National Assembly for Wales
Public Accounts Committee

Unscheduled Care

April 2014

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Public Accounts Committee
The Public Accounts Committee was established on 22 June 2011.

Powers
The Committee's powers are set out in the National Assembly for Wales' Standing Orders, with its specific functions of the Committee are set out in Standing Order 18 (available at **www.assemblywales.org)**. In particular, the Committee may consider reports prepared by the Auditor General for Wales on the accounts of the Welsh Government and other public bodies, and on the economy, efficiency and effectiveness with which resources were employed in the discharge of public functions.

The Committee also has specific statutory powers under the Government of Wales Act 2006 relating to the appointment of the Auditor General, his or her budget and the auditors of that office.

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Welsh Conservatives
Clwyd West

William Graham
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Jenny Rathbone
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Cardiff Central

Aled Roberts
Welsh Liberal Democrats
North Wales

The following Member was also a member of the Committee during this inquiry:

Jocelyn Davies
South Wales East
Plaid Cymru

Mohammad Asghar (Oscar)
Welsh Conservatives
South Wales East

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Chair's foreword

On the 12 September 2013 the Auditor General for Wales published a report detailing the challenges and opportunities for improvement and the progress made in transforming unscheduled care services. The report acknowledged that a renewed focus on unscheduled care had secured improvements but the transformational changes required for sustained improvement had not been fully implemented. As a Committee we agreed that the findings of the report warranted further investigation.

The evidence we heard concurred with the findings of the Auditor General's report and although we note recent reports of some improvements in the delivery and performance of unscheduled care services we have concluded that radical solutions are still required to address the challenges ahead.

The pressures facing the delivery of unscheduled care services in Wales are complex. Whilst there has been effort by those working within NHS Wales to drive forward improvement, the pace of change has been unable to deliver the transformation that is required.

There needs to be greater consistency and clarity around performance data to ensure information on service delivery and patient experience is accurate and meaningful. This will help to better identify problem areas and lead to better informed decisions on where future improvement is needed.

It is crucial that an end is brought to the uncertainty arising from service reconfiguration to improve the recruitment and retention of hospital staff along with a clear strategy to prevent future problems in the GP workforce.

It is equally important that work is undertaken to promote the choices available to patients to maximise their access to primary care services and reduce pressures on emergency departments.

We trust that the recommendations in this report will be useful in driving forward sustained improvement in unscheduled care across Wales.

The Committee's Recommendations

The Committee's recommendations to the Welsh Government are listed below, in the order that they appear in this Report. Please refer to the relevant pages of the report to see the supporting evidence and conclusions:

Recommendation 1. The Committee concludes that immunisation has a role in reducing pressures on unscheduled care services and we recognise the importance of public education on the benefits of immunisation programmes. We recommend that the Welsh Government undertakes further work with the NHS organisations to increase immunisation rates amongst the population, including significantly increasing its targets for vaccinating frontline NHS staff against influenza. (Page 15)

Recommendation 2. Evidence to the Committee suggests a lack of clarity around how data relating to ambulance arrivals and handovers are collected and that local variations apply. To end this confusion and ensure accurate recording of data, we recommend that the Welsh Government introduce clear and consistent guidelines that set out how ambulance handovers should be recorded. This should include guidance on how patients treated in ambulances outside the department are to be appropriately cared for and categorised (Page 18)

Recommendation 3. The Committee recognises the importance of recording Patient Related Outcome Measures (PROMS) but we remain concerned about the need to compare performance in Wales with that elsewhere in the UK and the willingness of patients, particularly older people, to share their experiences, especially if these are negative, at a time when they are poorly and vulnerable. We recommend that the Welsh Government work with health boards to develop a wider suite of performance measures for unscheduled care that allow quality of care and patient experiences to be measured and recorded in a way which allows for comparisons in the UK and beyond. (Page 19)

Recommendation 4. We believe there is a need to end uncertainty about the future provision of emergency department services across Wales and recommend that the Welsh Government continues to work with health boards to bring this uncertainty to an end in order to achieve safe and clinically sustainable medical staffing models in

emergency departments and to promote the necessary recruitment and retention of staff. (Page 23)

Recommendation 5. The Committee recognises that primary care may be provided through a number of services in addition to those provided by GPs and public awareness of this needs to be raised. We recommend that the Welsh Government undertake more work to promote the choices available to patients and the means by which these services might be delivered. For example, we acknowledge that access to primary care may be through access to a health professional other than a GP and this could be over the telephone. (Page 28)

Recommendation 6. The Committee notes that the provision of a telephone service can assist patients in determining when an appointment is urgent but believe that it is essential that such services have clinical input. The Committee recommends that the Welsh Government ensure that health boards are promoting clinically led telephone triage in GP practices and that patients have access to telephone advice on the most appropriate course of action when an urgent appointment with a GP is requested. (Page 28)

Recommendation 7. The Committee notes the approaches taken by Aneurin Bevan and Cwm Taf University Health Boards to improve access to GP services but note that despite these attempts to improve access significant progress is still required. We recommend that existing approaches to improving access to GP appointments, be evaluated so that good practice can be identified and shared across health boards. (Page 31)

Recommendation 8. The Committee notes the difficulties involved in introducing penalties for those patients who do not attend appointments with their GPs. While the Committee recognises there are existing initiatives in place to reduce 'did not attends', we believe the current rate is unacceptable and is contributing to difficulties in patients accessing GP appointments. We recommend that the Welsh Government consider this issue further and look to approaches adopted elsewhere, including the Republic of Ireland and Northern Ireland in reducing 'did not attends'. (Page 33)

Recommendation 9. The Committee received mixed evidence on the extent to which inappropriate attendance to emergency departments is a problem. We recommend that the Welsh Government

urge health boards to collect clearer data to identify the scale of inappropriate attendances to emergency departments to develop a consistent approach to addressing any issues identified. To further support this, initiatives to collect data on patient experiences in emergency departments should include questions to determine why patients chose to attend the A&E department. (Page 35)

Recommendation 10. The Committee was unable to clarify the progress that has been made in implementing the recommendations of the National Out- Of-Hours Steering Group. The Committee recommends that the Welsh Government publicly responds to the findings and recommendations of this Group and provide details to this Committee of the action it is taking in response to the Group's work. (Page 39)

Recommendation 11. The Committee notes the potential benefits of co-location of GP services with emergency departments, particularly where these are accessed via the emergency department front door. The Committee recommends that the Welsh Government works with health boards to encourage further co-location of GP services with emergency departments and, as part of this work, considers whether there would be any benefits in introducing walk-in centres as part of the integrated provision of unscheduled care services in Wales. (Page 40)

Recommendation 12. The Committee notes the concerns raised by the British Medical Association regarding the recruitment and retention of GPs and future workforce shortages. We also acknowledge that the problem varies across Wales with rurality being a particular issue. The Committee does not feel that we have received sufficient assurances from the Welsh Government that these concerns are being addressed. The Committee recommends that the Welsh Government undertake a detailed evaluation of the current GP workforce across Wales and that a strategy is developed to ensure capacity meets demand. We also recommend that such a strategy should include provision for the delivery of services in the Welsh language. (Page 42)

Recommendation 13. The Committee is concerned that not all of the strands of services listed by the Choose Well campaign are actually available in all parts of Wales. For example, not all areas have minor injury units and in those that do service provision and hours of operation varies. The Committee recommends that the Welsh

Government undertake more work to educate the public on what services are available in their specific areas and how these can be accessed. (Page 45)

Recommendation 14. The Committee recommends that the Welsh Government enhances the Choose Well campaign through better promotion of other opportunities for accessing health care, for example through community pharmacists and optometrists. (Page 45)

Recommendation 15. The Committee acknowledges that the approach being taken by the Welsh Government, towards implementing a 111 service is sensible. However, the Committee is keen to ensure that the timelines for the development and introduction of the service are met. The Committee recommends that the Welsh Government provides a written progress report on the 111 service by January 2015. (Page 47)

Recommendation 16. The Committee acknowledges the opportunities presented by telephone initiatives to reducing demand on unscheduled care but recognise there are challenges in its practical application. We note evidence that such systems can be prone to risk aversion with telephonists making judgements using algorithms. To address this, the Committee recommends that the new 111 service should include sound clinical protocols with telephonists equipped with the right skills to evaluate a call and escalate it to an appropriate clinician who should be readily available. (Page 50)

Recommendation 17. The Committee recommends that the Welsh Government provides evidence that health boards have sufficient bed capacity to meet unscheduled care demand. Where plans to provide "surge capacity" are in place, consideration is given to the use of GPs as well as hospital to enable the system to meet demand when necessary. (Page 54)

Recommendation 18. The failure to properly manage chronic conditions can have a significant impact on the demand for unscheduled care services. We therefore recommend that the Welsh Government sets out how it intends to respond to the Auditor General's findings and recommendations, and that this response is shared with the Committee alongside the Welsh Government's responses to the other recommendations in this report. (Page 55)

Recommendation 19. The Committee recommends that the Welsh Government emphasise, including to frontline staff, that transfers to hospital from care homes should not be automatic following a fall but that each case should be assessed individually to determine whether such a transfer is clinically required. (Page 59)

1. Introduction

Background

1. The Auditor General's for Wales' report on 'Unscheduled Care - An update on progress' was published on 12 September 2013. The report aimed to track progress made by public services in Wales in addressing the main issues raised by the Auditor General's report in December 2009. The report also highlighted the key remaining challenges and opportunities for improvement and the review examined whether there had been progress in transforming unscheduled care services to address the issues previously identified in Wales Audit Office publications

2. The Auditor General's report concluded that deteriorating performance since 2009 had prompted considerable focus on unscheduled care that is now securing early signs of improved performance. However, the transformational changes that are required for sustained improvement have not been fully implemented.

3. The Public Accounts Committee received a briefing from the Auditor General for Wales at its meeting on 3 October 2013 and arising from that, agreed to undertake an inquiry into the issues raised in the report and specifically focusing on primary care.

4. This report outlines the findings of the Committee's work and makes a number of recommendations to the Welsh Government.

2. Unscheduled care performance and pressure on services

Trends in unscheduled care performance

5. Part 1 of the Auditor General's report[1] states that unscheduled care performance had deteriorated, with patients continuing to face delays at various points in the system. The report recognises that waiting times were generally worse than in 2009 although it acknowledges early signs of improvement in spring 2013.

6. The Committee acknowledged the level of focus and scrutiny on unscheduled care services and signs of early improvement but questioned the Welsh Government on why there has been a trend of long-term deterioration in performance in key areas such as emergency department waiting times, ambulance response times and ambulance handovers.

7. The Director General for Health, Social Services and Children (the Director General) explained that:

> "The longer term view is a mixed one. There have been some areas where there has been improvement or stability in performance, but also some where we acknowledge – particularly under the circumstances last winter – where there has been some deterioration. We are focussing our efforts on continuing the pattern of improvement that the Wales Audit Office drew our attention to in the report."[2]

Maintaining recent improvements in Performance

8. Evidence suggested that recent improvements in performance needed to be treated with caution, with questions raised regarding the sustainability and differences of opinion on the underlying causes of such improvements.

9. The Auditor General for Wales stated that:

> "Since the spring of this year, there have been improvements in a number of the key performance measures for unscheduled care. This is positive, but I am cautious about the sustainability

[1] Wales Audit Office – Unscheduled Care – An Update on progress (September 2013)
[2] RoP, Public Accounts Committee, 12 November 2013, paragraph 129

of these improvements, because we have found that some of the key underlying challenges that we identified in 2009 remain unresolved."[3]

10. He added that:

> "More progress is needed in developing whole-system solutions with more community-based services in place to help to manage demand and to reduce reliance on the acute hospital sector."[4]

11. The Committee questioned the Welsh Government on the sustainability of recent improvements in performance and sought clarity on the actions being taken to ensure improvements to performance continued to progress in the right direction.

12. The Welsh Government attributed improvements in performance to the strong level of Ministerial interest and leadership, Chief Executives taking ownership of a comprehensive work programme, the appointment of a national unscheduled care lead and a much greater degree of collaboration between health bodies and local authorities.[5]

13. Evidence from those working within the NHS suggested that recent improvements were not a coincidence. The Chief Executive of Aneurin Bevan University Health Board (ABUHB), informed the Committee that:

> "The performance over the last 12 months is not just a coincidence. There has been a lot of concerted effort. Some of the issues that we had introduced in our own health board over the last two or three years do not simply change overnight. I can show you trends where there was some early movement, but it was over the last two or three years that we have seen a significant change as people have become used to the services and you stop the cycle of that repeat attendance."[6]

14. He added that:

> "It is also right to say that pressures can be influenced by issues like cold weather. It was an exceptional experience last

[3] RoP, Public Accounts Committee, 3 October 2013, paragraph 5
[4] RoP, Public Accounts Committee, 3 October 2013, paragraph 5
[5] RoP, Public Accounts Committee, 12 November 2013, paragraph 132
[6] RoP, Public Accounts Committee, 16 January 2014, paragraph 9

> winter. However, we can also target other ways of improving things by simply increasing things like immunisation rates for children, and targeting that type of issue, as they generally give your population a better health level and status. We have also seen some influence over the last 12 months about some of the higher immunisation levels kicking in as well."[7]

15. The Committee discussed with Chief Executive of ABUHB the impact of population health on pressures on emergency departments and focusing work on improving population health to reduce these pressures. For example, in Aneurin Bevan University Health Board, he explained that:

> "The reason that we focused on respiratory illnesses locally was simply because the highest level of hospital admissions in relation to emergency pressures are for respiratory problems. So, although it was a population health factor, we also know that we were driving it because it was where we thought that there would be the greatest impact if we were able to alter these kinds of services."[8]

16. On the issue of improving population health the Committee referred to the importance of immunisation and particularly the pressures on services arising from the measles outbreak of 2012 - 13 that could have been prevented through immunisation.[9] Similarly the impact of other virus outbreaks such as influenza put pressure on unscheduled care services and further highlights the importance of immunisation.

17. The Committee is aware that in giving evidence to the Health and Social Care Committee, the Minister for Health and Social Services stated that:

> "The approach that we have taken in Wales is that it is the responsibility of employers to make sure that vaccination is available to their staff. Many local authorities, which directly employ social work staff, for example, who are involved in going to people's homes, do exactly that. We are doing more

[7] RoP, Public Accounts Committee, 16 January 2014, paragraph 11
[8] RoP, Public Accounts Committee, 16 January 2014, paragraph 19
[9] RoP, Public Accounts Committee, 16 January 2014, paragraph 20

this year with the care home sector, and the domiciliary care home sector particularly."[10]

18. The Committee explored the impact of NHS staff being immunised specifically against influenza on reducing pressures on the workforce and also to prevent the spread of such viruses. We questioned the Chief Executive of ABUHB on what percentage of Aneurin Bevan Health Board's hospital front-line staff were immunised against flu. He confirmed that:

> "at the moment, we have a target locally of about 50%. We are currently heading for about 40%, and we are trying to make sure that we push it through to 50% by the end of January."[11]

19. He added that:

> "From a personal perspective, I would like to see a 75% or 80% level being achieved to get the coverage. It is a very personal choice that is made by people. It is not a mandatory requirement on people working within the NHS at this stage. So, we very much target campaigns—we run it through our occupational health areas—but we need people to accept it."[12]

20. The Minister also told the Health and Social Care Committee that there is a target to vaccinate 50% of NHS staff against influenza.[13]

The Committee concludes that immunisation has a role in reducing pressures on unscheduled care services and we recognise the importance of public education on the benefits of immunisation programmes. We recommend that the Welsh Government undertakes further work with the NHS organisations to increase immunisation rates amongst the population, including significantly increasing its targets for vaccinating frontline NHS staff against influenza.

[10] RoP, Health and Social Care Committee, 9 October 2013, paragraph 42
[11] RoP, Public Accounts Committee, 16 January 2014, paragraph 28
[12] RoP, Public Accounts Committee, 16 January 2014, paragraph 26
[13] RoP, Health and Social Care Committee, 9 October 2013, paragraph 45

3. Continued Pressures in Emergency Departments

21. The Auditor General's report highlighted concerns about the impact of frequent high workload pressures, on the morale of staff working in emergency departments.[14] His report also stated that because emergency departments are so frequently running at elevated pressure, some ways of working that can compromise the quality and safety of care are becoming the norm rather than the exception. These ways of working include patients being treated in hospital corridors, patients having to spend entire nights on emergency department trolleys and long delays in patient handovers between ambulance staff and hospital staff.[15]

22. The Auditor General's report also states that there have been some actions taken to improve measures of quality and outcomes in unscheduled care but overall progress has been disappointing.[16] The report also highlighted there is not yet a systematic approach to monitoring patient experience of unscheduled care services.[17] The report identified several issues relating to paucity of good quality data on unscheduled care and specific problems with Emergency Department Dataset (EDDS).[18]

23. Evidence from the Welsh Government states that EDDS may be superseded by the procurement of a new emergency department information system.[19]

Performance Indicators

24. On 10 December 2013, the Committee discussed potential weaknesses in NHS Wales's data regarding emergency department performance. In evidence, the Chair of the Welsh National Board of the College of Emergency Medicine informed the Committee that he did not recognise the picture painted by the national data showing the improved emergency department performance over recent months. He stated:

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[14] Wales Audit Office – Unscheduled Care – An Update on progress, paragraph 1.51
[15] Wales Audit Office – Unscheduled Care – An Update on progress, paragraph 1.52
[16] Wales Audit Office – Unscheduled Care – An Update on progress, paragraph 1.22
[17] Wales Audit Office – Unscheduled Care – An Update on progress, paragraph 1.32
[18] Wales Audit Office – Unscheduled Care – An Update on progress, paragraphs 1.38, 1.46, 2.6, 2.7
[19] Written evidence, PAC(4)-29-13 (paper2), 12 November 2013

> "I find that we feel that the pressure in the department is actually getting worse, if anything. That is part of the problem with the data that we collect. On the ground, it sometimes does not feel like the position being demonstrated by the statistics."

25. The Chair of the Welsh National Board of the College of Emergency Medicine also highlighted that certain patients are sometimes excluded from the data so they do not appear as long waits and he mentioned that when patients are deemed suitable for a clinical decisions unit, their care in the emergency department is deemed completed.

26. The Committee is aware of other well documented pressures at emergency departments across Wales that have been reported in the media. For example, patients being told to avoid Morriston Hospital Accident and Emergency department unless there was a 'genuine emergency', while staff dealt with a backlog of patients.[20]

27. Similarly, in January 2014, the media reported that the Accident and Emergency department at Wrexham Maelor hospital was "log-jammed" with others in north Wales in a similar situation.[21] The accident and emergency unit at Withybush Hospital in Pembrokeshire also faced increased pressure in January 2014, with managers urging patients only to attend if they "really need it".[22] Similar messages were also issued from other hospitals in Wales during this period.

28. In light of this evidence, the Committee is concerned that the suite of performance indicators currently used by the Welsh Government does not reflect the true extent of pressures in emergency departments.

29. The Committee is also concerned with the lack of clarity around how data is collected. The Chair of the Welsh National Board of the College of Emergency Medicine explained that there is confusion around how data, particularly regarding ambulance handovers, is recorded stating that:

> "I am trying to think of when the clock-on time in department actually starts. I must admit that I am not sure whether that is

[20] www.bbc.co.uk/news/uk-wales-south-west-wales-25315617,10 December 2013
[21] www.bbc.co.uk/news/uk-wales-south-east-wales-25652941, 8 January 2014
[22] www.bbc.co.uk/news/uk-wales-south-west-wales-25596782, 3 January 2014

the time when they are actually registered, or when they arrive initially in the ambulance."[23]

30. The Committee also discussed the lack of clarity around how admissions to emergency departments are recorded and when in the data collection process, patients who are treated in ambulances are counted as admissions to emergency departments. For example, if a patient is administered treatment in the back of an ambulance and completes this treatment whilst it is parked outside the emergency department, it is unclear to the Committee as to when, if at all, such activity is recorded as an admission to the emergency department.

31. The Committee is concerned about how patients treated in ambulances are categorised if they do not receive emergency treatment within the emergency department but receive emergency treatment in an ambulance before being admitted as an in-patient within the hospital.

32. The Committee has written to the Welsh Ambulance Service NHS Trust and unions representing ambulance personnel on these matters but neither response was able to provide the clarity we sought.

Evidence to the Committee suggests a lack of clarity around how data relating to ambulance arrivals and handovers are collected and that local variations apply. To end this confusion and ensure accurate recording of data, we recommend that the Welsh Government introduce clear and consistent guidelines that set out how ambulance handovers should be recorded. This should include guidance on how patients treated in ambulances outside the department are to be appropriately cared for and categorised.

33. Evidence presented to the Committee also suggested that although the current suite of performance indicators placed more focus on process rather than outcomes.[24]

34. The Chief Executive of ABUHB stated that:

"…the opportunity to set a different set of indicators for our whole system right through from GPs to the local government areas of service, or the integrated services that we provide, so it is not a debate about A&E departments only, that really is for

[23] RoP, Public Accounts Committee, 10 December 2013, paragraph 36
[24] RoP, Public Accounts Committee, 16 January 2014, paragraph 53

> us to look at and develop. My strong recommendation would be to make sure that it is not simply about looking at that as an industry, but about making sure that the indicators are very meaningful, certainly at the clinical level, as far as the system works, and I think that there are ways in which we can work it through."[25]

35. He agreed with the Auditor General's report conclusion that performance indicators needed to "make sure that the patient experience side of things is brought through more strongly."[26]

36. On the subject of patient experience and performance indicators, the Chair of the Welsh National Board of the College of Emergency Medicine used the example of figures on patients treated in ambulances highlighting that:

> "Unfortunately, sometimes you get to a situation where actually keeping them [the patient] in an ambulance outside is safer for that individual patient, but obviously not for your figures. As I say, with all the numbers and all the figures, at the end of every figure is an individual patient that has an individual experience, and that is the thing that we see from day to day."[27]

37. Baroness Finlay also commented on the need to gather data on patients experiences stating that:

> "The bit of data that I think that we are not collecting that we really should be collecting is what the patients are experiencing, and what they say. Until we really routinely find out, very simply, from patients what their experience is of the system, we are not going to get the change coming through. We introduced it in palliative care some years ago, and, although the return rate is low from the number of patients that are seen, and although some services are much better at going and seeking the patient opinion than others, the feedback that we have had has been invaluable."[28]

The Committee recognises the importance of recording Patient Related Outcome Measures (PROMS) but we remain concerned

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[25] RoP, Public Accounts Committee, 16 January 2014, paragraph 54
[26] RoP, Public Accounts Committee, 16 January 2014, paragraph 55
[27] RoP, Public Accounts Committee, 10 December 2013, paragraph 45
[28] RoP, Public Accounts Committee, 10 December 2013, paragraph 162

about the need to compare performance in Wales with that elsewhere in the UK and the willingness of patients, particularly older people, to share their experiences, especially if these are negative, at a time when they are poorly and vulnerable. We recommend that the Welsh Government work with health boards to develop a wider suite of performance measures for unscheduled care that allow quality of care and patient experiences to be measured and recorded in a way which allows for comparisons in the UK and beyond.

Risks

38. Some of the practical pressures on emergency departments were outlined in evidence from the Chair of the Welsh National Board of the College of Emergency Medicine who described the experiences of him and his staff having to treat patients in the back of ambulances in the hospital car park. He said this was problematic due to the alien environment, which was uncomfortable for experienced staff to be working in and more so for junior staff.[29]

39. We are seriously concerned about the risks involved in treating patients in the back of ambulances and the risks posed to the lives of those patients, particularly given recent cases where patients have died during the time when they have been treated in ambulances while their transfer into hospital has been delayed.

40. The Committee also heard evidence of the risks associated with lower morale and constant high pressure in emergency departments. In oral evidence, the Chair of Cwm Taf University Health Board (CTUHB), explained that there had been problems with morale in Cwm Taf's emergency departments but this is now improving. He added that:

> "We are there to care. I am immensely proud of the professions, as I have said before, and they are coping, but they are stressed."[30]

41. Baroness Finlay informed us that "we are working our staff very hard, and they are really exhausted".[31]

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[29] RoP, Public Accounts Committee, 10 December 2013, paragraph 56
[30] RoP, Public Accounts Committee, 16 January 2014, paragraph 345

42. Similar views were expressed by the Chair of the Welsh National Board of the College of Emergency Medicine who told the Committee that emergency departments are 'pressured environments by their nature'[32] but described a desensitisation to the constant pressures in the emergency department. He informed us that:

> "I think that that is an issue in that, essentially, when you work in that pressured environment, you become desensitised to that pressure, and over a period of time quality does slip because, when you are running a whole department, you are running it for all the patients who are there, and one has to balance that with the care that individual patients receive. Unfortunately, sometimes, the care that an individual patient receives suffers because you are trying to manage care for the collective group. Unfortunately, we see that care for individuals does deteriorate because we are trying to manage the safety of the overall department."[33]

43. In reference to the pressures on emergency departments the Director General told us that:

> "We also have escalation arrangements in place, so, when the pressure gets on within organisations and between organisations, they can make the right responses to increase capacity or to adopt an approach that is based on geography that goes beyond a single organisation."[34]

44. The Committee heard that the high workload pressure in emergency departments was one factor contributing to problems with recruitment and retention of medical staff. However, it was also acknowledged that this was a UK wide issue and not limited to Wales.

45. Indeed, in giving evidence to the Health and Social Care Committee, the Minister for Health and Social Services recognised the difficulties recruiting into emergency medicine in Wales and that the difficulties were experienced elsewhere in the UK.[35]

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[31] RoP, Public Accounts Committee, 10 December 2013, paragraph 195
[32] RoP, Public Accounts Committee, 10 December 2013, paragraph 61
[33] RoP, Public Accounts Committee, 10 December 2013, paragraph 53
[34] RoP, Public Accounts Committee, 12 November 2013, paragraph 210
[35] RoP, Health and Social Care Committee, 9 October 2013, paragraph 89

46. This Committee was told by Welsh Government that it was unlikely that 'either in Wales or beyond emergency departments will "get anywhere near close to the College of Emergency Medicines aspirations" about consultant numbers in emergency departments, unless services are reorganised and high-end services are provided in fewer places.[36]

47. On this matter, the Chair of the Welsh National Board of the College of Emergency Medicine informed us that:

> "We are unfortunately in a vicious spiral at the moment, in that the fewer staff you have, the greater the pressure on the existing staff and that is what they see as the future, and until we turn that corner, from a staffing perspective, that is very difficult."[37]

48. The Chief Executive of ABUHB also told the Committee that there were tight consultant rotas in some Welsh emergency departments and that:

> "You can be down to as few as two or three consultants in individual A&E units, which is well below standards. We have been open about that through the process. Where you are developing a more centralised approach, it tends to attract an interest in a more stable service for the future."

49. He also referred to the approach being undertaken in Aneurin Bevan Health Board to develop a centralised approach and explained that:

> "In our patch, because we are centralising our A&E services for the future, we know that, as we have recruited new individuals, they have reflected that that was quite an important part of their choice to come to Aneurin Bevan health board as an area. Nevill Hall Hospital had only one consultant four years ago. We are now up to five consultants in post in that area, because they have signed up to a general strategy, which is going to be about the centralisation of services within our patch."[38]

[36] RoP, Public Accounts Committee, 12 November 2013, paragraph 255
[37] RoP, Public Accounts Committee, 10 December 2013, paragraph 143
[38] RoP, Public Accounts Committee, 16 January 2013, paragraph 147

50. The Committee questioned the Chief Executive of ABUHB on this approach highlighting the need to have a strategic plan that says, "This is the team that we need, and this is how we have to recruit to it".[39] He agreed with this approach concluding that giving people a clear plan and certainty about services and demonstrating approaches to address standards and the development of specialism will help with recruitment.[40] He added that:

> "Our experience has been that that has helped us in our local area. I hope that, as we give the final recommendation on the south Wales programme, that will allow us to unlock some of the recruitment that will have naturally been affected over the last 12 months, as we have been going through the engagement and consultation"[41]

51. The Committee further questioned the Chief Executive of ABUHB about the impact on recruitment arising from the uncertainty of service reconfiguration and whether this was influencing the ability to recruit to the levels required. He informed us that:

> "All areas are struggling with their current service provision. We, in the south Wales programme, have to make a decision, because it has to be very clear to all those people who want to work within our system for the future. Although there will be interest, people will be waiting for that final call in terms of the security of their future, because people are looking to make careers. That is why I take very seriously the responsibility that we have to make the final recommendation."[42]

52. We note the evidence from witnesses that the pressures and increasing workloads of staff working in emergency departments are making roles within emergency departments unattractive and could be contributing to stress and increased staff sickness absences, which is further increasing pressures within emergency departments.

We believe there is a need to end uncertainty about the future provision of emergency department services across Wales and recommend that the Welsh Government continues to work with health boards to bring this uncertainty to an end in order to

[39] RoP, Public Accounts Committee, 16 January 2013, paragraph 148
[40] RoP, Public Accounts Committee, 16 January 2014, paragraph 149
[41] RoP, Public Accounts Committee, 16 January 2014, paragraph 151
[42] RoP, Public Accounts Committee, 16 January 2014, paragraph 160

achieve safe and clinically sustainable medical staffing models in emergency departments and to promote the necessary recruitment and retention of staff.

4. The Importance of Primary Care

53. Primary care is at the core of the unscheduled care system and improved patient access, together with better out-of-hours arrangements, could have considerable benefits for the whole system. The Auditor General's report highlights scope to ensure more GP practices remain open for their full core hours and sets out the Welsh Government's three-phased approach to improving access to GP services.[43] The Auditor General's report also highlights that some GP practices would benefit from studying their pattern of demand, revisiting their balance of same-day and face-to-face appointments and considering the use of telephone consultations.[44]

GP Opening Hours

54. The Auditor General's report report found there to be variability of service provision and a link between accessibility to GP appointments and pressures on emergency departments when patients cannot access GP appointments.

55. The report found that 65% of GPs are not complying with being open for the core hours under the GP contract.

56. However, in a briefing from the Auditor General for Wales on 3 October 2013, the Committee were informed that the definition of core hours is complicated.

> "I think that the contract says that the front doors need to be open between 8.00 a.m. and 6.30 p.m. without lunchtime closure, which I think is another complicating factor in the statistic that we just mentioned. A patient has to be able to come in and see a receptionist. That is the minimum. There are other complications within the contract that say 'Within those core hours, the practice has to meet reasonable patient need'. It is a cloudy picture."[45]

57. During this briefing the Auditor General referred to criticism of his report by the General Practitioners' Committee (GPC) Wales. He highlighted that GPC Wales appeared to disagree with his findings

[43] Wales Audit Office, Unscheduled Care: An Update on Progress, paragraph 3.14
[44] Wales Audit Office, Unscheduled Care: An Update on Progress, paragraphs 3.18 – 3.26
[45] RoP, Public Accounts Committee, 3 October 2013, paragraph 44

about scope to improve access to primary care, suggesting there is no spare capacity within general practice.[46]

58. The Committee received written evidence from Welsh Government highlighting that one of its priorities is to increase availability of appointments during the week after 6.30pm and that 11% of GP practices currently offer appointments after 6.30pm on one day per week.[47]

59. The British Medical Association (BMA) highlighted to the Committee the importance of primary care, stating that:

> "General practice is seeing well over 6 million to 7 million consultations per year, which is actually over 90% of the activity of NHS Wales. We do not think that that has been captured in the Wales Audit Office report."[48]

60. They added that:

> "General practice surgeries are open between 8 a.m. and 6.30 p.m, and within that time we have to balance the needs of those who have acute new problems that need to be dealt with quite quickly—essentially, on the day, or very shortly afterwards—versus those who need continuity of care, and the whole plethora of everything else that comes into general practice."[49]

61. The Committee questioned the BMA on whether all GP surgeries in Wales were open between 8am and 6.30pm given the personal experiences of Committee Members and those of their constituents. Committee Members were aware that arrangements at some practices involved patients having to telephone the surgery at 8am to make an appointment, only to be told that there were no appointments left and to call back tomorrow. The Committee was also concerned that the seemingly lack of daily available GP appointments was contributing to the pressures on emergency departments coupled with the frustration of patients trying to access GP appointments.

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[46] RoP, Public Accounts Committee, 3 October 2013, paragraph 10
[47] Written evidence PAC(4)-29-13 (paper 2), 12 November 2013
[48] RoP, Public Accounts Committee, 19 November 2013, paragraph 12
[49] RoP, Public Accounts Committee, 19 November 2013, paragraph 12

62. The Committee discussed whether it was appropriate for patients to have to challenge their GP practices in terms of whether it is providing services that meet the needs of the population across an area. The Committee felt that very few patients are going to be equipped to do that, or prepared to do that.[50]

63. The Committee also considered the obligation of GPs, under the GP contract, to provide a primary care appointment when patients consider that their circumstances to be urgent. The Committee heard from Dr Charlotte Jones that:

> "…the GP contract mandates that GPs have to provide an urgent appointment when an urgent appointment is needed. You cannot just say, 'I'm sorry, I'm full'. If the patient says that their need is urgent, you have to see them. That is in the contract, and it is up to LHBs to monitor that. LHBs can also, because everybody has to publish their appointment systems in the practice leaflets, collate that information and monitor what the appointment systems are in their local areas. You might perhaps want to ask the local health boards if they have done that, and, if not, why not."[51]

64. This statement prompted the Committee to discuss the difficulties arising from determining what constitutes being 'urgent' and whether it is appropriate to expect patients to determine this themselves when making an appointment. In response to this discussion Dr Charlotte Jones commented that:

> "That is the difficult call for a lot of patients. I think if somebody uses an urgent appointment inappropriately, it is up to the healthcare professional to educate them about that. I have seen patients who have waited four or five days to come to see me and I have asked, 'Why didn't you ring on the day?' and they have said, 'I didn't think it was an emergency', and I have said, 'No, but it should not have waited this length of time"[52]

65. This issue was also picked up in evidence from the Chair of CTUHB who explained to us that the question of what is urgent it is

[50] RoP, Public Accounts Committee, 3 December 2013, paragraphs 65 & 67
[51] RoP, Public Accounts Committee, 19 November 2013, paragraph 142
[52] RoP, Public Accounts Committee, 19 November 2013, paragraph 144

the most difficult question to answer and it was difficult for him, as a Doctor, to answer.[53] However, he suggested that, although it isn't without faults, the availability of a telephone service could assist with helping people to determine what is urgent stating that:

> "…having somewhere to ring helps. In England, it was called 111, and the thing was that you could get through, but you could not get an answer; you could not get your problem dealt with. Where it worked really well, and there were areas where it worked very well, there was excellent connectivity of services before the number was put in front of that."[54]

66. The Committee considered the need to raise patient awareness of their right to access same day urgent primary care appointments but acknowledge that whilst this could assist patients in accessing such appointments and reduce pressures on emergency departments, it could also lead to patients requesting appointments inappropriately.

The Committee recognises that primary care may be provided through a number of services in addition to those provided by GPs and public awareness of this needs to be raised. We recommend that the Welsh Government undertake more work to promote the choices available to patients and the means by which these services might be delivered. For example, we acknowledge that access to primary care may be through access to a health professional other than a GP and this could be over the telephone.

The Committee notes that the provision of a telephone service can assist patients in determining when an appointment is urgent but believe that it is essential that such services have clinical input. The Committee recommends that the Welsh Government ensure that health boards are promoting clinically led telephone triage in GP practices and that patients have access to telephone advice on the most appropriate course of action when an urgent appointment with a GP is requested.

[53] RoP, Public Accounts Committee, 16 January 2014, paragraph 227
[54] RoP, Public Accounts Committee, 16 January 2014, paragraph 227

67. The BMA informed the Committee that:

> "Your surgery should always have somebody available to meet your need between 8 a.m. and 6.30 p.m. Whether you are physically able to have an appointment between 8 a.m. and 6.30 p.m. is a different story, but there should be somebody available to speak to and sort your problem out. A lot of people can have telephone consultations; certainly within my own practice, we have seen a 40% to 50% increase in telephone consultations."[55]

68. The BMA also told the Committee that it would not defend GP practices that do not offer adequate access to patients and referred to its policy called 'Sort it in One Call'. They added that:

> "We will continue to work with practices and say, 'You need to have reasonable access for patients'. However, to criticise the access, I think, is wrong. You do not need a GP to see you from 8 a.m. to 6.30 p.m.; you need somebody available to manage your problem. That can be managed in a variety of ways."[56]

69. The BMA also stated that the GP contract is 'crystal clear'[57] in setting out the responsibilities for offering appointments. The BMA also said that health boards had existing levers for going into general practices and managing problems because if practices are not delivering their 'part of the bargain' it is a 'breach of contract'.[58]

70. The Committee is aware that the GMS contract requires practices to be operating between 8 a.m. and 6.30 p.m. We questioned the Director General on whether this part of the contract is being properly enforced by health boards and were informed that:

> "It is a matter of great focus over the last few years, and will continue to be an area of priority. There is evidence of improvement in terms of the availability of appointments, and the number of practices that are operating, broadly, within their full contractual hours, and are offering appointments. So, the analysis in the report, I think, showed improvement in terms of the number of practices that are operating to their full

[55] RoP, Public Accounts Committee, 19 November 2013, paragraph 15
[56] RoP, Public Accounts Committee, 19 November 2013, paragraph 30
[57] RoP, Public Accounts Committee, 19 November 2013, paragraph 155
[58] RoP, Public Accounts Committee, 19 November 2013, paragraph 116

> contractual hours. We also look at those that work their full hours, or within an hour of their full hours, and that is at a current level of 68%."[59]

71. The Committee is concerned that more should be done to hold GPs to account for delivering the requirements of the GMS contract and discussed the variation between health boards in the extent to which practices are open for their full daily core hours.

72. The Director General provided the Committee with details of the ways in which GPs are held to account for delivering the GMS contract stating that:

> "I suspect that there is more that we can do, as always, and we should always acknowledge that—we do not sit in a position of saying that everything is fine—but the mechanisms are there."[60]

73. The Director General also commented that there is a very extensive system of audit, checking, and monitoring of general practice[61] and in supplementary evidence provided a checklist of ways in which primary care is audited in Wales[62].

74. The Committee is concerned that health boards are not adequately holding GP practices to account on meeting the obligations set out in their contracts and there are no penalties in place for those failing to do so. We recommend that the Welsh Government introduce improved mechanisms to ensure GP practices fulfil their contractual obligations and implement processes for identifying breaches of contract. The Committee heard evidence from the Chief Executive of ABUHB about the 'A for Access scheme' which has been adopted within the Aneurin Bevan Health Board to improve access to GP services. He explained that:

> "We developed 'A' is for Access through the community health council and the local medical committee, which is representative of our local GPs. That was not insignificant in taking it forward. One of the reasons for developing it was that, when the CHC did a number of surveys—including the one that I shared with you—although 70% of people at the time said that

[59] RoP, Public Accounts Committee, 3 December 2013, paragraph 30
[60] RoP, Public Accounts Committee, 3 December 2013, paragraph 22
[61] RoP, Public Accounts Committee, 3 December 2013, paragraph 28
[62] Written Evidence, PAC(4)-03-14 (ptn2), 28 January 2014

they were able to get an appointment when they wanted it if they were an urgent patient, there were clearly a number of people who were saying that they could not."[63]

75. In evaluating this scheme, the Chief Executive of ABUHB explained that:

> "It has been a really good initiative, to make sure that we focus on some of the basics around the hours and the expectations, but it has also been something that the practices have aspired to. So, at the moment, I know that 55% of our practices are achieving 'A' grades in all of the five criteria that we have set, so we have moved that on from the much lower baseline of two years ago, which was operating at about 11%. Actually, however, all of the other practices have improved their performance across the range, so the majority of the others are achieving four 'A' grades, even if they are not quite there on the final criterion."[64]

76. The Committee also heard about the approach taken at Cwm Taf University Health Board to improve access to GP appointments. In written evidence the Committee were informed that:

> "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."[65]

The Committee notes the approaches taken by Aneurin Bevan and Cwm Taf University Health Boards to improve access to GP services but note that despite these attempts to improve access significant progress is still required. We recommend that existing approaches to improving access to GP appointments, be evaluated so that good practice can be identified and shared across health boards.

Missed GP Appointments

77. The Committee considered the problem of 'did not attends (DNAs)' whereby patients make appointments to see their GPs but

[63] RoP, Public Accounts Committee, 16 January 2014 paragraph 128
[64] RoP, Public Accounts Committee,16 January 2014 paragraph 129
[65] Written Evidence, Cwm Taf Health Board, 20 November 2013

simply fail to attend the appointment. Dr David Bailey highlighted to the Committee that:

> "In terms of 'did not attends', it is as much as 10% in some cases, and that has a huge impact. We would not suggest going along the payment route, although it is interesting to note that southern Ireland has a consultation rate in general practice of two and a half, whereas Northern Ireland has a consultation rate of six, the only difference being that one pays and one does not. The difference in outcomes is very small. So, there is an issue around that."[66]

78. Dr David Bailey made us aware that his GP practice has just started using a texting service to remind patients of their appointments. We believe this is an approach that could be usefully adopted elsewhere.

79. The Committee noted the findings of the Auditor General's report that identified many practices in Wales would benefit from implementing initiatives aimed at reducing the number of wasted appointments.[67] The report outlined a number of actions already taken by GPs to reduce 'did not attends'.[68] These include displaying posters in waiting rooms of the number of patients who DNA each week and patients being sent letters where they DNA twice. Such patients are then transferred out if there are further DNAs in a certain period. Another initiative involves ringing patients in advance reminding them when an urgent appointment request is made by the GP.

80. The Committee probed the idea of charging non-attendees for failing to attend without a reasonable excuse but were told by Dr David Bailey that it would be 'messy' and there would be questions around how it could be policed.[69]

81. Dr Charlotte Jones explained that:

> "With GPs, unfortunately, it is the case that the percentage of people who do not attend is higher among our most deprived and our most chaotic patients. While, in an intellectual sense, you think that that might persuade people, I do not think that it

[66] RoP, Public Accounts Committee, 19 November 2013, paragraph 96
[67] Wales Audit Office, Unscheduled Care: An Update on Progress, page 79
[68] ibid, box 6, page 80
[69] RoP, Public Accounts Committee, 19 November 2013, paragraph 107

would be terribly helpful in terms of providing an equitable service for the patients who need it most."[70]

82. She added that:

> "It is obviously potentially detrimental to the doctor-patient relationship, and, as David said, sometimes the patients have life-threatening conditions, and the continuity of care in that relationship is very difficult."[71]

83. As a Committee we presented the other side of the argument questioning whether it is detrimental to the doctor-patient relationship when a patient cannot get an appointment. We also posed the question of penalties against GPs who fail to deliver on accessibility between 8 a.m. and 6.30 p.m.

84. Dr Bailey informed us that:

> "…if practices are not delivering on their part of the bargain, the health board has the ability to go in and manage that. So, if that is happening, then I would be saying to the health board, 'Go in and sort that out'. They can already do that—it is a breach of contract."[72]

The Committee notes the difficulties involved in introducing penalties for those patients who do not attend appointments with their GPs. While the Committee recognises there are existing initiatives in place to reduce 'did not attends', we believe the current rate is unacceptable and is contributing to difficulties in patients accessing GP appointments. We recommend that the Welsh Government consider this issue further and look to approaches adopted elsewhere, including the Republic of Ireland and Northern Ireland in reducing 'did not attends'.

Inappropriate Attendance at Emergency Departments

85. An important issue for the Committee was to understand why patients attend emergency departments, as their default option, even when urgent access to primary care is available, and also the extent to which patients attend emergency departments because they are unable to access urgent primary care.

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[70] RoP, Public Accounts Committee, 19 November 2013, paragraph 109
[71] RoP, Public Accounts Committee, 19 November 2013, paragraph 112
[72] RoP, Public Accounts Committee, 19 November 2013, paragraph 116

86. The Auditor General's report discusses the findings from the National Survey for Wales in September 2012 that 31 per cent of patients find it 'fairly difficult' or 'very difficult' to get a convenient appointment with their GP. Adults of working age find it more difficult than older people to access such appointments. The report adds that a finding from the Welsh GP Patient Survey in June 2011, suggests that when people tried to access an urgent primary care appointment, 84 per cent of survey respondents said they were able to access an appointment on the same day or the next day.[73]

87. The report highlights the replacement of the Welsh GP Patient Survey with GP-related questions being added to the National Survey for Wales. The National Survey for Wales does not record the patient's GP practice and therefore data on patient experience of access are not now available at the practice level.[74]

88. A survey carried out by Newport City Council's 'Involve Newport Citizens' panel to better understand patient views on access to their GP indicated that 11.2% would choose to go directly to an emergency department if they needed to see a doctor urgently when their GP surgery was closed. 65% said they would contact the GP out of hours service and 20% would contact NHS direct.[75]

89. A different survey undertaken by Aneurin Bevan Community Health Council in 2011 found that there was a strong culture of people attending emergency departments instead of using primary care services. A majority of patients surveyed, 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. The survey also found that there was a view amongst some respondents that GPs had directed most of the sample to emergency departments could have done more and there were some concerns about their lack of availability.[76]

90. In looking for an alternative to attendance at emergency departments, the survey found that the box marked 'better/more available treatment via the GP' was ticked most often. The survey concluded that publicity around using the GP service as an alternative

[73] Wales Audit Office, Unscheduled Care: An Update on Progress, paragraphs 1.3 – 1.4
[74] Wales Audit Office, Unscheduled Care: An Update on Progress, paragraph 3.21
[75] Written evidence, PAC(4)-01-14 (ptn3), 16 January 2014
[76] Written evidence, PAC(4)-01-14 (ptn3), 16 January 2014

to emergency departments will only succeed if that service is available and responsive.[77]

91. Another survey conducted by Newport City Council's 'Involve Newport Citizens' panel in 2012 found that 29.7% of respondents were not generally able to get a GP appointment within 24 hours and 25% stated that telephone access was not easy. However, it must be noted that the response rate of 450 should be considered in the context of Newport's population of greater than 148,000 people.[78]

92. The Committee also heard some evidence to suggest that the numbers of patients inappropriately attending emergency departments were not significant. The Chair of the Welsh National Board of the College of Emergency Medicine explained that there are a group of patients that attend emergency departments, when they should definitely be dealt with in a primary care environment but he added that:

> "On the whole, these groups are not a huge problem, because they are often quick to turn around. They do clog up the system and, ideally, they should not be there. Some have more complex need so they take a bit of time, because although it is a primary care issue, you only know that after you have done a full assessment of the patient."[79]

93. Evidence from the BMA however indicated that inappropriate attendance to emergency departments is significant. The Committee was told that:

> "most people who look at casualty attendance will tell you that maybe as much as 20 per cent of the consultations are inappropriate or could be better dealt with elsewhere."

The Committee received mixed evidence on the extent to which inappropriate attendance to emergency departments is a problem. We recommend that the Welsh Government urge health boards to collect clearer data to identify the scale of inappropriate attendances to emergency departments to develop a consistent approach to addressing any issues identified. To further support this, initiatives to collect data on patient experiences in emergency

[77] Written evidence, PAC(4)-01-14 (ptn3), 16 January 2014
[78] Written evidence, PAC(4)-01-14 (ptn3), 16 January 2014
[79] RoP, Public Accounts Committee, 10 December 2013, paragraph 71

departments should include questions to determine why patients chose to attend the A&E department.

5. Out of Hours primary care services

94. The Auditor General's report discusses a range of problems with out-of-hours primary care services. It highlights that performance management of these services is problematic due to the lack of consistent, comparable information across Wales.[80]

95. The report outlines the difficulties facing out-of-hours services in recruiting medical staff, and it highlights specific difficulties in the Aneurin Bevan area.[81]

96. Evidence to the Health and Social Care committee highlighted that "there is no doubt that the out of hours service is under considerable pressure and needs to be refreshed"[82] This Committee also heard from the BMA that:

> "…money spent on GMS out-of-hours care has not risen since 2004, despite the service demand increasing, and there needs to be a significant amount of investment into those services to make them fit for the future."[83]

97. They added:

> "The amount of money that has been put in to out-of-hours services, which, let us not forget, are delivered or led by GPs right the way across Wales, has not moved since 2004. It is about £30 million, which I think is less than was paid recently for a catch-up programme for orthopaedic waiting lists. So, the whole of out-of-hours unscheduled care in Wales is valued at significantly less than an orthopaedic waiting list programme. So, I think that that is the issue that perhaps needs to be addressed."[84]

98. The Committee raised concerns regarding the impact of problems in accessing the out-of-hours services on attendances to emergency departments. The Welsh Government acknowledged that there were problems with the out-of-hours service and that this was putting

[80] Wales Audit Office, Unscheduled Care: An Update on Progress, paragraphs 3.32 – 3.34
[81] Wales Audit Office, Unscheduled Care: An Update on Progress, paragraph 2.41
[82] RoP, Health and Social Care Committee, 9 October 2013, paragraph 65
[83] RoP, Public Accounts Committee, 19 November 2013, paragraph 174
[84] RoP, Public Accounts Committee, 19 November 2013, paragraph 19

pressure on accident and emergency services. Dr Robinson stated that:

> "Out-of-hours services and the new 111 line, which, as you know, has had teething problems elsewhere in the United Kingdom, is one of the areas of focus for the unscheduled care programme. The work stream that tackles that has now started to meet and will be working over the course of the next year. So, that work stream has to do a number of things: it obviously has to make it easier for people to use it, but it also has to investigate capacity. We think that the measures that health boards have put in place should mean that out-of-hours services are more robust this year than they have been on occasions in the past, but it is important to make sure that you minimise the occasions when they cannot cope."[85]

99. The Committee also heard evidence that older people did not understand how the out-of-hours service works or who to contact. Baroness Finlay explained that older people:

> "…did not know who to phone, and that they thought that the only thing that they could do if they were ill out of hours was phone 999. They did not really understand how the out-of-hours service worked or what they could access, and they felt frightened and felt at sea."[86]

100. In terms of the future of out-of-hours primary care the Committee questioned the Chair of CTUHB, in his capacity as Chair of the National Out-Of-Hours Steering Group, on the progress that has been made in implementing the recommendations of the group. He informed us that:

> "…standards in the out-of-hours service are being worked through. We have had a process to generate it, and I think that that will come to fruition in the early spring. The key messages from that are that it is aligned to unscheduled care; it is aligned to outcomes for people who fall, for end-of-life care, and for making sure that you pick out those people who call out-of-hours services who could have had a stroke or a heart attack. It

[85] RoP, Public Accounts Committee, 3 December 2013, paragraph 54
[86] RoP, Public Accounts Committee, 10 December 2013, paragraph 177

is about making sure that we are doing the right things for those where we know the outcomes could be changed."[87]

The Committee was unable to clarify the progress that has been made in implementing the recommendations of the National Out-Of-Hours Steering Group. The Committee recommends that the Welsh Government publicly responds to the findings and recommendations of this Group and provide details to this Committee of the action it is taking in response to the Group's work.

Co-location – GPs working within emergency departments

101. The Committee heard mixed evidence on the co-location of GP services within emergency departments. The majority of witnesses recognised the benefits of co-location but there was also some acknowledgement that co-location wasn't possible everywhere and that more could be done to integrate services rather than co-locate.

102. Evidence from the Welsh Government outlined that there are several sites in Wales where the out of hours service is co-located with the emergency department and that the Welsh Government wants to develop this further, by increasing the integration between the services, rather than simply locating them on the same site.[88]

103. The BMA discussed with the Committee the benefits of 'inter-professional dialogue' where out of hours services are co-located with emergency departments and that co-location should be promoted where it is deliverable.[89]

104. The Committee heard from the Chair of the Welsh National Board of the College of Emergency Medicine that on the whole, co-location 'works very well'[90] and the Chief Executive of ABUHB highlighted that most areas of Wales are developing plans for co-location 'because it is a good solution'.[91]

105. The Chair of CTUHB outlined some of the benefits of co-location stating that:

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[87] RoP, Public Accounts Committee, 16 January 2013, paragraph 333
[88] RoP, Public Accounts Committee, 12 November 2013, paragraph 165
[89] RoP, Public Accounts Committee, 19 November 2013, paragraph 215
[90] RoP, Public Accounts Committee, 10 December 2013, paragraph 133
[91] RoP, Public Accounts Committee, 16 January 2014, paragraph 119

> "If you co-locate, people will know exactly where to come. So, if you want people to come, just co-locate. If you get co-location with a different way of working, so that primary care and the acute end benefit from the experienced practitioners, that is a great thing. However, you cannot do that everywhere.[92]The Committee is aware that the NHS confederation has recently recommended that NHS England continues to encourage more widespread use of co-located urgent and emergency care centres that cater for all attendees, particularly in urban areas.[93] In this model, patients are streamed to different parts of the centre on arrival and no condition is deemed inappropriate for treatment, advice or redirection. There are examples of this working well in the Netherlands"[94]

106. The report also found that a recent review[95] of the role of walk-in centres in the NHS has similarly recommended that they need to be better integrated with emergency departments if they are to have an effective role in demand management.

The Committee notes the potential benefits of co-location of GP services with emergency departments, particularly where these are accessed via the emergency department front door. The Committee recommends that the Welsh Government works with health boards to encourage further co-location of GP services with emergency departments and, as part of this work, considers whether there would be any benefits in introducing walk-in centres as part of the integrated provision of unscheduled care services in Wales.

[92] RoP, Public Accounts Committee, 16 January 2014, paragraph 338
[93] Ripping off the sticking plaster: Whole-system solutions for urgent and emergency care, NHS Confederation, 10 March 2014
[94] Thijssen W, Wijnen-van Houts M, Koetsenruijter J et al (2013): 'The impact on emergency department utilization and patient flows after integrating with a general practitioner cooperative: An observational study', Emergency Medicine International.
[95] Monitor (2013), Walk-in centre review

6. GP Recruitment and Retention Issues

107. The Committee was made aware of recruitment and retention issues in general practice. The BMA highlighted 'a very real workforce crisis in primary care with difficulties in recruiting GPs. They stated that there are:

> "…difficulties of recruiting GPs into general practices, and that will invariably affect access, I am afraid. The GPs left behind are trying to do all the work while trying to find more GPs to come to help."[96]

108. The BMA also raised concerns with the Committee about the 'intensity and the stress of the job'.[97]

109. In evidence to this Committee Dr Charlotte Jones raised serious concerns about the potential crisis in the GP workforce explaining that:

> "I would like to add to that that we are aware that, in the last year or two, GPs are having to cut back on some of the sessions that they do because of the intensity and the stress of the job. We are very anxious about that. We are noticing that fewer GPs want to work out of hours, or can take on other roles to develop patient services, because the intensity of the workload in the working day is so high. We also have a number of GPs who are rapidly approaching retirement. We have a workforce crisis, which, as we have been pointing out to Welsh Government, is coming—it is looming—quite quickly."[98]

110. The Committee questioned how many more GPs were needed in Wales in the future and if there is a crisis how many were we short by. Dr Charlotte Jones explained that the figure would be around 200 per annum.[99]

111. On this issue the Committee questioned the Welsh Government on its plans to address problems in the GP workforce. The Director General informed us that:

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[96] RoP, Public Accounts Committee, 19 November 2013, paragraph 16
[97] RoP, Public Accounts Committee, 19 November 2013, paragraph 40
[98] RoP, Public Accounts Committee, 19 November 2013, paragraph 40
[99] RoP, Public Accounts Committee, 19 November 2013, paragraphs 48 - 52

> "We clearly have information about the workforce, the age profile, anticipated retirement dates, pre-existing turnover in terms of leavers and our ability to recruit. That information guides us in terms of, for example, the number of commissions of GPs in the early stage of their career, and GP trainees. It has also allowed us to see one of the big issues, which is that there are some parts of Wales that are in a more challenging position than others. So, the process is in place, and we are not simply waiting for problems to develop—we are taking action."[100]

112. The Director General added that 'We are on top of it'.[101]

113. In supplementary evidence provided by the Welsh Government the Committee were given details of Deanery figures for GP Training. The information highlighted that:

> "The Wales Deanery reported the vacancy fill rate for 2013 as 97%. This compares to 81% in 2012 and 80% in 2011. Between 2008 and 2012, 544 Certificates of Completion of Training (CCT) were awarded by the Wales Deanery with an additional 86 in 2013. These are GP trainees who have completed training and obtained entry onto the specialist register'."[102]

The Committee notes the concerns raised by the British Medical Association regarding the recruitment and retention of GPs and future workforce shortages. We also acknowledge that the problem varies across Wales with rurality being a particular issue. The Committee does not feel that we have received sufficient assurances from the Welsh Government that these concerns are being addressed. The Committee recommends that the Welsh Government undertake a detailed evaluation of the current GP workforce across Wales and that a strategy is developed to ensure capacity meets demand. We also recommend that such a strategy should include provision for the delivery of services in the Welsh language.

[100] RoP, Public Accounts Committee, 3 December 2013, paragraph 167
[101] RoP, Public Accounts Committee, 3 December 2013, paragraph 167
[102] Written Evidence, PAC(4)-03-14 (ptn2), 28 January 2014

7. Managing Demand through Care Co-ordination

114. The Wales Audit Office 2009[103] report found that people can be uncertain of how and where to seek help, resulting in people using certain services when there may be better services available to address their needs.

115. In his recent report, the Auditor General highlighted that despite there being only limited data on demand, they have been able to show that some demand continues to be in the wrong place within the system. In other words, some people are not getting to the most appropriate service for their needs. The causes of misplaced demand are complex but, as currently configured, the system often pushes people towards the wrong service. This is often a fault of the system and not a fault of the patient.[104]

116. The Committee considered whether service reconfiguration could be pushing patients towards emergency departments. For example, the Committee is aware of the closure of some minor injury units in some parts of Wales and subsequent geographical variation in the availability of services.

117. On the closure of minor injury units the Chief Executive of ABUHB informed the Committee, in additional evidence, that Aneurin Bevan University Health Board had:

> "…already made decisions locally to close 3 minor injury units back 2011, following extensive public consultation and agreement with the Community Health Council. The level of activity had been insufficient to maintain local staffing, activity and standards and we had to reconfigure the local services as a result and where necessary ensure that alternative options were in place, including primary care options."[105]

[103] WAO Unscheduled Care Developing a whole systems approach (December 2009), paragraph 1.78
[104] Wales Audit Office, Unscheduled Care – An Update on Progress, paragraph 26
[105] Written Evidence, PAC(4)-05-14(ptn3), 13 February 2014

Choose Well Campaign

118. The Auditor General's report concludes that the Welsh Government's *Choose Well* campaign has so far had minimal impact in helping people access the right services.[106]

119. In the briefing from the Wales Audit Office, the Committee heard there had been an initial positive reaction to the *Choose Well* campaign. However, it did not seem to be embedded in making the change in behaviours that you need to get people to access systems. An official from the Wales Audit Office stated:

> "There is a little bit of a chicken-and-egg situation here, because, you can have all of the wonderful information that you want, but if those services are not in place for the patients to access as alternatives to A&E, they will go to A&E anyway. So, it is about having not just the information, but the services in place and properly mapped. So, it is about information, as to why people incorrectly access the system. I think that it is also about personal preference."[107]

120. The Committee heard that the Choose Well campaign had been disappointing so far in signposting people to services and promoting self-care. The Chief Executive of ABUHB expressed disappointment with the Choose Well campaign but suggested that public education might need to be dealt with over a number of years.[108] The Director General informed the Committee that there would be an evaluation of the Choose Well campaign and stated that:

> "We acknowledge that there is more to do with Choose Well. We take on Board the comments and the recommendations that we probably need to up our game."[109]

121. Further information provided to the Committee by the Welsh Government outlined that the Choose Well campaign had cost £159,604 since 2011 i.e. £53,000 per annum. This had been spent on the development of an application, national and local advertising, a comprehensive range of marketing materials, Social media

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[106] Wales Audit Office, Unscheduled Care: An Update on Progress, paragraph 2.19
[107] RoP, Public Accounts Committee, 3 October 2013, paragraph 83
[108] RoP, Public Accounts Committee, 16 January 2014, paragraph 165
[109] RoP, Public Accounts Committee, 12 November 2013, paragraph 240

development and development of 'room temperature' thermometer cards for elderly patients.[110]

122. The Committee was also informed that the Welsh Government was exploring various approaches to undertaking more formal evaluation in line with WAO recommendations. Furthermore, through their own internal evaluation, NHS Direct Wales has attributed a significant rise in the use of their website (240% increase in web hits over two years) to the campaign.[111]

123. In their paper to Committee, the Welsh Government outlined plans to establish Choose Pharmacy pathfinder sites to encourage more people to use community pharmacy services as opposed to other unscheduled care services.[112]

The Committee is concerned that not all of the strands of services listed by the Choose Well campaign are actually available in all parts of Wales. For example, not all areas have minor injury units and in those that do service provision and hours of operation varies. The Committee recommends that the Welsh Government undertake more work to educate the public on what services are available in their specific areas and how these can be accessed.

The Committee recommends that the Welsh Government enhances the Choose Well campaign through better promotion of other opportunities for accessing health care, for example through community pharmacists and optometrists.

NHS 111

124. The Auditor General's report concludes that the planned introduction of a 111 call service could have significant benefits for patients and for the unscheduled care system. However, the report warns of a range of risks and unanswered questions regarding 111 in Wales.[113]

125. Care co-ordination through the NHS 111 service is a significant opportunity for Wales and excellent planning is now required to ensure

[110] Written Evidence, PAC(4)-32-13(p2), 3 December 2013
[111] Written Evidence, PAC(4)-32-13(p2), 3 December 2013
[112] Written Evidence, PAC(4)-29-13 (p2),12 November 2013
[113] Wales Audit Office, Unscheduled Care – An Update on Progress, paragraphs 3.2 to 3.9

the right model is put in place. However, the Committee heard the service also presents a number of challenges as well as opportunities.

126. The BMA told the Committee that the 111 service was 'a huge opportunity for Wales' adding that 'the right solution will require the right resources'.[114] However, the BMA also expressed concerns that Wales should avoid the mistakes made in England, stating that:

> "The key is that the service is integrated. The mistake that they made in England was quite clearly that they separated the 111 service from ambulance controls and from out-of-hours units. So, they have very slow options—or no option—to get clinical advice directly. What happened was that they were using extremely risk-averse algorithms, and that drove demand right the way across the system and the whole thing fell over, until it was given back to GP out-of-hours co-operatives."[115]

127. They added that:

> "The Welsh Government has learned much from that and it is trying to develop something that has co-location for emergency 999 services, the 111 service and the out-of-hours service. If you can do that in a constructive way so that you can give clinical advice quickly for the difficult cases, then there is really the potential to make that work well in Wales."[116]

128. Dr Robinson informed the Committee that issues suffered by the 111 service elsewhere in the UK included "training for the people who were delivering it"[117] and "getting the skill mix right between non-clinical call handlers and clinical call handlers".[118]

129. On the future of the 111 service, the Welsh Government stated in additional evidence that:

> "It is important to note that 111 is a number that will provide an access point to a range of services to enable people to receive the right care, in the right place, at the right time. The availability of a broad range of services accessible through a national directory of services is pivotal to its success,

[114] RoP, Public Accounts Committee, 19 November 2013, paragraph 222
[115] RoP, Public Accounts Committee, 19 November 2013, paragraph 225
[116] RoP, Public Accounts Committee, 19 November 2013, paragraph 222
[117] RoP, Public Accounts Committee, 3 December 2013, paragraph 139
[118] RoP, Public Accounts Committee, 3 December 2013, paragraph 139

> regardless of the final agreed model for Wales. This has been reinforced as a part of the learning from the implementation of 111 in England."[119]

130. The Welsh Government's supplementary evidence to the Committee sets out a timeline for implementing the 111 service, which showed that the business case will be developed and agreed by December 2013 with phase 1 going live in October 2015 and phase 2 from 2016.[120]

The Committee acknowledges that the approach being taken by the Welsh Government, towards implementing a 111 service is sensible. However, the Committee is keen to ensure that the timelines for the development and introduction of the service are met. The Committee recommends that the Welsh Government provides a written progress report on the 111 service by January 2015.

Phone First

131. Cwm Taf University Health Board has launched a new system of telephone triage for patients with minor injuries called 'Phone First'.[121] Written evidence from the Chief Executive of Cwm Taf University Health Board includes a detailed appendix covering the Phone First service and notes that the Phone First approach is being rolled out to all minor injuries services in Cwm Taf.[122]

132. The Committee questioned the Chair of CTUHB on the lessons that could be learnt from the experiences of the phone first initiative at Cwm Taf. He commented that:

> "The 'phone first' service has shown that if members of the public pick up the phone, we can get them to the right place. I have bitter experience of a man with a sore throat who was having a little bit of difficulty breathing, who turned up and waited in a minor injuries unit, and had acute epiglottitis and died. If I had spoken to him on the phone, he would not have gone to a minor injuries unit; he would have been at a major A&E unit. Those experiences say that if we are getting people

[119] Written evidence, PAC(4)-32-13(p2), 3 December 2013
[120] Written Evidence, PAC(4)-03-14(ptn2), 28 January 2014
[121] Wales Audit Office, Unscheduled Care – An Update on Progress, Box 2, page 53
[122] Written evidence, PAC(4)-01-14 (ptn2), 16 January 2014

to work remotely, they have to be linked to the acute stuff at the highest level, so they can take that experience out. I think that is a way of sustaining local services very safely and very appropriately, and protecting acute, hot centres from things that can quite appropriately be done elsewhere."[123]

133. The Chief Executive of ABUHB also referred to the phone first initiative stating that:

> "…we are also developing options like 'phone first'. So, rather than somebody walking in to a unit, if there is an opportunity to have a conversation about the best location for them, we would direct them to a minor injuries unit, to an A&E department, or to an out-of-hours service as part of that phone call. We cannot just educate people, but make sure that they are signposted. I hope that somebody phoning in the first place and then being told that their appointment is in an hour and a quarter in a minor injuries or a nurse-led unit, rather than A&E, would be seen very quickly."[124]

134. A recent report published by the NHS Confederation in England has concluded that more needs to be done across the whole NHS to move towards a clear, single point of access for urgent and emergency care. The report stated:

> "It is crucial to establish effective and consistent triage to ensure people requiring both physical and mental health services are quickly directed to the correct part of the system, and there are a number of ways this form of triaging can be done. Patients could be encouraged to telephone before they visit an urgent care service (the so-called 'talk before you walk' approach). We recommend that NHS England promotes more widespread use of combined urgent and emergency care centres that cater for all attendees. Here, patients are streamed to different parts of the centre on arrival and no condition is deemed inappropriate for treatment, advice or redirection."[125]

[123] RoP, Public Accounts Committee, 16 January 2014, paragraph 219
[124] RoP, Public Accounts Committee, 16 January 2014, paragraph 116
[125] Ripping off the sticking plaster: Whole-system solutions for urgent and emergency care, NHS Confederation, 10 March 2014

135. The Committee were told that there was a need to coalesce the 111 service, NHS direct and the out of hours service.[126] Dr Robinson informed us that:

> "The first thing to say is that there will be much closer connections between the existing NHS Direct service, the 111 service and GP out-of-hours service, so that hopefully, within a fairly short space of time, it feels like you are coming to the same bunch of people who are going to help you, and direct you rapidly to where you want to go if you are trying to make contact with a service when you cannot get through to your in-hours general practice."[127]

136. Baroness Finlay raised concerns with the Committee that some telephone systems were risk adverse[128]. She also spoke about the problems arising from clinicians trying to diagnose patients over the phone. She explained that without being able to examine a patient:

> "You are not even doing it face to face where you are picking up all the non-verbal clues in communicating. We know that about 20% to 25% of communication is verbal. A huge amount is non-verbal. You are making it really difficult, if you rely on the telephone, to provide clinical advice to people who might be terribly ill. A classic, for example, might be a headache. There is the complete range from absolutely life threatening down to totally incidental, a bit of stress, have a cup of tea, benign. However, it is a headache, and the person might describe it as a blinding headache. It is really difficult to tell over the phone, however much you question. I cannot help feeling that, at the end of the day, if people really think that they are ill they need to be seen."[129]

137. Baroness Finlay also highlighted the important of telephone systems being linked to emergency departments to ensure it can take into account how busy they are and what is happening with the ambulance service and that it has direct access to general practice.[130] She added that:

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[126] RoP, Public Accounts Committee, 16 January 2014, paragraph 231
[127] RoP, Public Accounts Committee, 3 December 2013, paragraph 145
[128] RoP, Public Accounts Committee, 10 December 2013, paragraph 166
[129] RoP, Public Accounts Committee, 10 December 2013, paragraph 169
[130] RoP, Public Accounts Committee, 10 December 2013, paragraph 171

> "I do not see how it can really be an effective signposting service. The other thing is that, if it does not do that, it will work in isolation, and I wonder how it is going to audit its outcomes."[131]

The Committee acknowledges the opportunities presented by telephone initiatives to reducing demand on unscheduled care but recognise there are challenges in its practical application. We note evidence that such systems can be prone to risk aversion with telephonists making judgements using algorithms. To address this, the Committee recommends that the new 111 service should include sound clinical protocols with telephonists equipped with the right skills to evaluate a call and escalate it to an appropriate clinician who should be readily available.

[131] RoP, Public Accounts Committee, 10 December 2013, paragraph 171

8. Managing the Balance between Scheduled and Unscheduled Care

138. The Auditor General's report covers issues relating to problems with patient flow through acute hospitals and delayed transfers of care. Figure 22 on page 60 shows the long-term reduction in bed numbers in the NHS and paragraph 2.49 raises the possibility that beds have been taken out of the system too soon, before health boards have done enough to improve discharge planning and strengthening alternative community service provision.[132]

139. The report also highlights that Aneurin Bevan University Health Board's survey return to the Wales Audit Office said that one of the main barriers to further improvement in unscheduled care was related to issues in the development of community services that pull patients from the acute hospital.[133]

140. In written evidence, we note that experiences in Aneurin Bevan University Health Board and across the NHS in Wales show that commissioning more beds without underpinning these with other system changes, causes the beds simply to fill up.[134]

141. The Minister for Health and Social Services informed the Health and Social Care Committee the winter planning processes have been strengthened. He stated:

> "…planning for next winter began in the Welsh Government back in March, while there was still snow on the ground, and planning has gone on at both national and local health board level ever since."[135]

142. The Director General informed us that:

> "All the health boards have dedicated an enormous amount of attention to planning for this winter. They are now doing a similar exercise for the next three years. Those plans are comprehensive and they do not simply focus on hospital issues—they look at the healthcare system and are as

[132] Wales Audit Office, Unscheduled Care – An Update on Progress Paragraphs 2.46 to 2.63
[133] Wales Audit Office, Unscheduled Care – An Update on Progress Paragraph 2.26
[134] Written evidence, PAC(4)-01-14(p1), 16 January 2014
[135] RoP, Health and Social Care Committee, 9 October 2013, paragraph 8

> concerned about the alternatives out of hospital as in hospital."[136]

143. Evidence from the Chief Executive of ABUHB indicated that winter planning had improved stating that "…winter planning this winter does feel far more robust, from the systems perspective".[137] He also informed the Committee that the national winter planning forum that launched in September 2013 "has made us work through each of the health boards experiences together".[138] This work has involved sharing of good practice, and evaluation of other health board's plans.

144. Other evidence highlighted that winter planning had been more robust this year. The Chief Executive of Cwm Taf University Health Board said that:

> "the intensity and the integrity of the planning for this winter, based on last years' experience, has been at a level I have not experienced before in the NHS and that is very positive."[139]

145. The Committee is aware that it is normal practice for health boards to plan to do less elective surgery in the winter to allow for peaks in unscheduled care but nevertheless, some health boards still have to cancel planned operations.

146. The Chief Executive of ABUHB explained that that:

> "…we have made judgements across Wales in our winter planning arrangements to generally slow down and reduce elective activities, certainly during these first couple of weeks of January."[140]

147. He added that:

> "…we have made some local decisions within Aneurin Bevan Local Health Board to slow that down, and to not book patients in the first place in order to avoid cancellations as such, so we are deferring some of that activity."[141]

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[136] RoP, Public Accounts Committee, 12 November 2013, paragraph 145
[137] RoP, Public Accounts Committee, 16 January 2014, paragraph 76
[138] RoP, Public Accounts Committee, 16 January 2014, paragraph 72
[139] RoP, Public Accounts Committee, 12 November 2013, paragraph 44
[140] RoP, Public Accounts Committee, 16 January 2014, paragraph 61
[141] RoP, Public Accounts Committee, 12 November 2013, paragraph 61

148. The Chair of CTUHB also detailed work being undertaken at Cwm Taf Health Board to improve winter planning processes.[142]

149. However, the Committee also heard evidence that improved winter planning processes were not the case everywhere. The Chair of the Welsh National Board of the College of Emergency Medicine referred to a case in Swansea on the 9 December 2013 where all non-cancer operations were cancelled.[143]

150. The Committee is also aware of reports about Betsi Cadwaladr University Health Board having to postpone the majority of planned surgery in North Wales due to increased pressure.[144]

151. The Director General also confirmed that Hywel Dda University Health Board was "exploring several options, one of which looks at some reduction in some elective capacity, for a period of time".[145]

152. However, evidence suggests that problems remain in ensuring patients can flow through hospitals and more work is needed to ensure that there is sufficient surge capacity available across the whole system. The Auditor General's report highlighted a reduction of 21% in the average daily available beds in Wales between 2000-01 and 2012-13.[146]

153. In commenting on this matter, the Chair of the Welsh National Board of the College of Emergency Medicine stated that:

> "…if you asked all of my colleagues in emergency departments 'if you were allowed one thing, what would that one thing be?', that one thing would be to get the patients who have to wait for long periods of time in the departments into the hospital beds."[147]

154. In providing evidence to the Health and Social Care Committee, the Minister for Health and Social Services referred to the work being undertaken with the Health Foundation to consider unscheduled care and patient flow. He stated that the programme:

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[142] RoP, Public Accounts Committee, 12 November 2013, paragraphs 284 - 285
[143] RoP, Public Accounts Committee, 10 December 2013, paragraphs 64
[144] www.bbc.co.uk/news/uk-wales-25830185, 21 January 2014
[145] RoP, Public Accounts Committee, 12 November 2013, paragraph 173
[146] Wales Audit Office, Unscheduled Care – An Update on Progress Paragraph 2.48
[147] RoP, Public Accounts Committee, 10 December 2013, paragraph 143

> "does exactly what we want it to do to free the system up so that there is a flow through A&E into the hospital itself and out of hospital at the end."[148]

155. However, in describing projects put in place to bolster community services and result in the need for fewer hospital beds, the Chair of the Welsh National Board of the College of Emergency Medicine informed the Committee that:

> "…the beds are taken out before the system is actually up and running, and that the true effect of that system and the natural consequences have not been fully considered."[149]

156. In further evidence to the Health and Social Care Committee, the Minister highlighted that local winter plans show "around 460 beds as surge capacity – beds that they do not have now, but that they will be able to open if they need to do so."[150]

157. In relation to surge capacity in in-hours and out-of-hours primary care, community services and local government, the Minister said it "is right to say that we have to have surge capacity throughout the entire system".[151]

158. Dr Robinson said GPs "have not previously been employed to meet surges in the winter. I am very interested to explore different and innovative ways to use GPs as part of the system".

The Committee recommends that the Welsh Government provides evidence that health boards have sufficient bed capacity to meet unscheduled care demand. Where plans to provide "surge capacity" are in place, consideration is given to the use of GPs as well as hospital to enable the system to meet demand when necessary.

Keeping patients well in the community

159. A key factor in the management of demand for unscheduled care services is the extent to which people are kept well in the community so that unnecessary emergency care episodes are avoided. This

[148] RoP, Health and Social Care Committee, 9 October 2013, paragraph 96
[149] RoP, Public Accounts Committee, 12 November 2013, paragraph 110
[150] RoP, Health and Social Care Committee, 9 October 2013, paragraph 61
[151] RoP, Health and Social Care Committee, 9 October 2013, paragraph 113

applies particularly to people with chronic or long term conditions. On 27 March 2014, the Auditor General published an update report on the management of chronic conditions in Wales (insert footnote ref). This showed that improvements had been made leading to a general downward trend in emergency hospital admissions for chronic condition related illnesses. However, the Auditor General's report also indicated that further progress was necessary in relation to the planning, co-ordination and accessibility of community services, and that better information is needed to help health plan and monitor the delivery of these services.

The failure to properly manage chronic conditions can have a significant impact on the demand for unscheduled care services. We therefore recommend that the Welsh Government sets out how it intends to respond to the Auditor General's findings and recommendations, and that this response is shared with the Committee alongside the Welsh Government's responses to the other recommendations in this report.

9. Meeting the Needs of Older and Frail People

160. The NHS in Wales is focusing on the needs of older and frail people who are frequent users of unscheduled care and there appears to be a need to strengthen skills and avoid risk aversion when providing older people with the care they need. Evidence suggests an increase in older people attending emergency departments and these patients tend to experience the longest waiting times.

161. The Auditor General's report shows a marked increase in the proportion of people attending emergency departments aged 85 and over. The report also shows that most people who spend 12 hours or more in the emergency department tend to be older people who are more susceptible to complications.[152]

162. These findings were supported in evidence to the Committee from the Chief Executive of ABUHB who stated that:

> "Our experience over the last four years or so is that, having the good news that life expectancy is growing, and therefore that there will be more older people for us to support, the impact has been seen very speedily within the NHS setting."[153]

163. The Chair of the Welsh National Board of the College of Emergency Medicine informed the Committee that:

> "…it is almost the case that the older you are when you present to an emergency department, the higher chance you have of waiting for a prolonged period. That is even more detrimental to these patients' outcomes.'[154]

164. The Committee also heard from Baroness Finlay who is currently leading work on a national conversation on needs of the ageing population. In additional evidence to the Committee, the Welsh Government highlighted that Baroness Finlay agreed to start the new conversation on how care services in Wales can best meet the needs of our ageing population and took up this role in May 2013.[155]

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[152] Wales Audit Office, Unscheduled Care – An Update on Progress, Figure 10, page 31
[153] RoP, Public Accounts Committee, 16 January 2014, paragraph 33
[154] RoP, Public Accounts Committee, 10 December 2013, paragraph 61
[155] Written Evidence, PAC(4)-29-13(p2), 12 November 2013

165. Baroness Finlay told the Committee about the tendency for staff to act in a risk-averse way when trying to meet the needs of older people. She explained that the inspection regime of nursing homes puts pressure "on nursing homes to manage patients how have had a fall precipitates them towards pushing those patients to A&E, who, of course mount up at A&E, meaning that that is another group of patients going in who could possibly be managed differently".[156] She added that:

> "…we have felt that, in many parts of the system, there is a risk aversion that works against anybody other than the patient in front of whoever is doing the assessment and, sometimes, works against the patient as well, because there is no such thing as zero risk."[157]

166. In explaining this further Baroness Finlay highlighted that staff "feel inhibited from taking what might appear to be bold decisions for the patients because they are frightened that they will be told off, that they should not be doing it, that it is outside the guidelines for the unit".[158] She concluded that:

> "…the outcome of not doing something may be worse than the outcome of doing something. It is always a balance; it is always a weighing-up process, but that is not in the language. We will not change the culture until we address the language that people operate in."[159]

167. The Committee heard about some improvements in the planning for some patients' inevitable decline and in frailty services but there is a need to bolster skills in the emergency department for meeting older peoples' needs. The Chair of the Welsh National Board of the College of Emergency Medicine explained that:

> "for patients with on-going conditions and patients from nursing homes and residential homes, it is almost about preplanning their care and trying to anticipate what may go wrong so that they do not get dragged out of their beds kicking and screaming, in the night, but that the assessments are done

[156] RoP, Public Accounts Committee, 10 December 2013, paragraph 150
[157] RoP, Public Accounts Committee, 10 December 2013, paragraph 150
[158] RoP, Public Accounts Committee, 10 December 2013, paragraph 191
[159] RoP, Public Accounts Committee, 10 December 2013, paragraph 200

in the hone and that as much as can be done in those environments as possible is done."[160]

168. The National Programme lead for end of life care provided the Committee with several examples of improvements in end of life care, including the introduction of seven-day working for clinical nurse specialists which has reduced admissions for people at the end of life.[161]

169. The Committee discussed the role of geriatric specialists being available in emergency departments to manage the care of older people. We were informed by that:

> "…all areas of Wales are developing acute care physician roles at the front door, and I think that, in terms of our services, we need to recognise that that co-ordination of older people's care, and having someone with that experience to move them from the front door to their final discharge, is important."[162]

170. The Chief Executive of ABUHB also told the Committee about successes within the Gwent Frailty Scheme, stating that:

> "…we have seen it impacting on the level of admissions to our services' and 'it receives excellent individual patient experience feedback as well – probably the strongest feedback that I have seen."[163]

171. The Clinical Lead for Unscheduled Care talked about plans for a frailty assessment unit at Morriston Hospital and frailty care doctors at the front door in Aneurin Bevan Health Board. He said "we need to re-engineer the system around service users and encourage people to see the service through the eyes of the people who use it2."[164]

172. The Committee is concerned at the high proportion of older and frail people being automatically transferred to emergency departments unnecessarily. We note the evidence to suggest that the social care inspection regime contributes to patients being automatically relayed to hospital following an incidence such as a fall, without a prior clinical decision having been taken.

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[160] RoP, Public Accounts Committee, 10 December 2013, paragraph 82
[161] RoP, Public Accounts Committee, 10 December 2013, paragraph 203
[162] RoP, Public Accounts Committee, 16 January 2014, paragraph 186
[163] RoP, Public Accounts Committee, 16 January 2014, paragraph 104
[164] RoP, Public Accounts Committee, 3 December 2013, paragraph 132

The Committee recommends that the Welsh Government emphasise, including to frontline staff, that transfers to hospital from care homes should not be automatic following a fall but that each case should be assessed individually to determine whether such a transfer is clinically required.

10. Ensuring a sustainable model of services for the future

173. Radical solutions must be considered if whole-system improvement is to be secured in unscheduled care. The Committee heard about the important opportunity provided by on-going reconfiguration plans and about delays in the South Wales Programme.

174. The Chief Executive of ABUHB suggested that centralising services, and being clear about the future model, is important in attracting senior staff to Wales. He explained that:

> "in our patch, because we are centralizing our A&E services for the future, we know that, as we have recruited new individuals, they have reflected that that was quite an important part of their choice to come to Aneurin Bevan Health Board."[165]

175. The Chair of CTUHB commented that the South Wales Programme, the issues in Hywel Dda University Health Board and in North Wales were clear signals that the care system needs to change."[166]

176. Baroness Finlay also spoke about reconfiguration suggesting that:

> "We have to be real and honest with people that we cannot have highly specialised services everywhere in Wales. We need general services in the community, and we need some generalist in-patient beds that are there specifically for people with the aim of turning things around and transferring patients back to the community once they are stable."[167]

177. Baroness Finlay drew attention to the difficulties of travel times in rural areas stating that:

> "…we have a roads problem in Wales and rurality is a real problem, so the organisation of services will need some courageous template-developing for the whole of Wales. We will need to be absolutely clear with people about what they will have locally and the reason that it is not appropriate if somebody is only doing something occasionally—they will not have the skill set and they will not get the clinical outcomes. We

[165] RoP, Public Accounts Committee, 16 January 2014, paragraph 147
[166] RoP, Public Accounts Committee, 16 January 2014, paragraph 238
[167] RoP, Public Accounts Committee, 10 December 2013, paragraph 214

know that from surgery—oesophageal surgery was an absolute classic, and gut surgery altogether."[168]

178. The Chief Executive of ABUHB apologised for delays in the South Wales Programme setting out its recommendations and emphasised the importance of implementing the recommendations quickly. He told the Committee that:

> "I apologise for the delay that happened. It is always a difficult call in that sense. I know that it will have taken time. I can only argue about the complexity of trying to bring so many organisations together and have so much involvement, but, if you want to know whether we will be making a recommendation on the south Wales programme on everything that we have done through the consultation, the answer is 'yes'. We will be setting up board meetings that will make sure that our boards make their respective decisions on that, because the community health councils have had a chance and an opportunity."[169]

179. The Clinical Lead for Unscheduled Care suggested service reorganisation was necessary to ensure sufficient numbers of emergency medicine consultants in each emergency department. He informed the Committee that:

> "The first thing to say is that it is unlikely, either in Wales or beyond, looking at emergency department care, that we will get anywhere near close to the College of Emergency Medicine's aspirations unless we reorganise services to provide those red-stream, high-end services in fewer places in future. That is a conversation that is not just going on in Wales, but is going on generally. Having said that, there has been a significant increase since 2009, the number of A&E consultants has gone up by 50%. That is one of the biggest expansions of the consultant workforce anywhere."[170]

180. The Committee heard arguments that radical solutions to improving unscheduled care are required. The previous Wales Audit Office review on unscheduled care in 2009 concluded that given the

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[168] RoP, Public Accounts Committee, 10 December 2013, paragraph 215
[169] RoP, Public Accounts Committee, 16 January 2014, paragraph 44
[170] RoP, Public Accounts Committee, 12 November 2013, paragraph 255

backdrop of severe pressures on public funding, radically new ways of delivering unscheduled care needed to be introduced.

181. In commenting on this, Baroness Finlay said:

> "I think that the whole system that we are operating in needs to be looked at very carefully, and our conclusion overall is that we need to be pretty radical if we are actually going to make a difference in the long term."[171]

182. She added that "looking at radical solutions, one must look at the way that everybody works across the whole system to make access available".[172]

183. Baroness Finlay also raised the important of providing seven-day services stating that "illness does not respect the clock or calendar, and therefore the services have to be there for those who are really sick".[173]

184. On this issue the Chief Executive of ABUHB referred to the Royal College of Physicians' report on seven-day working and that the Royal Gwent Hospital is one of three sites in the UK that has acute care physicians working seven days per week.[174]

185. In evidence to the Health and Social Care Committee, the Director for Delivery and Deputy Chief Executive of NHS Wales, explained that:

> "…it is important to recognize that part of the reason for flow inside a system is to try to avoid the creation of the need for a surge. So, this working seven days a week, 365 days a year is really important."[175]

186. Most witnesses referred to the importance of a whole system approach. Dr Charlotte Jones representing the BMA told the Committee that:

> "We need to think about the whole-system approach, and not just focus on one aspect of the system. Given that I have worked out of hours, I think that we have to have some very

[171] RoP, Public Accounts Committee, 10 December 2013, paragraph 150
[172] RoP, Public Accounts Committee, 10 December 2013, paragraph 211
[173] RoP, Public Accounts Committee, 10 December 2013, paragraph 159
[174] RoP, Public Accounts Committee, 10 December 2013, paragraph 186
[175] RoP, Health and Social Care Committee, 9 October 2013, paragraph 120

> real, honest conversations about what is achievable. Do we really think that it should be about what is convenient for patients and what it is that they want, or should it be about what they need? There is a lot more that we need to do around self-care, and educating the public about the services that are available out there. I do not think that we use our other colleagues, such as optometrists, as much as we can do, and I do not think that patients particularly use NHS Direct Wales as much as they could, or pharmacists."[176]

187. The Committee notes the general views of witnesses that radical solutions are needed to improve the delivery of unscheduled care and to prevent current problems from reoccurring. We have made a recommendation earlier in this report aimed at ending the uncertainty arising from service reconfiguration to assist in improving the recruitment and retention of staff delivering emergency health care.

188. The Committee concludes that all parts of NHS Wales must work together to provide the whole system approach that is needed to ensure that patients are provided with the care that is appropriate to their needs.

[176] RoP, Public Accounts Committee, 19 November 2013, paragraph 13

Witnesses

The following witnesses provided oral evidence to the Committee on the dates noted below. Transcripts of all oral evidence sessions can be viewed in full at www.senedd.assemblywales.org/mgIssueHistoryHome.aspx?IId=1311.

Thursday 3 October 2013

Huw Vaughan Thomas	Auditor General for Wales
Dave Thomas	Director of Health and Social Care, Wales Audit Office
Stephen Lisle	Performance Specialist, Wales Audit Office

Tuesday 12 November 2013

David Sissling	Chief Executive, NHS Wales
Kevin Flynn	Deputy Chief Executive NHS Wales
Dr Grant Robinson	Clinical Lead for Unscheduled Care

Tuesday 19 November 2013

Dr Charlotte Jones	Chair BMA GPC Wales
Dr David Bailey	Deputy Chair BMA GPC Wales

Tuesday, 3 December 2013

David Sissling	Chief Executive, NHS Wales
Kevin Flynn	Deputy Chief Executive NHS Wales
Dr Grant Robinson	Clinical Lead for Unscheduled Care

Tuesday 10 December 2013

Dr Mark Poulden	Welsh Chair of the College of Emergency Medicine
Baroness Finlay of Llandaff	
Veronica Snow	National Programme lead for end of life care

Thursday 16 January 2014

Dr Andrew Goodall	Aneurin Bevan Health Board
Dr Chris Jones	Cwm Taf Health Board

List of written evidence

The following people and organisations provided written evidence to the Committee. All written evidence can be viewed in full at www.senedd.assemblywales.org/ieListMeetings.aspx?CommitteeId=230

Organisation	*Reference*
David Sissling, Chief Executive, NHS Wales	PAC(4)-29-13 Paper 2
BMA Cymru Wales	PAC(4)-30-13 Paper 1
Kevin Flynn, Director Delivery & Deputy Chief Executive of NHS Wales	PAC(4)-32-13 Paper 1
David Sissling, Chief Executive, NHS Wales	PAC(4)-32-13 Paper 2
Dr. David Bailey, Chairman, General Practitioners Committee (Wales)	PAC(4)-33-13 (ptn2)
Mrs Allison Williams, Chief Executive, Cwm Taf Health Board	PAC(4)-01-14 (ptn2)
Dr Andrew Goodall, Chief Executive, Aneurin Bevan Health Board	PAC(4)-01-14 (ptn3)
Geoff Lang, Acting Chief Executive, Betsi Cadwaladr University Health Board	PAC(4)-01-14 (ptn4)
Dr Andrew Goodall, Chief Executive, Aneurin Bevan Health Board	PAC(4)-01-14 Paper 1
David Sissling, Chief Executive, NHS Wales	PAC(4)-03-14 (ptn2)
Hywel Dda Community Health Council	PAC(4)-03-14 (ptn3)
Professor Trevor Purt, Chief Executive, Hywel Dda University Health Board	PAC(4)-03-14 (ptn4)
Wales Ambulance Service Trust Staff Side	PAC(4)-05-14 (ptn2)
Dr Andrew Goodall, Chief Executive, Aneurin Bevan Health Board	PAC(4)-05-14 (ptn3)
David Sissling, Chief Executive, NHS Wales	PAC(4)-06-14 Paper 5
Wales Ambulance Services NHS Trust	PAC(4)-07-14 (ptn4)