stressed the importance of referring patients appropriately. The patient was then called back and redirected to A&E. The patient had her own transport

Incident 2 - Other

A patient arrived at the hospital looking for the Minor Injuries Unit. Staff were initially unable to contact the reception at the MITC so allowed the patient to phone the designated number where, after eight minutes, they were still on hold. Patient was then put through to MITC internally where they spoke to the reception staff. The receptionist advised that the patient needed to phone the designated number again. Staff tried again and the patient was on hold 10 minutes. The sister in charge advised the patient to put down the phone and arranged for someone in the MITC to speak to them. When, after half an hour, no one had arrived from the MITC, staff went over to the unit. Eventually someone was able to leave the MITC to speak to the patient and advised them that they didn't meet the criteria to be seen in the MITC. The patient then had to leave after being on the premises for more than 1½ hours without seeing any one.

Incident 3 - Delays

An ambulance was called to take an unwell patient from the MITC to the A&E department at the RGH at 4pm as the patient had some facial numbness and drooping of the eyelid. An ambulance attended at 6.50pm. Ambulance control was contacted three times and the urgency was explained to officers. The patient was continually monitored in department.

Incident 4 – Patient Injury

The automatic door at the MITC hit a patient's foot when she was waiting to enter the unit. The patient was attending the MITC with a separate problem and was then assessed and treated for the injury. Notices were placed on the doors to warn patients that they opened outwards and all patients waiting are told by receptionist.

Incident 5 - Admission / Transfer / Discharge

A patient was referred from the out of hours centre at YCR with shortness of breath. Patient was let into the MITC and spoke to receptionist who called an ENP for advice. Patient was informed of MITC remit by the receptionist and chose to leave the department with his wife, to attend the A&E department, before being seen by the ENP.

Incident 6 - Delays

A patient was brought to the MITC by the porters following a call from the general office. Patient had a wound to the forehead and was assessed and deemed to require treatment at the A&E department. An ambulance was requested at 2.40pm and it arrived at 4.35pm. Ambulance control was contacted three times to try to expedite the ambulance. Wound to forehead sutured and analgesia given.

Incident 7 – Patient External Transport

A patient came to the MITC suffering an asthma attack and was extremely short of breath. Patient was given immediate treatment and an ambulance was called to transfer the patient to the A&E department. The ambulance took 50 minutes to arrive at the MITC.

Incident 8 – Organisational / Staffing issues

Nurse practitioner asked to work at Prince Charles Hospital A&E department leaving one ENP, a bank nurse and a (supernumery) training nurse practitioner at the MITC. The agreed staffing levels are two ENPs and a band three HCA. Only half the appointments were therefore available that day.

Incident 9 – Organisational / Staffing issues

Qualified nurse was asked to work at Prince Charles Hospital A&E department leaving one ENP in the MITC. The agreed staffing levels are two ENPs and a Band three HCA. Only half the appointments were therefore available that day.

Ysbyty Cwm Cynon

Incident 1 – Patient Injury

While removing a below-the-knee DCC cast it was noted that there was no stockinette next to the skin. The plaster saw touched the patient's skin causing a superficial laceration to the lower leg. No dressing was required. The patient's carer was informed and shown the area.

Concerns

To date only one formal concern has been raised about the new approach and this related to the attitude of staff at the A&E department when a patient attended there inappropriately rather than accessing services at the MITC using "Phone First!". An informal concern relating to access was raised via an Assembly Member and this related to a patient who was seen in the first week of the new service. Both concerns have allowed the departments to refine their processes and no further concerns had been raised at time of writing the report.

Conclusion

The incidents reported at the MITC at YCR illustrate two key points: -

- There continues to be a need to raise awareness of the minor injuries that can be treated at the MITC and this is addressed as part of the communications plan set out later in this evaluation report.

- There continues to be a delay when ambulances are called to the unit and this has been discussed with the Welsh Ambulance Services NHS Trust and will be closely monitored.

ACCIDENT & EMERGENCY DEPARTMENT AT THE ROYAL GLAMORGAN HOSPITAL

The figures set out overleaf relate to the number of patients attending the Emergency Care Centre at Prince Charles Hospital (PCH) and the A&E department at the Royal Glamorgan Hospital (RGH) over the same period during 2011-12 and 2012-13.

Emergency Care Centre PCH

Month	2011-12	2012-13	Variance
May	4873	5247	374
June	4865	5043	178
July	5169	5324	155
August	4863	4972	109
September	4730	4881	151
October	4568	5001	433
November	4440	4653	213
December	4656	4703	47
January	4838	4537	-301
TOTALS	**43002**	**44361**	**1359**

A&E department Royal Glamorgan Hospital

Month	2011-12	2012-13	Variance
May	5306	5821	515
June	5189	5585	396
July	5405	5675	270
August	5186	5354	168
September	5206	5482	276
October	5852	5338	-514
November	5806	4950	-856
December	5641	5005	-636
January	5815	4886	-929
TOTALS	**49406**	**48096**	**-1310**

The table above illustrate that the Emergency Care Centre at PCH saw an increase of 1,359 patients during the period whilst the A&E department at the RGH saw a reduction of 1,310 in the number of patients seen.

One explanation could be that the Phone First! approach for minor injuries is having a positive impact on the provision of services at the A&E department in the Royal Glamorgan Hospital. As mentioned earlier, five out of 10 calls to Phone First! continue to be safely triaged away from the minor injuries service or A&E department to more appropriate sources of care thereby ensuring patients were seen by the right person, at the right time, in the right place.

No other rationale for the overall reduction in the patients seen at the RGH A&E department has been highlighted although it should be noted that further work needs to be undertaken to measure and confirm this impact.

GP LOCAL ENHANCED SERVICES (LES) SCHEME

The Phone First! approach is supported by the GP Local Enhanced Service (LES) Scheme for minor injuries which means that the practice has agreed to provide wound care and minor injuries services for its patients or as part of an affiliation with other practices in the area. Not all parts of the Rhondda are covered by a GP LES Scheme with eight practices included at the present time. The Locality Team continues to work with primary care colleagues to further implement the GP LES Scheme.

Only surgery-based services for ambulatory patients in the categories below will be covered by the LES: -

1. Requests for removal of sutures, where the operative procedure and insertion of the sutures was performed outside general medical practice as a consequence of a referral to, or ongoing care by, secondary care services, and where it is either inconvenient or undesirable for the patient to attend at hospital.

2. Requests for wound dressing where the operative procedure was performed outside general medical practice as a consequence of a referral to, or on-going care by, secondary care services, and where it is either inconvenient or undesirable for the patient to attend at hospital.

3. A minor injury service would cover the following treatments:

    (i) lacerations capable of closure by stripping
    (ii) bruises
    (iii) following recent injury of a severity not amenable to simple domestic first aid
    (iv) partial thickness thermal burns or scalds involving broken skin not over one inch diameter not involving the hands, feet, face, neck, genital areas
    (v) foreign bodies superficially embedded in tissues
    (vi) minor trauma to hands, limbs or feet

Only accredited persons will actually provide wound care and minor injuries on behalf of the practice.

A number of issues have been highlighted with the GP LES scheme over recent weeks and these include lack of awareness within the practice, inappropriate referrals from the GP to the MITC, availability of staff within the practice to undertake the LES scheme and difficulty obtaining appointments at the practices.

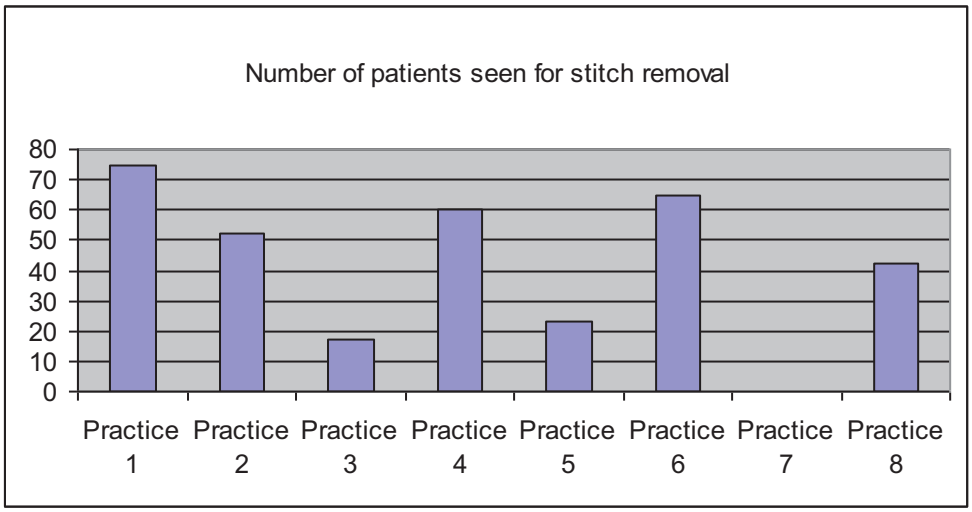
These issues are being discussed with the GPs, at the Practice Managers Forum and with other practice staff to ensure that the GP LES scheme is

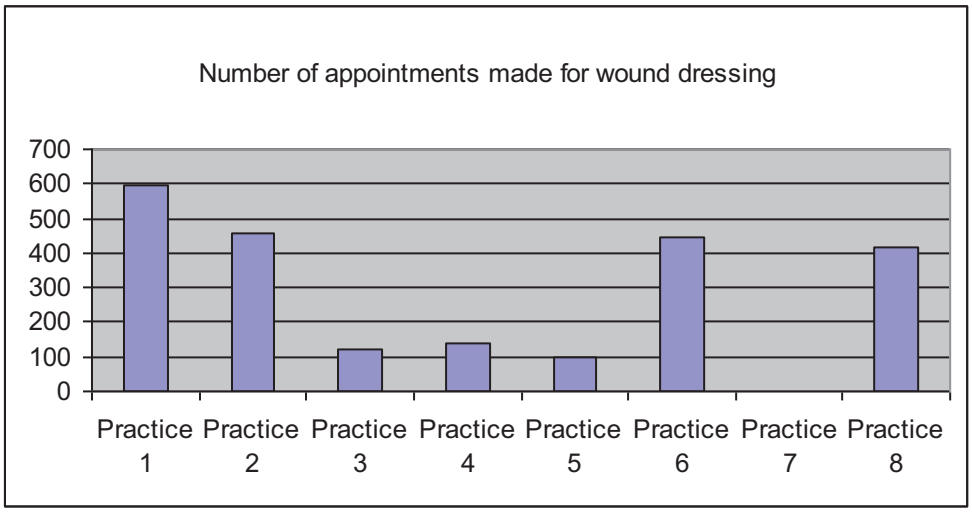
operating effectively in support of the Phone First! approach. Staff within the MITC support individual patients through the process and make direct contact with the practices when appropriate.

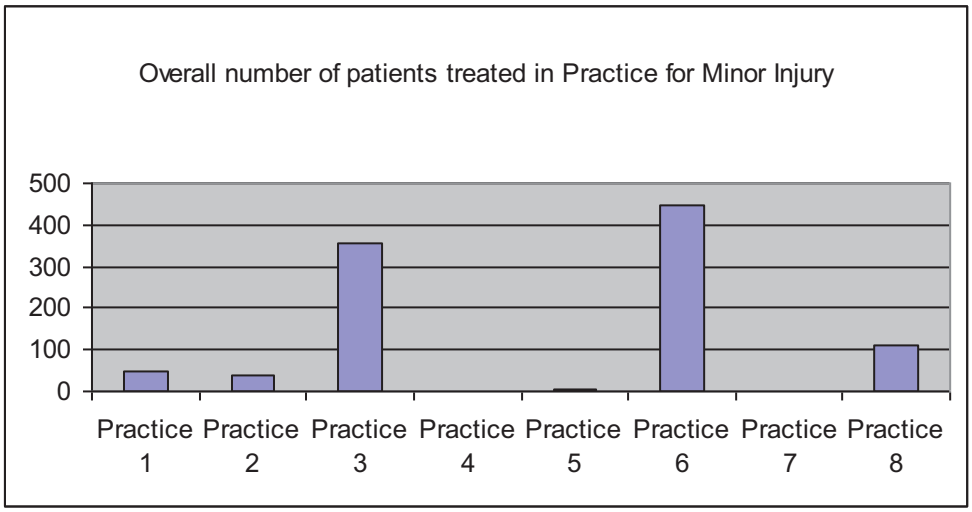
The Locality Team has undertaken practice visits and information is now available from seven of the eight practices in respect of the LES scheme. It should be noted however that further work is needed to ensure that the information collected to date is robust and to ensure that the one practice returns the required activity data. The activity levels at some practices seem much higher than for others but this may not mean that the practice has not seen the numbers of patients. The way that the information has been recorded requires uniformity and this work is underway.

The charts below illustrate: -

- The number of patients seen for stitch removal;
- The number of appointments made for wound dressings;
- The number of patients treated for a minor injury.







The cost to the Health Board for the GP LES scheme in the Rhondda Locality is £39,085 per annum. This figure does include stitching as the LES scheme is for minor injuries and wound care only. It should be noted that the funding comes from the GMS budget and careful consideration may need to be given to using the money to provide the service in a different way within the primary care setting.

It should be noted also that the cost of the GP LES scheme across the whole of Cwm Taf is in excess of £200k per annum. Should the Health Board consider the provision of a different model for minor injury services in primary care this would need to be replicated across the Health Board.

PATIENT SATISFACTION

Discussion following the initial evaluation report concluded that further surveys needed to be undertaken to ensure that the views of patients who were redirected away from the MITC were taken into account. We have therefore attempted to gain feedback from three groups of patients: -

- Those who attended the MITC at YCR
- Those who attended the A&E department at the Royal Glamorgan Hospital with a minor injuries deemed suitable to be seen at the MITC
- Those redirected to other services by NHS Direct following the initial call to the Phone First! number

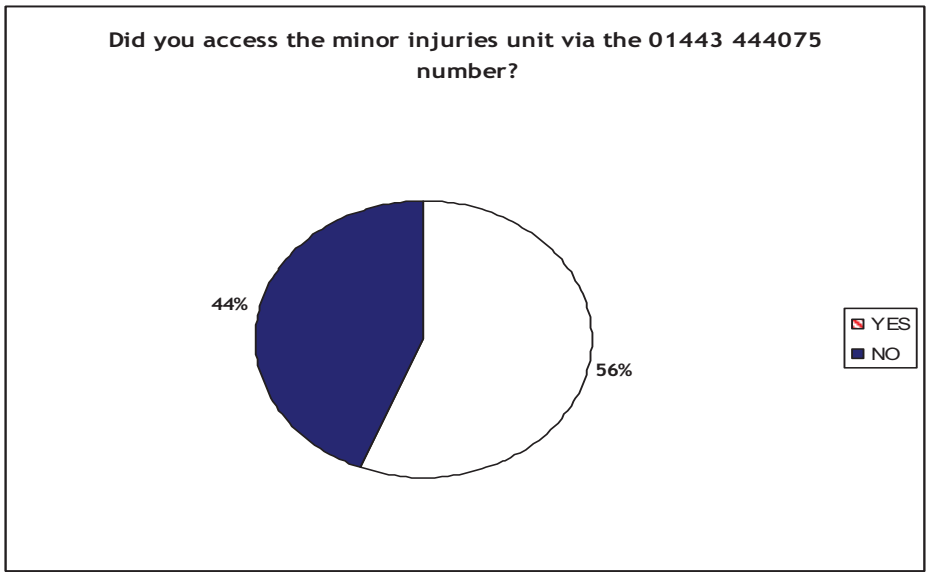
Ysbyty Cwm Rhondda

As part of the evaluation of the Phone First! approach it was agreed that all patients attending the MITC would be asked to complete a satisfaction survey. Generally patient satisfaction with the service is high, with two patients commenting:

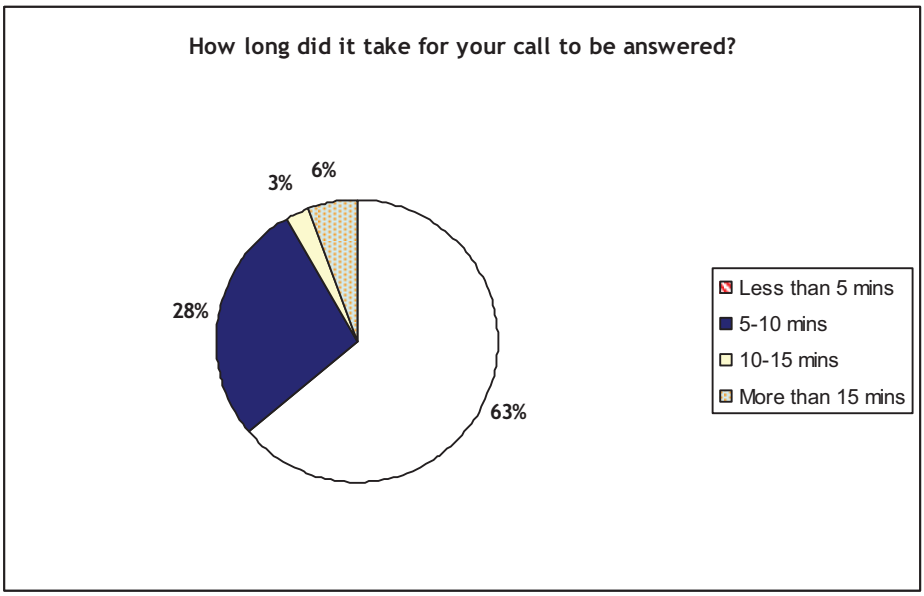
"Fantastic service from first phone call all the way through."

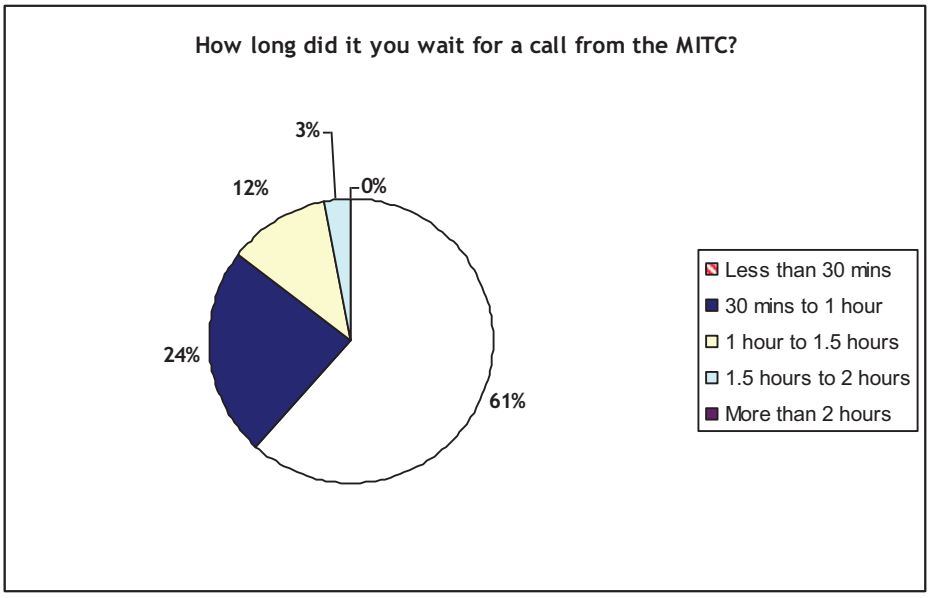
"Excellent service from start to finish."

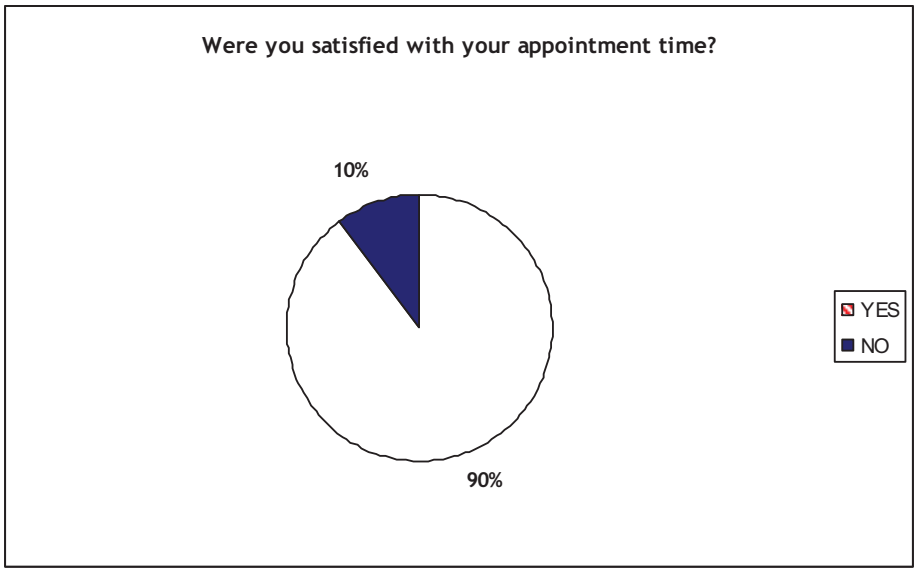
Nevertheless the level of satisfaction was not as high as the previous evaluation and the number of negative comments was higher. The outcome of the evaluation is illustrated in the charts that follow.



56% accessed the service with the 01443 444 075 number. This was a fall from 74% in the June analysis. 12 patients walked in, eight were referred from the Royal Glamorgan Hospital A&E department and one was referred by their GP. Two of those who rang first were given the number by, in one case, their GP and, in the other, an unspecified hospital. One patient who walked in stated that they did not know that they had to call first.







Five patients were not satisfied and commented: -

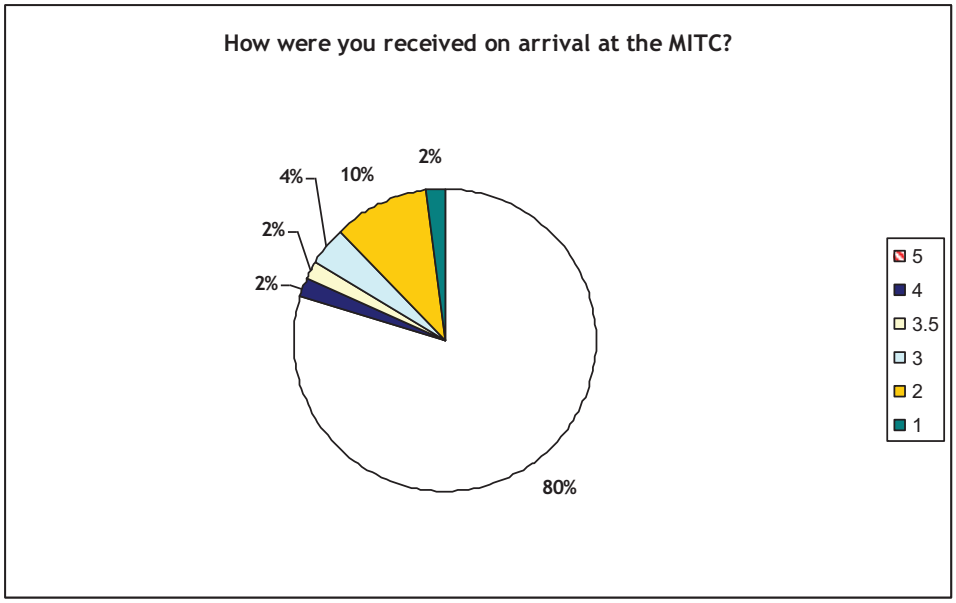
"Had to wait until next day as gone half past four."

"Had to go to Royal Glamorgan then Minor Injuries not happy."

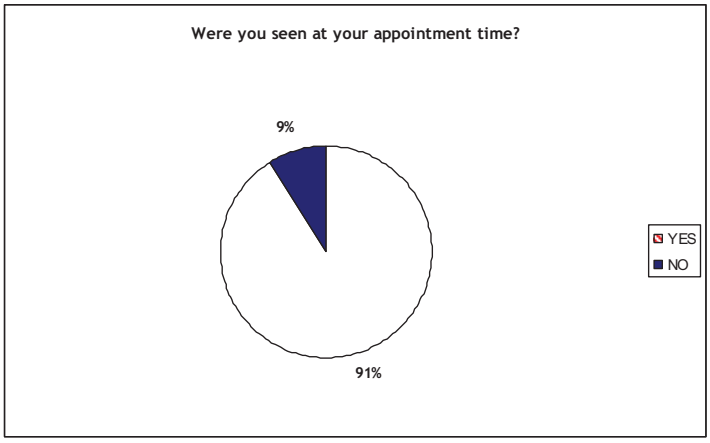
"Minor Injuries yes, being sent elsewhere no."

"I live in Pontypridd and was told I was out of area. Had to go to Royal Glamorgan who were very busy they referred me back to YCR."

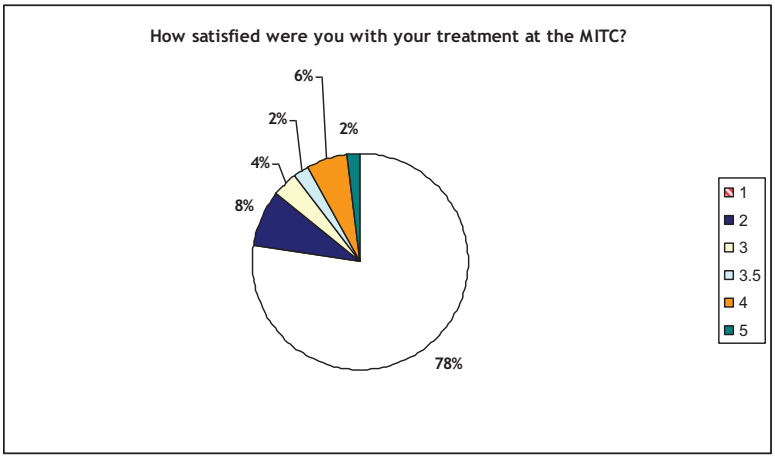
"I first phoned at 9.30 and finally got an appointment at 12.30. Appointment time was 2.20."



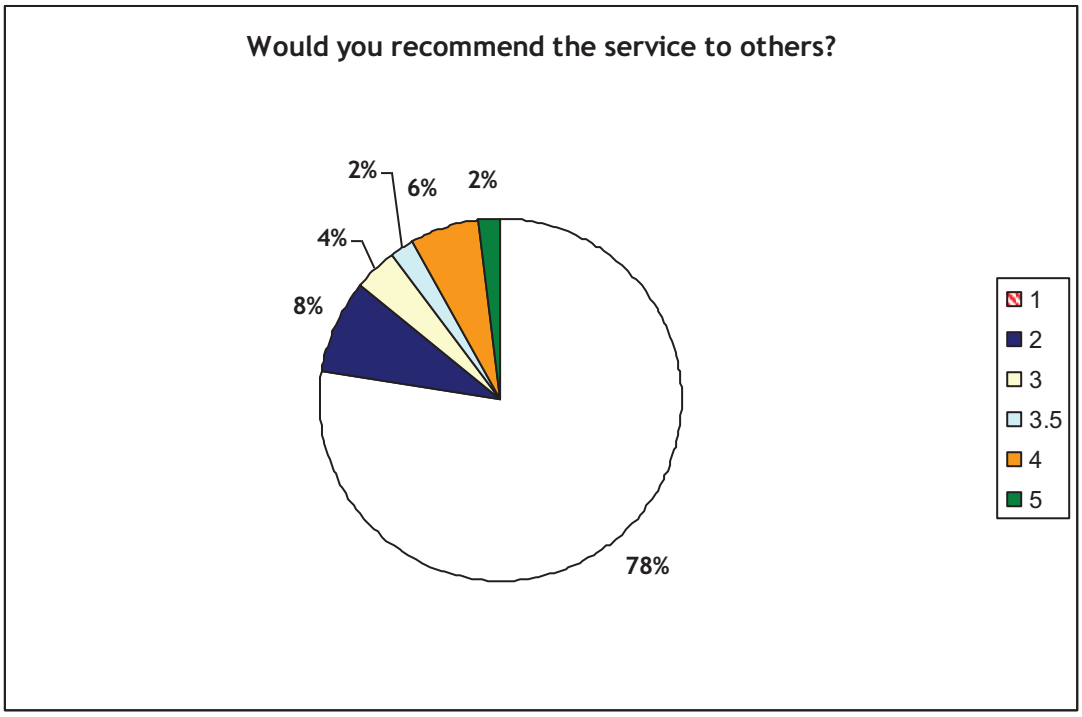
(Scale 1-5: 5= Very well, 1= Unsatisfactory) The 3.5 is for a patient scoring 3 & 4



One patient was not seen on time as they arrived late. They are not included in the above figures. One noted that the appointment was only 10 minutes late and rated the service as excellent.



(Scale 1-5: 1= Very well, 5= Unsatisfactory) The 3.5 is for a patient scoring 3 & 4.



(Scale 1-5: 1= Excellent, 5= Unsatisfactory) The 3.5 is for a patient scoring 3 & 4.

One patient scored the service as one and five, making it clear that the service at YCR was excellent but that they were not happy to be redirected from the Royal Glamorgan Hospital.

A&E department, Royal Glamorgan Hospital

In addition to the patient satisfaction survey at the MITC, patients suitable to be redirected from the A&E department at the Royal Glamorgan Hospital following triage were asked for their views. The patients included in the survey were those identified as category green (four - standard) or blue (five - non urgent) as per the Manchester Triage System. The tables below give an illustration of the patients surveyed over a two week period in October 2012.

Number of forms completed	371
Number of patients redirected to the MITC at YCR	74
Number of patients redirected to the GP Out of Hours Service	12
Number of patients redirected to their GP	11
Number of patients redirected to dental services	2
Number of patients redirected to the eye clinic	1
TOTAL NUMBER REDIRECTED	**100**

The triage nurses felt also that a number of other patients could have been redirected but this was not possible for the following reasons: -

91	Patients presented out of the opening times for the MITC
61	Patients did not have transport to get up to MITC
4	No appointments available at the MITC
1	Patient was not able to get a GP appointment
1	Patient not registered with a GP
3	Patients had been sent to the A&E Department by a GP
161	**TOTAL NUMBER SUITABLE but redirection not possible**

In summary, during the period of the survey, out of the 371 patients triaged as green or blue, 216 were identified as suitable for redirection from the A&E department to the MITC.

While this survey was undertaken over a relatively short period of time, it illustrates that there is potential to redirect patients away from the A&E department thereby reducing the waiting times and increasing the level of patient satisfaction with the service provided. The Health Board needs to encourage the development of this new and innovative Phone First! service model across the Cwm Taf area to ensure sustainable services into the future. It is important that we ensure that we are getting the right patient to the right place for the right care by the right clinician in the most timely manner.

NHS Direct Patient Survey

Following discussion with NHS Direct it was agreed that those patients who accessed the Phone First number and were then signposted away from the MITC would be contacted and asked to complete a patient satisfaction survey. This survey took place over a three week period during February / March 2013.

It should be noted that NHS Direct made one attempt to contact each caller and the following patients were excluded during the survey: -

- Anyone who had been transferred to the 999 emergency services
- Patients under 18 who were calling for themselves
- Calls where a child protection or POVA issue arose during the original call and referral was made without consent.

Feedback has now been provided in respect of the following areas and is set out in the table at the Appendix 1(a): -

- Date of contacts
- Injury/condition
- Recommended level of care
- Date of call back
- Compliance with advice
- Service rating

- Treated with respect during the call
- What could be done to improve the service

EQUALITY IMPACT ASSESSMENT AND ASSOCIATED RISKS

While the creation of the Phone First service for minor injuries in the Rhondda locality is deemed to have been a positive development to generally improve the efficiency and efficacy of service provision, it should be recognised that the service inadvertently disadvantages those who are deaf or hard of hearing, people with learning disabilities or those who speak other languages. Consequently discussions have taken place, initially with deaf club members, about their general and often unique difficulties in accessing NHS services in order to fully appreciate and consider appropriate solutions relating to telephone based services.

There is clearly a need for an all-Wales approach to address the wider difficulties of access issues which are supported by the Equality Act 2010; the Public Sector Equality Duties Wales; and the Accessible Healthcare for People with Sensory Loss Report. In this regard links have been established with the South Wales Programme to explore a joint approach and: -

"*It was agreed the South Wales Programme offered an opportunity to do an equality impact assessment in a new and different way—working together as health boards, not only to understand the impact, but to make a real difference for people who already have significant barriers to accessing services."* - South Wales Programme - News Update - 15 February 2013

Consequently there is due regard in relation to the impact of such telephone based service developments, and progress is being made to not only mitigate such disadvantage, but also to make real difference. It is intended that this work will then in turn raise general appreciation and understanding of any disadvantages experienced by other protected characteristics.

COMMUNICATIONS ACTIVITY AND FUTURE PLANS

The delivery of a comprehensive communications campaign to launch the Phone First Pilot and to ensure that we get the right patients to the right place according to clinical need was essential. We took every opportunity to engage with the public, our staff and stakeholders prior to the launch of the pilot project and this included: -

- Discussion with the Cwm Taf Community Health Council;
- Regular briefings issued to key stakeholders including the AMs, local councilors, primary care practitioners etc;
- Further face-to-face meetings with staff at YCR and other areas

affected by the changes;
- Regular communication with all Health Board staff via briefing notes, core brief messages, CEO emails, SharePoint site etc;
- Engagement campaign with the public - posters, leaflets;
- Media engagement including radio interviews, newspaper articles etc;
- Attendance at community group meetings and public forums.
- Use of social media sites such as Twitter to convey messages, the Phone First! number and patient stories;
- Leaflet campaign to target local schools implemented in September 2012.

Over the coming weeks and months, a fresh communications campaign will be launched to build on previous work to raise awareness of the Phone First! minor injuries treatment service at Ysbyty Cwm Rhondda and as part of a renewed focus on the wider Choose Well campaign.

An interactive Choose Well presentation and quiz has been developed to take to the February and March Taff Ely and Rhondda Valleys public forum meetings, which includes specific targeted information about Phone First! and gives examples of the types of patients who can be seen at the unit. A similar version has been developed for use in the Cynon Valley and Merthyr Tydfil.

The Phone First! number will be tweeted weekly with details about the types of cases which are suitable to be seen at Ysbyty Cwm Rhondda and a new poster is being developed. This will be distributed throughout the Rhondda Valleys and Taff Ely area.

A new poster will be developed giving details of what injuries are suitable to be seen at minor injuries. This will be displayed throughout the Phone First! area, including in GP surgeries.

In addition, Phone First! business cards are in the process of being reprinted, together with a new card for the minor injuries unit at Ysbyty Cwm Cynon. Both of these cards can be given to patients attending the A&E Department at the Royal Glamorgan Hospital and the Emergency Care Centre at Prince Charles Hospital with minor injuries.

Some more focused press work will be carried out in the Spring as case studies and fresh data becomes available to help promote the benefits of the Phone First! approach.

STAFFING PROFILE AND FINANCIAL ANALYSIS

The financial evaluation of the Phone First! approach is ongoing and further information will be available in due course. The cost of staff within the current MITC is set out below and it should be noted that the cost per attendance equates to **£23.80** per patient seen: -

Staff Group	Cost Per Month
ENPs Band 7 x 2	8,185.84
HCSW Band 3 x 1	1,907.33
Receptionist Band 3 x 1	1,907.33
TOTAL	**12,000.50**

The staffing of the Minor Injuries Unit prior to the temporary closure in 2011 was as set out below. This is a difference of £15,667-08 and the cost per attendance at the old model of service equated to **£24.28** per patient seen.

Staff Group	Cost Per Month
ENPs band 7 x 6.72	16,440.16
Band 6 RGNs x2	6,782.36
Band 5x0.43	1,036.48
Admin x 2 equates to 1 WTE	2,449-41
TOTAL	**26,708.41**

The staffing of the Minor Injuries Unit at Ysbyty Cwm Cynon is set out below it should be noted that the cost per attendance equates to **£25.80** per patient seen: -

Staff Group	Cost Per Month
ENP Band 7	4,092.92
ENP Band 6	3,473.92
HCSW Plastering Band 3	1,907.33
HCSW Receptionist Band 3	1,907.33
TOTAL	**11,381.50**

Staff within the MITC had moved temporarily to the A&E department and they have now returned to the service at Ysbyty Cwm Rhondda.

Two of the previous WTE ENPs that worked in the MIU at YCR now work out of A&E department at the Royal Glamorgan Hospital as do the two band six staff and the 0.43 band five, thus having a positive impact on the bank costs for the A&E department. The administration costs were previously held within Medical Records and the budget has been transferred to the MITC.

The impact of the new approach has been positive as patients are now being redirected to the MITC and this has alleviated pressure on the staff at the A&E department and allowed them to concentrate their efforts of more appropriate urgent cases.

Costs Associated with Telephone Triage

It should be noted that there are no costs associated with the service provided by NHS Direct Wales. There are however costs associated with the local number at the Communications Hub and the major cost will be associated with the cost of the calls redirected to NHS Direct Wales as these will be borne by the Health Board.

It has proved difficult to unpick the telephone costs associated with the Phone First! service from the overall costs within the Communications Hub as there have also been a number of other changes during the course of the last year e.g. transfer of the Cardiff GP Out of Hours Service. The estimated cost for the period 10 May 2012 to 28 February 2013 was £3,053 i.e. for 9½ months. The full year is therefore approximately £3,850.

*****

OUTCOME – NHS DIRECT WALES PATIENT SATISFACTION SURVEY

INITIAL CALL	INJURY	ADVICE GIVEN	RING BACK	ADVICE FOLLOWED	RATE SERVICE	RESPECTFUL SERVICE	COMMENTS
12 Feb 13	Burn to leg, new symptoms	GP Urgent / same day	15 Feb 13	Yes	Excellent	Yes	No thinks the service is really good
12 Feb 13	Neck injury fell off toboggan 10/02/13	A&E	15 Feb 13	Yes	Excellent	Yes	Telephone service is excellent but the long wait in A/E was terrible
12 Feb 13	Foot injury 6 days ago	A&E	15 Feb 13	Yes	Good	Yes	None but did state he tried to access service yesterday & failed
18 Feb 13	Back pain	GP Urgent / same day	19 Feb 13	No	Excellent	Yes	Long wait to get through to service - continued to take analgesia but reduced NSAID
18 Feb 13	Cut finger bleeding/pus	A/E	19 Feb 13	No	Excellent	Yes	Went to MITC as it was nearer
18 Feb 13	Injury to right hand	A/E	19 Feb 13	Yes	Excellent	Yes	NHSDW & YCR is excellent but cannot say the same for Royal Glamorgan healthcare professionals.
18 Feb 13	Facial injury	A&E	19 Feb 13	Yes	Excellent	Yes	Waited a long time to get through to someone. Thought it was really good to be able to arrive at a given time rather than wait in A/E for a long time
18 Feb 13	Foot injury	GP next day / routine	22 Feb 13	Yes	Excellent	Yes	No thinks it's really good.
19 Feb 13	Hep B Vaccine information	Other	20 Feb 13	Yes	Good	Yes	Looked into details given and visited HSE Executive website
20 Feb 13	Painful swollen hand last 3-4 weeks	GP next day / routine	21 Feb 13	Yes	Good	Yes	None
20 Feb 13	Knee injury	GP next day / routine	21 Feb 13	Yes	Excellent	Yes	Difficult to get GP appointments & felt that A/E was for real emergencies so rang MITC
20 Feb 13	Chest pain for 5 days	GP Urgent / same day	21 Feb 13	Yes	Excellent	Yes	Nurse made the appointment - when you try yourself you are given one for a week's time.
21 Feb 13	Hand Injury	GP Urgent / same day	22 Feb 13	No	Good	Yes	Knew that an x-ray would be required so went directly to A&E. Had to make a second call as did not receive a ring back within the time stated. The information leaflet obtained from Royal Glamorgan A&E did not specify that the MITC is only for injuries under 7 days old. Did not wait in A&E but called the MITC number after obtaining a leaflet, but wouldn't have done this if knew that I couldn't go there. Please make leaflet more explicit.
21 Feb 13	Ankle Pain	Other	22 Feb13	-	Good	Yes	Caller did not proceed with call but thought the service was really useful
25 Feb 13	Shoulder injury for 3 weeks	A&E	26 Feb 13	Yes	Good	Yes	Attended but 4 hour wait so left with intention to return today

INITIAL CALL	INJURY	ADVICE GIVEN	RING BACK	ADVICE FOLLOWED	RATE SERVICE	RESPECTFUL SERVICE	COMMENTS
25 Feb 13	Cuts & bruises to neck	GP Urgent/ same day	26 Feb 13	No	Good	Yes	Attended A/E. GP refused to see the patient, who then had a 4.5 hour wait in A/E. Was told by A&E that NHSDW should not have sent her to the GP.
25 Feb 13	? torn hamstring	A&E	26 Feb 13	Yes	Excellent	Yes	None
25 Feb 13	Worsening leg pain	GP next day/ routine	26 Feb 13	Yes	Good	Yes	None
25 Feb 13	Ankle Injury	A&E	26 Feb 13	Yes	Good	Yes	Nurse phoned within the hour as told by the call handler
27 Feb 13	Facial Injury	A&E	28 Feb 13	Yes	Good	Yes	Waited a long time for someone to answer the telephone
27 Feb 13	Wrist injury	GP Urgent/ same day	28 Feb 13	Yes	Excellent	Yes	Could not get a same day appointment – Tuesday was the earliest
27 Feb 13	Head injury	Self care	28 Feb 13	Yes	Excellent	Yes	None
27 Feb 13	Injury to hand	Other	28 Feb 13	No	Good	Yes	Didn't phone GP as knew would not get an appointment for 2 weeks anyway
27 Feb 13	Injury to hand	A&E	28 Feb 13	Yes	Good	Yes	5 hr wait at A\E Father had waited 3 hrs on a trolley in the corridor the day before and the queue was much bigger so didn't wait
4 March 13	Rib Injury one week ago	A&E	6 March 13	Yes	Excellent	Yes	None
4 March 13	Swollen painful ankle for 2 weeks	A&E	6 March 13	No	Good	Yes	No transport and not feeling well so did not seek treatment
4 March 13	Facial injury – second day	A&E	6 March 13	Yes	Excellent	Yes	None
4 March 13	Blurred vision left eye for 4 days	A&E	6 March 13	Yes	Excellent	Yes	No excellent service - wasn't too bothered but nurse told me I needed to be seen in a main A/E department ASAP. Seen in the Eye Clinic and admitted to hospital.
4 March 13	Swollen ankle, painful	A&E	6 March 13	No	-	-	Caller terminated call as he did not think the service had helped him.

GIG CYMRU NHS WALES
Bwrdd Iechyd Aneurin Bevan Health Board

Our Ref: AG/JP/sc Direct Line: 01633 435948 12 December 2013

Darren Millar AM
Chair - Public Accounts Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

Dear Mr Millar

Re: Unscheduled Care – Patient Survey

Thank you for your letter of the 8th November 2013. Within it I note that the Public Accounts Committee has been considering the Wales Audit Office report on Unscheduled Care – 'Unscheduled Care – An Update on Progress', published in September 2013. I also note that the committee is seeking further information on the demands on accident and emergency services - particularly in relation to potentially avoidable emergency attendances who may have attended their GP/practices. Your letter makes reference to two surveys carried out by ABHB Heath community stakeholders, the Aneurin Bevan Community Health Council and the 'Newport Involve' panel. You have requested further information on these surveys.

In regard to the Aneurin Bevan Community Health Council survey carried out in August 2011, I can confirm that this survey was undertaken between the 1st and 7th August when the CHC surveyed responses from patients attending the Royal Gwent Hospital Emergency Department. I have attached a summary of the survey report provided by the CHC. With regard to the specific questions in your letter, the survey indicates that out of 120 people surveyed, 79 had self-referred. 77 patients had made contact with another NHS agency in advance, 36% of which was contact with Welsh Ambulance and 35% was GP contact. 52 people surveyed had been advised to attend A&E and 24 of these had received that

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Headquarters
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www.aneurinbevanhb.wales.nhs.uk

advice from GPs. Further information on why patients made this choice is contained within this report.

The second survey was carried out by Newport City Council's 'Involve Newport Citizens' panel. This survey was carried out to better understand patient views on access to their GP. The report summary is attached. But you will note that out of 450 responses 11.2% stated that they would choose to go directly to an emergency department if they needed to see a doctor urgently when their GP surgery was closed. 65% responded that they would contact the GP Out of Hours Service and 20% responded that they would contact NHS direct. Further responses were received on the ease of access to GP services, with 29.7% if patients responding that they were not generally able to get a GP appointment within 24 hours and 25% stating that telephone access was not easy. It must be noted however that the response rate (450 responses) should be considered in relation to an overall Newport City population of greater than 148,000 people i.e. a 0.3% sample.

The Health Board regularly reviews its own data on emergency department presentations. It is consistently reported that 50% of its 999 ambulances conveyances do not result in a hospital admission. In addition, 80% of those patients conveyed to hospital via 999 ambulance and discharged do not require any primary or secondary care follow up.

The Health Board welcomes engagement from its stakeholders and the Gwent CHC and 'Involve Newport Citizens' panel surveys have been considered in conjunction with its own analysis to steer an evidence-based approach to managing the demands on its services.

A range of initiatives have been put in place to limit patient demands on emergency services. They range from establishing a robust A&E redirection policy, co-funding advanced paramedic practitioners within WAST to improve clinical decision making 'in the field', establishing a range of pathways as alternatives to conveyance e.g. a Falls Pathway. One of the Health Board's central approaches, however, has been the establishment of the Gwent Frailty Programme which aims to avoid admission through the development of medical care and support services within the patients home. These are some of the measures being driven through a reform programme which is steered by the Health Board's Unscheduled Care Transformation Board. Key stakeholders including WAST and social services colleagues are members of this Board to ensure planning is integrated and holistic.

It must also be noted that the GP survey carried out by Newport City Council's 'Involve Newport Citizens' panel was undertaken in early 2012. You may be aware that the Health Board has implemented a 'A is for Access' scheme with the aim of improving access to GP services, with 5 standards for improving GP access including extended opening times, live person telephone access and early evening appointments. The information from this survey further supports the principles

of this work. At the launch of the 'A is for Access Scheme' in 2011, 11 out of 21 GP practices in Newport met the 5 core access standards, with 2 further practices meeting the standards shortly after.

From October 2013, 16 out of 21 GP Practices met the 5 core access standards and the remaining 5 met the 4 core standards.

In addition, of those GP Practices that have attained the 5 core access standards, the Health Board has commissioned the Extended Hours Local Enhanced Service from 10. This offers an additional 21 clinical hours per week, provided outside of core hours (8.00-18.30).

This is detailed in the table below:

NEWPORT	Oct-13	Extended Hours
Beechwood Surgery	5As	
Bellevue Group Practice	5As	✓
Bryngwyn Surgery	4As	
Central Surgery	4As	
Eveswell Surgery	4As	
Gaer Medical Centre	5As	
Grange Clinic	5As	✓
Isca Medical Centre	5As	✓
Lliswerry Medical Centre	5As	
Malpas Brook Health Centre	5As	✓
Riverside Surgery	4As	
Park Surgery	4As	
Richmond Clinic	5As	
Ringland Health Centre	5As	✓
Rogerstone Practice	5As	✓
Rugby Surgery	5As	
St Brides Medical Centre	5As	✓
St Davids Clinic	5As	✓
St Julians Medical Centre	5As	
St Pauls Clinic	5As	
Underwood Health Centre	5As	✓

I hope you find this information helpful and, as promised, I have attached the Gwent CHC survey, the Newport Involved Team survey and the Health Board data referring to the non-admitted and non-followed up conveyance volume trend. I look forward to meeting with the Committee in January to discuss these matters further.

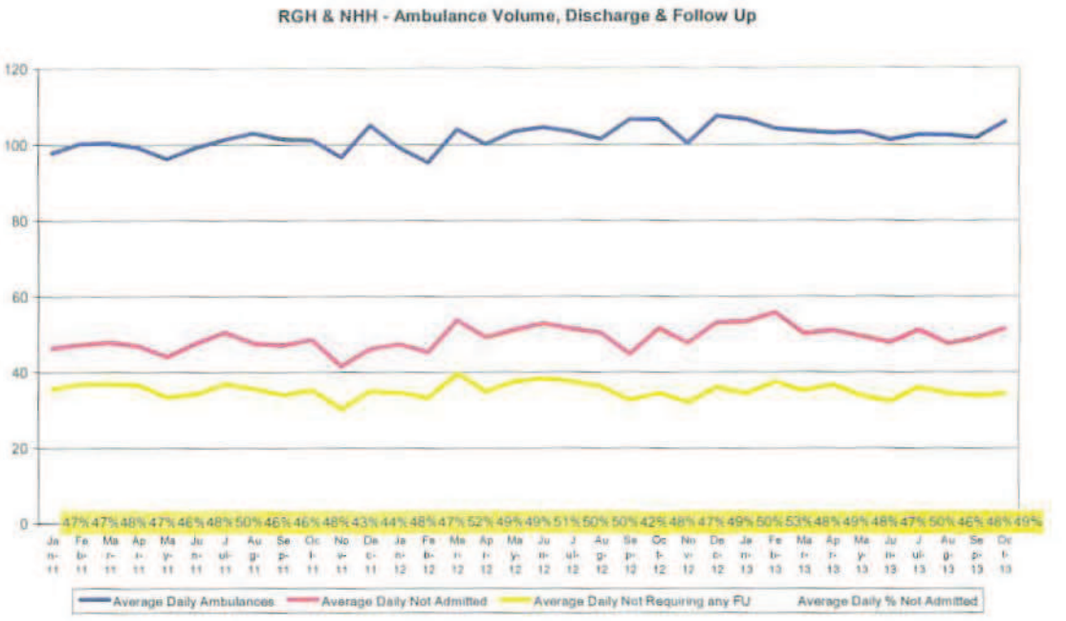
In the meantime should you require any further information please do not hesitate to contact me.

Yours sincerely

Dr Andrew Goodall
Chief Executive

Encs

Ambulance Non-Admits



Involve Newport

Summer greetings - and welcome to the third Involve Newport survey!

One Newport, the Local Service Board for our City, would like to hear your views.

Please read through the following survey and answer as many questions as you can. This survey is completely confidential and no personal information will be disclosed. Completing the survey should take no more than fifteen minutes.

There are three parts to this survey. The first part is about **GP Services in Newport**. The second part is about **Housing in Newport**, and the last part is from **Safer Newport**, the Community Safety Partnership. There are **thirteen** questions in total.

Simply read through the questionnaire and answer all the questions that you can. There are no right or wrong answers, and if you feel you can't answer any of the questions, just leave them blank.

We appreciate your time and assistance in providing this very important information, which will be used to help various agencies in the City to better plan their services to you. Click **next** to start the survey!

GP Services in Newport

Q1 **What do you do if you need to see a doctor urgently when your GP surgery is closed? Please tick one of the boxes below:**

Contact the Out of Hours Service	313 (65.1%)
Go to the Accident & Emergency Department	54 (11.2%)
Ring NHS Direct for advice	98 (20.4%)
Other (please specify):	29 (6.0%)

Q2 **Are you generally able to get an urgent appointment with your GP within 24 hours?**

Yes	321 (66.7%)
No	143 (29.7%)

Q3 **How easy is it to get through to your GP surgery by phone?**

Very easy	109 (22.7%)
Fairly easy	245 (50.9%)
Not very easy	70 (14.6%)
Not at all easy	44 (9.1%)

	Don't know	7 (1.5%)
Q4	**How easy is it to book a GP appointment that is convenient to you?**	
	Very easy	53 (11.0%)
	Fairly easy	204 (42.4%)
	Not very easy	104 (21.6%)
	Not at all easy	103 (21.4%)
	Don't know	9 (1.9%)
Q5	**How easy is it to book a GP appointment in advance?**	
	Very easy	105 (21.8%)
	Fairly easy	182 (37.8%)
	Not very easy	80 (16.6%)
	Not at all easy	85 (17.7%)
	Don't know	18 (3.7%)
Q6	**How easy is it to speak to your GP if you need advice?**	
	Very easy	53 (11.0%)
	Fairly easy	129 (26.8%)
	Not very easy	123 (25.6%)
	Not at all easy	83 (17.3%)
	Don't know	84 (17.5%)
Q7	**What GP surgery opening time would best suit you (please pick one)?**	
	Morning - between 8 and 11 AM	116 (24.1%)
	Morning - between 9 and 12 PM	132 (27.4%)
	Lunchtime - between 12 and 2 PM	4 (0.8%)
	Afternoon - between 1 and 3 PM	17 (3.5%)
	Afternoon - between 3 and 5 PM	26 (5.4%)
	Evening - between 5 and 8 PM	136 (28.3%)
	Saturday morning surgery	38 (7.9%)

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL
ANEURIN BEVAN

Survey of patients attending the Accident and Emergency Department, Royal Gwent Hospital

Week commencing 1st August – 7th August 2011(Monday to Sunday)

The rota for the survey appears at Appendix 2.

1) Summary of the findings

1) We interviewed 120 people - mostly from Gwent but a small number (5) from England. The great majority (50 – 42%) were from the Newport area. A surprisingly high number came from Blaenau Gwent (22-18%), with the lowest number (10- 8%) attending from Caerphilly.

2) 110 respondents identified how long they had been waiting. A total of 13 had been waiting longer than 4 hours. Only 1 of the patients seen in A and E minor had been waiting more than 4 hours. The respondents in A and E major included 1 who reported having to wait 10 hours and 1 who had been waiting 12 hours and 15mins.

3) 79 had made the decision to attend A and E themselves. 40 said they had not.

4) A clear majority of people had contacted another agency of the NHS beforehand - 77 as against 43 who said they had not.

5) Within the 77, the largest number had been in contact with the ambulance service (28 – 36%), closely followed by contacts with GP practices (27- 35%). There were a small number of contacts with the GP out-of-hours service and from NHS Direct (6 cases each). 3 patients had follow-up appointments at A and E.

6) Within that number 52 people had been advised to come to A and E. Just under half of these respondents (24) identified the agency and approaching half had been advised by a GP source (9 by their practice and 2 by GP out-of-hours).

7) 55 people commented on why they had arrived by ambulance – over half (30) expressing concerns that their condition might deteriorate.

The next highest number of respondents (9) said there was no other available or affordable transport.

8) The great majority of respondents (90) did not feel that their visit to the A and E Department could have been avoided, against 12 who thought it could have been. Of those who commented the largest number highlighted the unavailability of GPs –"unable to see or speak to a GP for 3-4 hours" or that it would have been a waste of time – "you would only have been sent to A and E anyway." Of those who didn't think their journey was avoidable, 5 mentioned actual or suspected broken bones and the need for an X-ray.

9) A similarly high number (89) did not feel that any alternatives could have avoided attendance at A and E. Of those who did comment the largest number (12) mentioned better/more available treatment via the GP, with 8 mentioning a more local minor injuries unit.

10) Only around a third of respondents (44) commented on how pressure on A and E Departments and waiting times for patients could be reduced. A number of respondents were critical of waiting times and suggested extra doctors and more beds. Just over half (24) were, however, full of praise for staff, making light of waiting times and convinced that they were in the best place.

2) Conclusions

There is clearly a strong culture of people coming directly to A and E instead of using primary care services. A majority of patients – 2 out of 3 had made the decision to attend themselves and were keen to defend it and often reluctant to engage in a debate about alternatives:

"If you need to come to A and E, you come to A and E."

A and E was the "best place when ill" where you get the "best treatment".

A number of respondents were unapologetic about their decision to by-pass the GP "waste of time",
"live nearer A and E than the GP."

There was, however, a detectable view that GPs, who were the health professionals who directed most of our sample to A and E could have done more and there were some concerns about their lack of availability. One patient was indeed directed to A and E by a receptionist; two respondents said they were suffering from a long term/on-going condition which made their attendance unavoidable, yet with appropriate chronic disease management that might indeed have been avoided.

We understand the Health Board routinely identifies attendances at A and E Departments by GP practice and those statistics should be scrutinised to see

if there is a pattern of excessive attendances at A and E Departments and if there is any correlation with access to primary care services.

In looking for an alternative to attendance at A&E the box marked "better/ more available treatment via the GP" was ticked most often. Publicity around using the GP service as an alternative to A and E will only succeed if that service is available and responsive.

The alternative of a more local minor injuries unit also had support. The Health Board is developing plans for locally based and sustainable minor injuries services which would improve the patient experience and be important in keeping patients out of busy A and E Departments if they don't need to be there.

A high number of patients were identified as coming from Blaenau Gwent (18) – the next highest total after Newport (50). There may be need to investigate why more of these patients are not accessing the Local Emergency Centre at Ysbyty Aneurin Bevan or the A and E Department at Nevill Hall hospital.

We noted that two or three patients in the sample were attending for follow-up appointments at A and E.

Detailed responses to the questions in the survey appear at Appendix 1

Recommendations

We recommend that the Health Board

1) Scrutinises the attendance based on condition and frequency and assesses any correlation with the availability of Primary Care services to see if there is a pattern of excessive avoidable attendances at A and E Departments and continues to work with GP practices to ensure that they offer accessible, responsive and timely alternatives for patients.

2) Undertakes a robust awareness campaign to support the development of locally based minor injuries services to ensure that patients can access the most appropriate services for their needs.

3) Investigates why relatively high numbers of patients appear to be attending the Royal Gwent A and E Department from Blaenau Gwent and mechanisms to encourage people to utilise the services in their locality.

4) Satisfies themselves that the small number of patients who attend for follow-up appointments at A and E could not be seen more conveniently and appropriately in a primary care setting.

David Kenny
Deputy Chief Officer (Patient and Pubic Engagement)
September 2011

Appendix 1

1) 120 patients were surveyed in total (56 in Major A and E, 64 in Minor)

Waiting times: 110 people identified how long they had been waiting.
Of the 57 people interviewed in A and E minor, only 1 had been waiting longer than 4 hours (i.e. 4 hours 30 mins)
Of the 50 people identified in A and E major, 10 had been waiting more than 4 hours: 6 of these had been waiting between 4 and 5 hours. 1 reported having waited 10 hours and the longest person waiting 12 hours and 15 minutes.
Of the 3 who didn't specify the area, 1 was waiting 4 hours and 1.5 hours and 25 mins.

2) Where do you live?

114 patients were from Gwent:
Blaenau Gwent: 22, Caerphilly: 10, Newport: 50, Monmouthshire: 13, Torfaen: 19
5 from England (1 local from Gloucestershire others from further afield)
1 from outside UK (St Kitts)
A few patients from Caerphilly (10)

3) Did you make the decision to attend yourself?

Of the total, 79 had made the decision to attend themselves, 40 said No to that question, 1 wasn't clear.

4) Did you contact any other part of the NHS beforehand?

77 of the sample said Yes

NHS Direct: 6
Your GP practice: 27
Ambulance service: 28
GP Out-of hour's service: 6
Referred from other hospital/minor injuries unit: 4
A and E appointment: 3
Health professional: 3

43 said No

Miscellaneous comments
Taken ill/accident at work: 4
Alert via safety alarm/lifeline: 2
Police: 1
Don't know: 1
Not a UK resident: 1

5) Did any of these contacts advise you to come to A and E?

Yes: 52
No: 29
Not applicable: 39

Who advised you to come (23 people specified)

GP practices: 9 - in one case the receptionist
Doctor: 2 (unspecified)
Ambulance: 5
(GP) Out of hours: 2
NHS Direct: 1
District nurse: 1

Non NHS
Firm/employer/ first aider at work: 3

6) If you arrived by ambulance why did you think an ambulance was needed?

55 people answered this question

Thought condition serious (taken ill/injured/collapsed at home): 4
Fearful condition would deteriorate: 30
Arranged for me (NHS Direct/GP/Paramedic): 5
Felt arrival by ambulance would improve waiting time: 1
Thought ambulance would take me to the right hospital: 6
No other available/affordable transport: 9

7) Do you think your visit to the A and E Department could have been avoided if your condition had been recognised or treated earlier?

12 Respondents said Yes
90 respondents said No
9 said Not Applicable

The largest number of comments (9) made reference to GPs
"Could have been dealt with by GP or midwife perhaps"
"GP sent me home the day before"
"Would have visited GP if one was open and available in Cwmbran"
"Possibly – unable to see or speak to a GP for 3-4 hours"
"Would have liked to have seen a GP –was advised by practice nurse to come to A and E"
"Would have liked to see GP again"
"Why use a GP? You would only have been sent to A and E anyway"
"So far so good time wise in A and E, live nearer A and E than GP
"Good so far, going to see a GP would have wasted time –was worried so straight to A and E"

1 Felt the problem should have been sorted out earlier at Nevill Hall.
1 Had sustained a head injury which was getting worse.
1 said possibly.
1 wasn't sure.

Amongst the No responders:

2 Didn't have GP/in Newport

3 Appointments/ Revisits
"Several days ago treated here at minor injuries and given an appointment to revisit today"
"Operation a month ago, back for check-up"

2 Long term condition/ on-going condition

5 people had actual or suspected broken bones for which an X-ray was indicated.

2 Had suffered accidents

1 Considered they were an emergency

8) Are there any alternatives which would have avoided you coming into a busy A and E Department?

Better more available treatment via the GP (12 people agreed)
A more local minor injuries unit (8)
Better advice or assessment via telephone contact with a doctor or health professional (4)
Assessment treatment in the home (3)
Other (11)
Attendance at A and E could not have been avoided (89)
"if you need to come to A and E, you need to come to A and E"
"(Royal) Gwent is the local injuries unit for me"

Explanatory comments around the category "Other" were:

"avoided if my problem had been resolved at a previous visit to RGH"
"if had X-ray perhaps"
"GP not able to help"

9) Do you have any additional comments on how the pressure on A and E Departments and waits for patients could be reduced?

44 comments were received:

24 – just over half were full of praise for staff , some indicating that waits were not too long or unavoidable. A number strongly endorsed the fact that A and E was the best option

"Best place when ill"
"Best treatment in A and E"
"Think attending A and E on this day was a sensible move"
"Brilliant"

4 people suggested extra staff, particularly doctors were needed.
I suggested "more beds while waiting to free up ambulance trolleys"
A number of people were critical of waiting times.
2 suggested more minor injuries units/better out of hours services could help.

1 suggested there should be more awareness raising that GPs should be used in "non-urgent cases"
2 people felt that GP could have dealt with their condition – "GP could have done more"

SURVEY OF PATIENTS IN GWENT ACCIDENT AND EMERGENCY DEPARTMENTS

Hospital:..... Major or Minor Dept..... (if applicable)

Date:.....

Time: .....

Preamble:

The number of attendances at A and E departments goes up every year. According to statistics a high proportion of people (perhaps 50%) who attend do not need the specialist services they offer and could be treated elsewhere. This could perhaps reduce pressure on A and E departments and reduce the time people have to wait. This questionnaire explores your experience and ideas. It is being carried out independently of the hospital by members of Aneurin Bevan Community Health Council – we do not need your name and your comments will be treated in confidence.

1 Where do you live (Town /Village) .....

2 What time did you arrive in the A and E Department? .....

3 Did you make the decision to come yourself?

YES

NO

4 Did you contact any other part of the NHS beforehand? (tick any which apply)

NHS Direct
Your GP practice
The GP out-of-hours service
Ambulance/999 service
Other (please specify) .....

NO did not make contact

5 Did any of these contacts advise you to come to A and E

YES (please specify) .....

NO

NOT APPLICABLE

6 If you arrived by ambulance why did you think an ambulance was needed? (tick as many as apply)

1) Fearful that your condition would deteriorate en route
2) Felt that an arrival by ambulance would improve the waiting time to see a doctor or nurse
3) Thought that an ambulance would take you to the right hospital
4) No other available or affordable transport
5) Other (please specify)

.....
.....
.....
.....

7 Do you think your visit to the A and E Department could have been avoided if your condition had been recognised or treated earlier?

YES

NO

NOT APPLICABLE

Additional comments:
.....
.....
.....
.....

8 Are there other alternatives which would have avoided you coming into a busy A and E Department today (please tick any you might like to see)

Better/ more available treatment via the GP

A more local minor injuries unit

Better advice or assessment of my condition via telephone contact with a doctor or health professional

Assessment /treatment in the home (eg by ambulance paramedics or specialist nurses)

Any other (please specify) .....

NO – my attendance at A and E could not have been avoided today

9 Do you have any additional comments on how the pressure on A and E Departments and waits for patients could be reduced

.....
.....

.....
.....

Thank you for your time and help with this survey

June 2011

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL
ANEURIN BEVAN

Survey of patients attending the Accident and Emergency Department, Royal Gwent Hospital

Week commencing 1st August – 7th August 2011(Monday to Sunday)

The rota for the survey appears at Appendix 2.

1) Summary of the findings

1) We interviewed 120 people - mostly from Gwent but a small number (5) from England. The great majority (50 – 42%) were from the Newport area. A surprisingly high number came from Blaenau Gwent (22-18%), with the lowest number (10- 8%) attending from Caerphilly.

2) 110 respondents identified how long they had been waiting. A total of 13 had been waiting longer than 4 hours. Only 1 of the patients seen in A and E minor had been waiting more than 4 hours. The respondents in A and E major included 1 who reported having to wait 10 hours and 1 who had been waiting 12 hours and 15mins.

3) 79 had made the decision to attend A and E themselves. 40 said they had not.

4) A clear majority of people had contacted another agency of the NHS beforehand - 77 as against 43 who said they had not.

5) Within the 77, the largest number had been in contact with the ambulance service (28 – 36%), closely followed by contacts with GP practices (27- 35%). There were a small number of contacts with the GP out-of-hours service and from NHS Direct (6 cases each). 3 patients had follow-up appointments at A and E.

6) Within that number 52 people had been advised to come to A and E. Just under half of these respondents (24) identified the agency and approaching half had been advised by a GP source (9 by their practice and 2 by GP out-of-hours).

7) 55 people commented on why they had arrived by ambulance – over half (30) expressing concerns that their condition might deteriorate.

The next highest number of respondents (9) said there was no other available or affordable transport.

8) The great majority of respondents (90) did not feel that their visit to the A and E Department could have been avoided, against 12 who thought it could have been. Of those who commented the largest number highlighted the unavailability of GPs –"unable to see or speak to a GP for 3-4 hours" or that it would have been a waste of time – "you would only have been sent to A and E anyway." Of those who didn't think their journey was avoidable, 5 mentioned actual or suspected broken bones and the need for an X-ray.

9) A similarly high number (89) did not feel that any alternatives could have avoided attendance at A and E. Of those who did comment the largest number (12) mentioned better/more available treatment via the GP, with 8 mentioning a more local minor injuries unit.

10) Only around a third of respondents (44) commented on how pressure on A and E Departments and waiting times for patients could be reduced. A number of respondents were critical of waiting times and suggested extra doctors and more beds. Just over half (24) were, however, full of praise for staff, making light of waiting times and convinced that they were in the best place.

2) Conclusions

There is clearly a strong culture of people coming directly to A and E instead of using primary care services. A majority of patients – 2 out of 3 had made the decision to attend themselves and were keen to defend it and often reluctant to engage in a debate about alternatives:

"If you need to come to A and E, you come to A and E."

A and E was the "best place when ill" where you get the "best treatment".

A number of respondents were unapologetic about their decision to by-pass the GP "waste of time",
"live nearer A and E than the GP."

There was, however, a detectable view that GPs, who were the health professionals who directed most of our sample to A and E could have done more and there were some concerns about their lack of availability. One patient was indeed directed to A and E by a receptionist; two respondents said they were suffering from a long term/on-going condition which made their attendance unavoidable, yet with appropriate chronic disease management that might indeed have been avoided.

We understand the Health Board routinely identifies attendances at A and E Departments by GP practice and those statistics should be scrutinised to see

if there is a pattern of excessive attendances at A and E Departments and if there is any correlation with access to primary care services.

In looking for an alternative to attendance at A&E the box marked "better/ more available treatment via the GP" was ticked most often. Publicity around using the GP service as an alternative to A and E will only succeed if that service is available and responsive.

The alternative of a more local minor injuries unit also had support. The Health Board is developing plans for locally based and sustainable minor injuries services which would improve the patient experience and be important in keeping patients out of busy A and E Departments if they don't need to be there.

A high number of patients were identified as coming from Blaenau Gwent (18) – the next highest total after Newport (50). There may be need to investigate why more of these patients are not accessing the Local Emergency Centre at Ysbyty Aneurin Bevan or the A and E Department at Nevill Hall hospital.

We noted that two or three patients in the sample were attending for follow-up appointments at A and E.

Detailed responses to the questions in the survey appear at Appendix 1

Recommendations

We recommend that the Health Board

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2) Undertakes a robust awareness campaign to support the development of locally based minor injuries services to ensure that patients can access the most appropriate services for their needs.

3) Investigates why relatively high numbers of patients appear to be attending the Royal Gwent A and E Department from Blaenau Gwent and mechanisms to encourage people to utilise the services in their locality.

4) Satisfies themselves that the small number of patients who attend for follow-up appointments at A and E could not be seen more conveniently and appropriately in a primary care setting.

David Kenny
Deputy Chief Officer (Patient and Pubic Engagement)
September 2011

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1) 120 patients were surveyed in total (56 in Major A and E, 64 in Minor)

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55 people answered this question

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7) Do you think your visit to the A and E Department could have been avoided if your condition had been recognised or treated earlier?

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The largest number of comments (9) made reference to GPs
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5 people had actual or suspected broken bones for which an X-ray was indicated.

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1 Considered they were an emergency

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Other (11)
Attendance at A and E could not have been avoided (89)
"if you need to come to A and E, you need to come to A and E"
"(Royal) Gwent is the local injuries unit for me"

Explanatory comments around the category "Other" were:

"avoided if my problem had been resolved at a previous visit to RGH"
"if had X-ray perhaps"
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Hospital:..... Major or Minor Dept..... (if applicable)

Date:.....

Time: .....

Preamble:

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1 Where do you live (Town /Village) .....

2 What time did you arrive in the A and E Department? .....

3 Did you make the decision to come yourself?

YES

NO

4 Did you contact any other part of the NHS beforehand? (tick any which apply)

NHS Direct
Your GP practice
The GP out-of-hours service
Ambulance/999 service
Other (please specify) .....

NO did not make contact

5 Did any of these contacts advise you to come to A and E

YES (please specify) .....

NO

NOT APPLICABLE

6 If you arrived by ambulance why did you think an ambulance was needed? (tick as many as apply)

1) Fearful that your condition would deteriorate en route
2) Felt that an arrival by ambulance would improve the waiting time to see a doctor or nurse
3) Thought that an ambulance would take you to the right hospital
4) No other available or affordable transport
5) Other (please specify)

.....
.....
.....
.....

7 Do you think your visit to the A and E Department could have been avoided if your condition had been recognised or treated earlier?

YES

NO

NOT APPLICABLE

Additional comments:
.....
.....
.....
.....

8 Are there other alternatives which would have avoided you coming into a busy A and E Department today (please tick any you might like to see)

Better/ more available treatment via the GP

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Better advice or assessment of my condition via telephone contact with a doctor or health professional

Assessment /treatment in the home (eg by ambulance paramedics or specialist nurses)

Any other (please specify) .....

NO – my attendance at A and E could not have been avoided today

9 Do you have any additional comments on how the pressure on A and E Departments and waits for patients could be reduced

.....
.....

.....
.....

Thank you for your time and help with this survey

June 2011

Involve Newport

Summer greetings - and welcome to the third Involve Newport survey!

One Newport, the Local Service Board for our City, would like to hear your views.

Please read through the following survey and answer as many questions as you can. This survey is completely confidential and no personal information will be disclosed. Completing the survey should take no more than fifteen minutes.

There are three parts to this survey. The first part is about **GP Services in Newport**. The second part is about **Housing in Newport**, and the last part is from **Safer Newport**, the Community Safety Partnership. There are **thirteen** questions in total.

Simply read through the questionnaire and answer all the questions that you can. There are no right or wrong answers, and if you feel you can't answer any of the questions, just leave them blank.

We appreciate your time and assistance in providing this very important information, which will be used to help various agencies in the City to better plan their services to you. Click **next** to start the survey!

GP Services in Newport

Q1 **What do you do if you need to see a doctor urgently when your GP surgery is closed? Please tick one of the boxes below:**

Contact the Out of Hours Service	313 (65.1%)
Go to the Accident & Emergency Department	54 (11.2%)
Ring NHS Direct for advice	98 (20.4%)
Other (please specify):	29 (6.0%)

Q2 **Are you generally able to get an urgent appointment with your GP within 24 hours?**

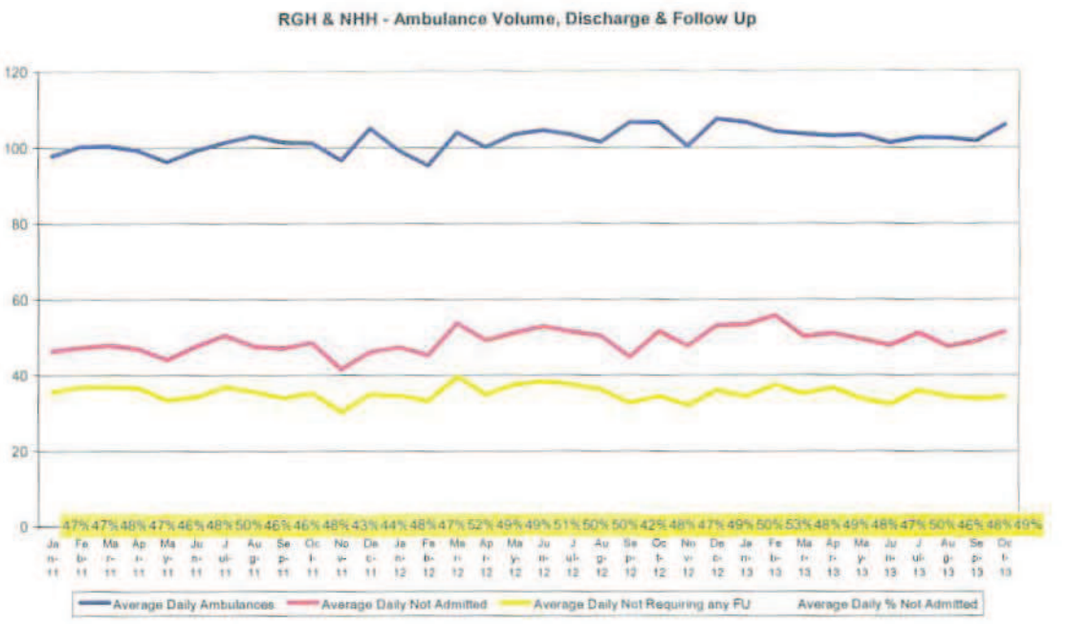
Yes	321 (66.7%)
No	143 (29.7%)

Q3 **How easy is it to get through to your GP surgery by phone?**

Very easy	109 (22.7%)
Fairly easy	245 (50.9%)
Not very easy	70 (14.6%)
Not at all easy	44 (9.1%)

	Don't know	7 (1.5%)
Q4	**How easy is it to book a GP appointment that is convenient to you?**	
	Very easy	53 (11.0%)
	Fairly easy	204 (42.4%)
	Not very easy	104 (21.6%)
	Not at all easy	103 (21.4%)
	Don't know	9 (1.9%)
Q5	**How easy is it to book a GP appointment in advance?**	
	Very easy	105 (21.8%)
	Fairly easy	182 (37.8%)
	Not very easy	80 (16.6%)
	Not at all easy	85 (17.7%)
	Don't know	18 (3.7%)
Q6	**How easy is it to speak to your GP if you need advice?**	
	Very easy	53 (11.0%)
	Fairly easy	129 (26.8%)
	Not very easy	123 (25.6%)
	Not at all easy	83 (17.3%)
	Don't know	84 (17.5%)
Q7	**What GP surgery opening time would best suit you (please pick one)?**	
	Morning - between 8 and 11 AM	116 (24.1%)
	Morning - between 9 and 12 PM	132 (27.4%)
	Lunchtime - between 12 and 2 PM	4 (0.8%)
	Afternoon - between 1 and 3 PM	17 (3.5%)
	Afternoon - between 3 and 5 PM	26 (5.4%)
	Evening - between 5 and 8 PM	136 (28.3%)
	Saturday morning surgery	38 (7.9%)

Ambulance Non-Admits



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Ein cyf / Our ref: GL/JB/NWA13/431
Eich cyf / Your ref:
☎: 01248 384911
Gofynnwch am / Ask for: Chief Executive's Office
Ffacs / Fax: 01248 384937
E-bost /Email: janerose.buyiekha@wales.nhs.uk
Dyddiad / Date: 11th December 2013

Private & Confidential

Darren Millar AM
Shadow Minister for Health
Constituency Office
North Wales Business Park
Abergele
Conwy
LL22 8LJ

Dear Mr Millar

Re: Unscheduled Care – A&E Inappropriate Referrals

Thank you for your letter dated 8th November 2013 regarding the above

An audit was carried out in February 2009 of potential inappropriate attendees in ED. Triage category 5 was used to select the patients. A total of 53 patients fell in this category. Details of 48 patients were retrievable for analysis.

The table below outlines the finding from the audit carried out.

Number of inappropriate ED attendee	Percentage	Reason
24/48	50%	Were not inappropriate attendees.
9/48	19%	Patients were suitable for ED or GP. All were then referred to Out of Hours (OOH) which is co-located with ED.
2/48	4%	Did not require ED services but had genuine reason to access support from ED during OOH/weekends.
13/48	27%	Were inappropriate ED attendees. Out of 13 patients, only 8 were seen by ED staff.

Conclusion

Out of the total ED attendees in the month of February 2009, only 2.25% were deemed truly inappropriate attendees. This reflects as a low percentage which would have had minimum impact on the ED department. However we continue to work closely with GP surgeries, OOHs and other stakeholders to ensure that all patients are seen by the appropriate service in the necessary timescale. We do use unscheduled care forms at Ysbyty Gwynedd to discuss and feedback to others concerned including Welsh Government, Social Services and the Voluntary sector. The ED matron is actively involved in the choose well campaign.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

We will endeavour to carry out another audit in the near future for monitoring purpose and to retrieve a breakdown on ED inappropriate attendances.

Should you require further clarification on the above, please do not hesitate to contact me.

Yours sincerely

GEOFF LANG
ACTING CHIEF EXECUTIVE

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref SF/MD/4012/13

David Rees AM
Health and Social Care Committee
National Assembly for Wales
Ty Hywel
Cardiff Bay
Cardiff
CF99 1NA

13 December 2013

Dear David

I am writing to inform and update you on the work to review the Continuing NHS Healthcare (CHC) Framework.

Since its introduction in 2010, the Framework has provided a number of benefits including greater governance on CHC within Local Health Boards, improved consistency regarding assessment and eligibility decisions and stronger arrangements for reviewing assessments. However, I also recognise the need for a further review of these arrangements. This was reflected in the recent report by the Auditor General for Wales, although the report made clear that a complete rewrite of the Framework is not necessary. I agree with this view.

Considerable work has been undertaken, involving a number of themed Task and Finish groups, with experts drawn from across the health and social care sector, as well as staff from the Auditor General's office, to look at how we can ensure future arrangements remain fit for purpose. These views have contributed to a draft revision of specific aspects of the Framework and it has been issued for consultation today, for a period of 12 weeks. The intention is for the final version of the revised Framework to be published in the Summer.

I am copying my letter to the Chair of the Public Accounts Committee, Chair of the Petitions Committee, Andrew R T Davies, Kirsty Williams and Leanne Wood.

Best wishes

Mark

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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Welsh Government

Consultation Document

insert front cover photo or link to image, if required

Continuing NHS Healthcare (CHC) – The 2014 National Framework

Date of issue: **13 December 2013**
Responses by: **13 March 2014**

Overview	This document seeks views on what arrangements the Welsh Government should put in place to support the effective delivery of Continuing NHS Healthcare (CHC) by the NHS. These arrangements will be set out in the 2014 National Framework for Continuing NHS Healthcare. The consultation poses a number of questions about the best way forward.
How to respond	You can respond to this consultation by completing, **by 13 March 2014**, the consultation response form at the back of this document and returning it by post to: Continuing NHS Healthcare Team Integration, Policy and Delivery Division Social Services and Integration Directorate Welsh Government 4Th Floor Cathays Park Cardiff CF10 3NQ Alternatively, the consultation response form is available on our website (http://wales.gov.uk/consultations/?lang=en) and can be returned to us by e-mail to : CHCFrameworkConsultation@wales.gsi.gov.uk
Further information and related documents	There are Easy-to-Read and Easy Read versions of this consultation document available. Large print and Braille versions are also available on request.
Contact details	For further information: Continuing NHS Healthcare Team Integration, Policy and Delivery Division Social Services and Integration Directorate Welsh Government 4Th Floor Cathays Park Cardiff CF10 3NQ E-mail: CHCFrameworkConsultation@wales.gsi.gov.uk Telephone: Cardiff (029) 2082 5860 or 2082 6950

Data protection

Any response you send us will be seen in full by Welsh Government staff dealing with this consultation. It may also be seen by other Welsh Government staff to help them plan future consultations.

The Welsh Government intends to publish a summary of the responses to this document. We may also publish responses in full. Normally, the name and address (or part of the address) of the person or organisation who sent the response are published with the response. This helps to show that the consultation was carried out properly. If you do not want your name or address published, please tell us this in writing when you send your response. We will then blank them out.

Names or addresses we blank out might still get published later, though we do not think this would happen very often. The Freedom of Information Act 2000 and the Environmental Information Regulations 2004 allow the public to ask to see information held by many public bodies, including the Welsh Government. This includes information which has not been published. However, the law also allows us to withhold information in some circumstances. If anyone asks to see information we have withheld, we will have to decide whether to release it or not. If someone has asked for their name and address not to be published, that is an important fact we would take into account. However, there might sometimes be important reasons why we would have to reveal someone‟s name and address, even though they have asked for them not to be published. We would get in touch with the person and ask their views before we finally decided to reveal the information.

Contents

Summary

Arrangements for the delivery of Continuing NHS Healthcare (CHC) are set out in the existing guidance *The 2010 National Framework for Continuing NHS Healthcare in Wales* (the Framework), published in May 2010.

The Framework covers adults and sets out the Welsh Government‟s revised policy for eligibility for CHC and the responsibilities of Local Health Boards (LHBs) and Local
Authorities (LAs). It sets out a process for the NHS, working with local authority partners, to assess health needs, decide on eligibility for CHC and provide appropriate care.

Our new Framework will be published this June and will replace the 2010 Continuing NHS Healthcare: The National Framework for Implementation in Wales. The new Framework will not be a complete re-write of existing arrangements. Instead, it will provide further robustness, clarity and assurance on areas identified for improvement by stakeholders. This consultation therefore focusses only on the proposed updated areas.

The new Framework will provide clear, practical and user-friendly guidance based on the views of stakeholders, including CHC nursing leads, the Wales Audit Office and Public Service Ombudsman for Wales.

The Framework will be accompanied by the CHC Toolkit, which will act as a web-based resource, as well as an implementation and training plan. Further work will be undertaken during the consultation period to pilot new processes and refine the content of the Toolkit, such as policies, protocols, resources, practical examples and Frequently Asked Questions.

All LHBs and Local Authorities in Wales will be required to follow it. The new Framework will sets out a process for the NHS, working together with local authority partners, to assess health needs, decide on eligibility for CHC and provide appropriate care.

We therefore welcome your views in shaping the proposed Framework, in order to deliver more effective CHC arrangements.

Section 1

Purpose of this consultation

1. The purpose of this consultation is to revise the Framework to provide a consistent foundation for assessing, commissioning and providing CHC for adults across Wales. This is to ensure that there is a consistent, equitable and appropriate application of the process for determining eligibility. This framework is not intended to replace existing joint commissioning strategies.

2. We have identified various questions for you to consider in your response to the Framework. These are set out in detail in Section 4 of this consultation, and you are asked for your views on which option you support.

3. The options set out in this consultation will need to be developed further and fully costed before any final decision is taken. The Welsh Ministers will make a decision in June 2014 following this consultation.

4. The Welsh Government will want to monitor the impact of the Framework to make it is robust and practical. We would welcome your views on the best way to do this.

Section 2 Background and context

Definition of Continuing NHS Healthcare

5. Continuing NHS Healthcare (CHC) is a package of care arranged and funded solely by the NHS, where it has been assessed that the individual"s primary need is a health need.

General Principles of CHC

6. CHC is just one part of a continuum of services that local authorities and NHS bodies need to have in place to support people with health and social care needs. CHC is one aspect of care which people may need as the result of disability, accident or illness to address both physical and mental health needs.

7. The Framework makes it clear that the whole process of determining eligibility and planning and delivering services for continuing NHS healthcare should be „person centred". This is vital since individuals going through this process will be at a very vulnerable point in their lives. There may well be difficult and significant choices to be made, so empowering individuals at this time is essential. The ongoing assessment and review process should therefore be explained to the individual and/or their representative from the outset and confirmed in writing. Communication tools and template letters for various stages of the process can be accessed via the CHC Toolkit.

8. Where an individual lacks capacity to make informed choices, under the Mental Capacity Act Code of Practice, staff may disclose information about the individual, providing it is in the best interests of the person concerned, or there is a lawful reason to do so.

9. CHC should not be viewed as a permanent arrangement. Care provision should be needs-led and designed to maximise ability and independence. Any care package, regardless of the funding source, should be regularly reviewed in partnership with the individual and/or their representative to ensure that it continues to meet their needs. CHC is just one part of a continuum of services that local authorities and NHS bodies need to have in place to support people with health and social care needs. CHC is one aspect of care which people may need as the result of disability, accident or illness to address both physical and mental health needs.

Responsibilities of the NHS and Local Authorities

10. The NHS is responsible for assessing, arranging and funding a wide range of services to meet the health care needs, both short and long term, of the population. In addition to periods of acute health care, some people need care over an extended period of time, as the result of disability, accident or illness to address physical and mental health needs. These services are normally provided free of charge.

11. An individual is eligible for CHC when they are assessed as having a primary health need. They then receive a package of support that is fully funded by the NHS. There are around 5,700 people in Wales who receive CHC at an annual cost to the LHBs of approximately £280 million. By its very nature, the provision of CHC is often long term and costly, although it can be episodic in nature, with some people moving in and out of eligibility. Given these pressures, CHC was identified as an area of healthcare that would benefit from a nationally co-ordinated approach and since 2010 has been supported by the National Framework for Implementation in Wales guidance, published by Welsh Ministers.

12. Local authorities also provide a range of services to support their local population, including people who require extended care. These services include accommodation, education, personal and social care, leisure and other services. Local authorities must charge for residential care in accordance with the Charging for Residential Care Guidance (CRAG) and they may charge for other care services subject to any guidance or regulation by the Welsh Government.

13. When an individual has been assessed as having a primary health need and is therefore eligible for CHC, the NHS has responsibility for funding the full package of health and social care. Where the individual is living at home, this does not include the cost of accommodation, food or general household support.

14. NHS bodies and local authorities have responsibilities to ensure that the assessment of eligibility for, and provision of, CHC takes place in a consistent fashion and the process is actively managed to avoid unnecessary delays.

15. If an individual does not meet CHC eligibility, they can still access a range of health and social care services that are likely to be both part of mainstream services or individually planned to meet specific need.

Issues

Wales Audit Office Review of the Framework

16. Over the last two years the Wales Audit Office (WAO) undertook a study into the implementation of the Framework and its effectiveness in ensuring individuals are dealt with fairly and consistently. The study did not examine in any detail the operational delivery of CHC, such as service redesign.

17. The WAO published their report, "*Implementation of the National Framework for Continuing NHS Healthcare"* in June this year. It recognised the current Framework delivered a number of benefits, including governance issues, arrangements for continuing eligibility and the basis for a consistent assessment of care needs. The Report raised concerns over the effectiveness of the implementation of the Framework as well as the fairness and consistency in decision-making on CHC by LHBs. In summary the Report noted:

- CHC governance issues within Health Boards had been strengthened, but provided limited assurance that people are being dealt with consistently and fairly;
- the effectiveness of joint working between health and social services was highly variable;
- there was a fall in the number and expenditure of CHC cases, albeit the impact of the Framework in this was not clear. The report noted mixed evidence on the extent and consistency that individuals and their families are involved in the assessment process
- despite additional funding provided, there was a perceived risk that processes to deal with backdated claims for CHC would not be processed to completion to meet the deadline of June 2014; and,
- Many of the challenges to CHC eligibility decisions not dealt with promptly, there is currently no deadline set for the cases that individual Local Health Boards are dealing with.

18. The Report also advocated the introduction of a Screening Tool, as used in England, would ensure clarity and consistency in the criteria used to assess people.

Public Service Ombudsman for Wales

19. Following a number of complaints received, the Public Service Ombudsman for Wales ("the Ombudsman") has raised concerns over the consistency and fairness of these eligibility decisions, and a large number of backdated claims ("retrospective reviews") have been made to Local Health Boards challenging earlier decisions. Following his investigation into the administration of some of those claims, the Ombudsman received legal advice from Queen"s Counsel on the funding and provision of CHC, which proposed a number of improvements to the Framework. These

include; “fast-tracking” cases, the issuing of refunds guidance, guidance to Local Health Boards on where their financial liabilities start, and setting out expectations on Local Health Boards where there has been inaction or delay in progressing a claim.

20. Some of those measures have already been taken. For example, over the last twelve months Welsh Ministers have issued interim guidance to clarify and strengthen arrangements relating to eligibility for CHC.

The Proposed 2014 Framework for CHC

21. These new measures are built into the proposed 2014 National Framework for Continuing NHS Healthcare. They aim to strengthen the guidance and strategic oversight given to LHBs. The proposed Framework is fairly complex in terms of detail but a breakdown of the areas in which it has been revised is set out in Section 3. The proposed Framework replaces the previous arrangements set out in the 2010 National Framework for Continuing NHS Healthcare and is supported through:
    - communication tools;
    - an online „CHC Toolkit" to assist CHC staff, including template documentation for LHBs on contracts, policies and protocols;
    - structured opportunities for shared learning, through annual conference, newsletters and an online staff forum for problem-solving; and,
    - a National Performance Framework, to be implemented from the date of the launch of the updated Framework.

22. It should be noted that the proposed Framework refers to various legislation, regulations and statutory guidance. It should be borne in mind that some of these will be revised over the course of time. The interpretation of the guidance in this document should therefore take into account future changes.

Assessment

23. An individual"s eligibility for CHC is comprehensively assessed through a Multi Disciplinary Team (MDT) and in discussions with the person and/or their family. The complexities and unique circumstances surrounding each person"s claim for CHC mean that the entire process can take up to several weeks to proceed.

24. The LA should usually be represented on the MDT completing the CHC eligibility process. This means that, in most cases, the key assessment information needed for LA support is already available to prevent a delayed discharge. Therefore, where an individual is found to be ineligible for continuing NHS healthcare, the LA should be in a position to respond and action their responsibilities quickly.

25. Central to CHC arrangements is the multidisciplinary team"s (MDT) assessment of the individual"s care needs which inform the completion of a Decision Support Tool. Throughout the assessment process, the assessment team must keep the individual informed and detail the individual"s view of their own care/support needs. This should all be done through a care co-ordinator, employed by the LHB. As part of the „person-centred approach", individuals, their family, or their chosen representatives, should be actively involved in the process.

26. The differing levels of need and risk to the individual should be identified and reflected within an Integrated Assessment and the care planning and management approach must consider a number of care options, which should be recorded within the service delivery plan. Examples of these care options may include (but are not confined to):

The role of the DST

27. The purpose of the Decision Support Tool is to help identify eligibility for continuing NHS healthcare; it is not designed as an assessment tool in its own right. A good quality multidisciplinary assessment may well identify care/support needs requiring a response by the LHB or LA regardless of eligibility for continuing NHS healthcare.

28. Any new CHC arrangements will need to be fully integrated into the new Integrated Assessment process. This is set out in Chapter 7 of the Framework.

Section 3

The Revision of the Framework

29. We recognise the existing CHC arrangements need to be looked at. We have acted on this, taking on board the views of the WAO and other parties to produce a plan for revising those arrangements, in partnership with stakeholders. In doing so, we have acknowledged their consensus that a complete rewrite of the Framework is not necessary. Instead we have revised certain areas, adopting best practice as appropriate, to ensure the Framework provides clear, practical and user-friendly guidance.

30. The proposed Framework sets out the underpinning principles where practitioners must be able to demonstrate that they have adopted good practice in the following areas:

    - Putting the needs of the individual first (“People first”).
    - „No decisions about me without me"; involving the individual, or their families or carers.
    - No delays in meeting an individual"s needs due to funding discussions.
    - Focus on need not diagnosis.
    - Co-ordinated care.
    - Communication.

31. In implementing the principles detailed above, the proposed Framework clarifies the roles and responsibilities of those being assessed, their carers/representatives, the lead professional (“care co-ordinator”) responsible for the assessment, the multi-disciplinary team members (MDT) who assess and recommend any package of care and the panel that commissions the persons required services.

The proposed Framework also provides contains the following excerpts:

Underpinning Principles – Welsh Language

32. The updated Framework contains a new provision reinforcing that for Welsh speakers, effective communication through the medium of Welsh is a key requirement of assessment and the provision of any support required.

Chapter 2 - Governance and Strategic Ownership

33. Chapter 2 of the proposed Framework strengthens LHB ownership of CHC by setting out, at Director Level, responsibility for monitoring CHC performance and maintaining strategic oversight.

34. Under the new Framework, each LHB must identify a named executive, at Director level, who is responsible for monitoring CHC performance and maintaining strategic oversight. They should present, as a minimum, a quarterly CHC performance report to their Board, as well as an annual report based on the CHC Toolkit. They will escalate required actions for which the LHB will be held to account. LHBs are required to utilise the national CHC Performance Framework which can also be accessed via the CHC Toolkit and the Self-Assessment Tool developed by the Wales Audit Office.

35. The Welsh Government will collate a national report and will provide the support mechanisms required to share learning

Chapter 7 – The Assessment process and Decision Support Tool (DST)

a) *The Assessment Process*

36. The proposed Framework notes that the guidance document „Creating a Unified and Fair System for Assessing and Managing Care" (National Assembly for Wales 2002)[1] has now been replaced in relation to older people by the new interim guidance – Integrated Assessment, Planning and Review Arrangements for Older People. This interim guidance aims to simplify and minimise administrative burdens so the professional can spend more time working directly with people to better understand their needs and act earlier in helping them. It should also serve to integrate assessments more effectively by rationalising processes for gathering and recording information to avoid duplication of effort. More effective assessments should, for example, reduce the burden concerning the application of the „decision support tool" used for CHC purposes.

37. The proposed Framework stipulates that the new assessment process should utilise, not duplicate, the integrated or unified assessment framework and align with good discharge practice, as detailed in Welsh Government Guidance[2] and *Passing the Baton*[3].

38. The Multi-Disciplinary Team also consider the optimum environment in which the assessment for longer-term care should take place in order to maximise the individual"s potential for independence. Care must be taken to ensure that no premature presumptions are made. regarding the requirements for long-term care whilst the individual is acutely unwell. „Home first" should be the default position and rehabilitation/ reablement to support the retention of as much independence as possible, must

[1] Creating a Unified and Fair System for Assessing and Managing Care, National Assembly for Wales 2002
[2] NAFWC 17/2005 Hospital Discharge Planning Guidance
[3] Passing the Baton: A Practical Guide to Effective Discharge Planning (2008)

always be considered. Options to be considered include step-down/intermediate assessment facilities in the community, or the person‟s own home with intensive short-term support.

b) The Decision Support Tool (DST)

39. We have carefully considered the findings of the WAO report and agree that there are benefits of adopting the English DST, including its user-friendly approach. We shall therefore adopt this as part of the new Welsh arrangements. Our new DST will address the anomalies highlighted in the WAO report and facilitate seamless cross-border delivery of CHC. We will monitor this through the Performance Framework.

40. The focus must be on a rounded and holistic assessment of the individual rather than DST scores. If the integrated assessment and care plan are sufficiently robust there is no requirement to duplicate paperwork by copying information into the DST document. It will be acceptable in these circumstances to only complete the DST matrix plus the summary record of the MDT discussion and recommendation on eligibility. We have also stipulated that the final discussion and recommendation on CHC eligibility should be undertaken in a formal MDT meeting, to which the person and/or their carers must be invited.

41. Finally, the proposed Framework requires LHBs to have robust quality assurance mechanisms in place to ensure consistency of decision making. A decision not to accept the recommendation must not however be made by one person acting unilaterally. In such circumstances the nominated manager should refer the case to the decision Panel. We have also made clear in the proposed Framework that LHB‟s responsibility for the funding of CHC commences at the point at which the Panel makes the final decision on behalf of the Board.

Chapter 8 - Care Provision and Monitoring

42. The Proposed Framework sets out the support carers must have provided to them and also stipulates the responsibilities LHBs have in commissioning and delivering the care package for the individual. This section also sets out the requirements for the contracts and service specifications for registered settings and the operational procedures to ensure its responsibility for commissioned services are effectively secured and monitored, where care is provided by external agencies. The chapter also notes the need for a written agreement between t he LHB and the individual and/or their representative, clearly setting out what is covered

by CHC funding. It also expects that LHBs and local authorities must work together to identify gaps in current and future service provision

43. The Chapter also instructs LHBs to have regard to compliance with statutory guidance, including *„Escalating Concerns With, and Closures of, Care Homes Providing Services for Adults*‟ (8.13)

44. The proposed Framework also sets out new arrangements for additional Personal Contributions from a person who is eligible for CHC, including additional services and extras, as well as retaining an existing provider. It also clarifies the use of Direct Payments and CHC as well as joint funding arrangements.

Chapter 9 - Reviews

45. Chapter 9 strengthens arrangements for existing reviews, stipulating that the individual and/or their representative and the service provider must be provided with the contact details of a named care co-ordinator/lead professional, so that any changes in the person‟s condition or circumstances can be promptly addressed.

46. Those receiving NHS Funded Nursing Care in a care home must also be reviewed on at least an annual basis. It adds that such a review should include the completion of the CHC Checklist Screening Tool in order to identify those whose needs may now indicate eligibility for CHC. The LHB must ensure that the individual, their family/representative and care home provider have the information and contacts available to enable them to identify changes in need which indicate a timely review is required. Care home providers should be encouraged to complete the Checklist themselves and alert the health board when a full assessment for CHC eligibility is required.

Chapter 10 - Other Policies and Specialist Areas of Practice

47. The proposed Framework now also contains a section highlighting how it will link to other areas, such as:

- Mental Health Act 1983 After Care Services;
- Deprivation of Liberty Safeguards;
- The Transition from Child and Young Persons to Adult Services;
- Applying the CHC Framework to adults with a Learning Disability;
- Entitlement to other NHS Funded Care;
- Community Equipment; and,
- Joint Training.

Chapter 11 - Dispute Resolution

48. Chapter 11 of the proposed Framework sets out the expectation that LHBs and their partners work together to deliver the best possible outcomes for the citizens of Wales through effective partnership working and integration. It specifies where the MDT is unable to reach a consensus view on CHC eligibility, they should escalate the dispute to the appropriate manager and access objective expertise from within, or outside of, their LHB. Where the individual and/or their representative disputes the clinical assessment of the MDT, external peer review should be offered to avoid escalation to the formal disputes or complaints procedure and applications for retrospective reviews.

49. This chapter also notes that LHBs are expected to participate in an annual case review exercise which will be co-ordinated by Welsh Government and supported with materials in the CHC Toolkit.

Chapter 12 - Independent Review Panel (Appeals Process) and Complaints

50. The proposed Framework sets out the need for consistency in the operation of Independent Review Panels and that the deliberations must be properly recorded and communicated.

Chapter 13 - Retrospective Claims for Reimbursement.

51. The final chapter of the Framework is a new one, devoted to backdated ("retrospective") claims for when an individual paid for their care but met the eligibility criteria for CHC which were applicable at that time. It notes an individual or their representative(s), may request a retrospective review where they contributed to the cost of their care, but have reason to believe that they may have met the eligibility criteria for CHC which were applicable at that time. If eligibility is demonstrated for either the full or part period of the claim, the principles of good public administration demand that timely restitution be made. No retrospective claim should take more than two years to process.

52. This section outlines the process for making a claim and the cut-off dates by which a claim must be made, as well as the responsibility for managing such claims.

Section 5 Questions

1. The Wales Audit Office concluded elements of the existing Framework lacked clarity. Does the updated Framework successfully address this? Are there areas which require further attention?

2. Does the Framework provide a clear overall road map to help you understand where you are within the process?

3. Does the proposed Framework provide sufficient assurance about the responsibility, ownership and governance of CHC by Welsh Government, LHBs and their partners?

4. Are the proposed Assessment Process, Checklist/Screening Tool and Decision Support Tool, fit for purpose?

5. Do you think it is helpful to move from the existing Welsh Decision Support Tool (DST) within the existing Framework, to the new proposed version, which will be based on the English DST?

6. Do you think that individuals and their families are involved enough in the updated assessment process? If not, in which additional ways would you like to see the process improved?

7. In your view does the proposed Framework link effectively with other health and social services policy and guidance? Are there any other linkages to good guidance or innovative practice we should be making?

8. An online-based toolkit of resources to support the implementation of CHC will be developed (the contents list is annexed to the Draft Framework). Are there other products you would wish to see addressed in such a toolkit?

9. The Framework is a technical document aimed at specialist professionals who oversee assessment and care provision. We would welcome your thoughts on the potential publication of a simplified Framework for frontline practitioners (e.g. ward staff) and service users. Comments on its appropriateness, including suggested format, content and style are welcome.

Consultation Response Form

Your name:

Organisation (if applicable):

email / telephone number:

Your address:

Responses to consultations are likely to be made public, on the internet or in a report. If you would prefer your response to remain anonymous, please tick here: ☐

If you are responding on behalf of your organisation, please tick here: ☐

Question 1: The Wales Audit Office concluded elements of the existing Framework lacked clarity. Does the updated Framework successfully address this? Are there areas which require further attention?
Comment:

Question 2: Does the Framework provide a clear overall road map to help you understand where you are within the process?
Comment:

Question 3: Does the proposed Framework provide sufficient assurance about the responsibility, ownership and governance of CHC by Welsh Government, LHBs and their partners?
Comment:

Question 4: Are the proposed Assessment Process, Checklist/Screening Tool and Decision Support Tool, fit for purpose?
Comment:

Question 5: Do you think it is helpful to move from the existing Welsh Decision Support Tool (DST) within the existing Framework, to the new proposed version, which will be based on the English DST?
Comment:

Question 6: Do you think that individuals and their families are involved enough in the updated assessment process? If not, in which additional ways would you like to see the process improved?
Comment:

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Comment:

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Comment:

Document is Restricted