GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Our Ref: AG/CG/vep Direct Line: 01633 435958 31 January 2014

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Cardiff Bay
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Dear Claire

Public Accounts Committee: Attendance in respect of Unscheduled Care

I am writing further to my recent attendance at the Public Accounts Committee. I hope my response helps the Committee with its discussions. I am of course very happy to provide any further information requested or to clarify if this is needed.

- **Figure of inappropriate admissions to A&E by ambulance across ABUHB**

I highlighted this issue in my both my submission and discussion with Assembly Members. It is important to note that there are two 'streams' of patients attending emergency departments. 'Majors' patients (who mostly attend via 999 ambulance) and 'minors' patients who are most often self-presenting. In terms of 'inappropriate' attendances, there is no specific data collection that classes patients as being inappropriate. It is often the case

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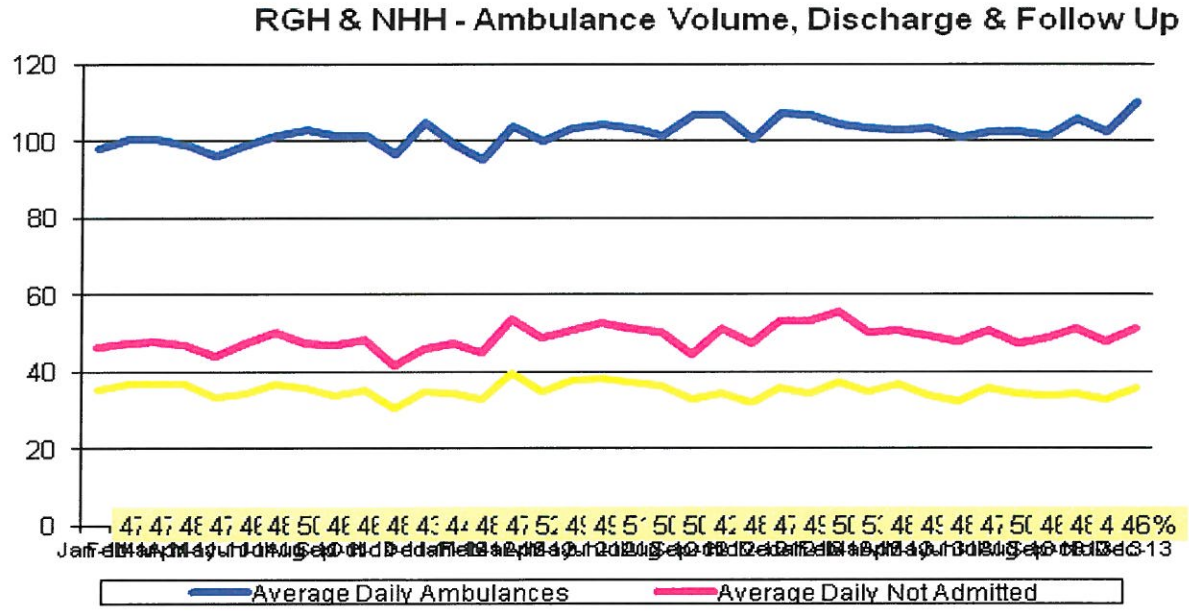
that most patients have some health need, but that health need could be met somewhere other than an ED department. However, we have developed some local measures that act as a proxy for where patients could have been referred or where they may not have needed to have requested an emergency ambulance. Reference to the opportunities for meeting the health needs of some of these patients in other settings stems from ABUHB continuous analysis of the volume of patients being conveyed to ED by 999 ambulance which are subsequently discharged without being admitted.

In addition to this, we monitor the volume of those patients not admitted who do not require any primary or secondary care follow-up. The percentage of patients conveyed via 999 ambulance and not admitted, is reasonably consistent. The graph below shows the non-admitted and non-followed-up conveyance rates over time. You will see that the non-admitted rates are reasonably constant at about 50% of all conveyance rates (pink line). You will also note that the majority of these patients do not require any primary or secondary care follow-up once discharged (yellow line).



Noting the discussion we had, locally this is seen to be a significant opportunity to work closely with the ambulance service to manage ambulance and therefore A&E demand differently, but still to ensure that the right patients end up receiving specialist care in our A&E departments.

From a national perspective, A&E departments currently operate under some pressure, and the transfer of a patient to A&E may not always be the most appropriate response to the request for an emergency ambulance. The scope to reduce conveyance rates in Wales is indicated by similar audits of the proportion of patients transferred to hospital by 999 ambulance who are subsequently discharged from A&E without the need for hospital treatment

or follow-up.

There are, broadly, three approaches to improving the effectiveness of emergency ambulance transport to A&E departments, and all of these will be facilitated by robust informatics support, both within and between organisations, to make care pathways and key patient information visible to care givers when needed:

Handling more calls by phone – 'Hear and Treat'
The Welsh Ambulance Service has piloted the use of clinical call handling to divert low-acuity 999 calls to appropriate destinations, and has conducted field work in ambulance Trusts that have successfully implemented a telephone triage service. This approach, which has proved safe and acceptable to service users, will be a key part of the clinical model implemented by the ambulance service in Wales as part of its programme of clinical transformation. This will involve the use of clinical staff in call centre roles, and a validated pathways-of-care tool.

Handling more calls at the scene – 'See and Treat'
Improvements in the ability and confidence of paramedics to treat patients at the scene are another important part of the new ambulance clinical model. There is scope to increase the proportion of patients dealt with at scene in Wales. Currently in Wales around two thirds of patients are conveyed from the scene. In some areas of the UK fewer than half of patients are conveyed, and in a pilot of an enhanced paramedic role of only a third of patients were conveyed. There are currently 22 advanced paramedic practitioners (including one consultant paramedic) operating in the Welsh Ambulance Service, with training places identified for a further 12.

Development of alternatives to A&E
The development of access to non-emergency facilities as alternative destinations to A&E requires collaboration between the ambulance service and other care providers. Appropriate hospital or community-based services need to be available and visible to ambulance staff as a local Directory of Services. Agreed pathways for the care of appropriate patients should be in place (the ambulance service has already piloted the use of such pathways for falls, hypoglycaemia in diabetes, and epilepsy) and ambulance staff need to be trained in their use.

In addition to these three approaches, designed to reduce conveyance rates to hospital once a 999 call has been made, there is potential to forestall these calls through optimised access to in-hours and out-of-hours primary care services, and through the ready provision of information to service

users on the best way to access healthcare.

- **Overview of the spread of (unscheduled care) services across ABHB**

I have set out below an overview of local services, but am happy to give any further information if it would help individual Assembly Members.

Primary & Community Care Services
ABUHB provides access to unscheduled care across all parts of the health continuum. Patients can access primary care through in hours GP services, being visited at home or through a booked appointment at a GP surgery.

The Health Board also provides a comprehensive GP Out-of-Hours service (GPOOHs). Using clinical triage and call handling, patients are offered telephone advice or streamed to be seen by a GP in one of 3 Primary Care Centres. Sicker more vulnerable patients are offered GP home visits or referred to secondary care for further medical assessment or admission to hospital. As alternatives to hospital admission GPs also refer into a range of community based services such as multi-agency frailty services, but also of course our core community services such as district nursing, offering nursing and therapies support to safely maintain patients in their own homes where clinically appropriate.

Secondary Care Hospital based Services
ABUHB delivers acute services from 3 local general hospital sites namely, Royal Gwent Hospital (RGH), Newport, Nevill Hall Hospital (NHH), Abergavenny & Ysbyty Ystrad Fawr (YYF) at Caerphilly. NHH & RGH have major A&E units accepting 999 Ambulance conveyances with YYF having a Nurse-led Minor Injuries Unit and Medical Assessment Unit only.

Both RGH & NHH receive an 'unselected' intake providing clinical support for medical, surgical and trauma emergencies via A&E. Due to the absence of surgical, anaesthetic and critical care provision at YYF, the hospital receives a 'selected' intake of lower acuity patients matched to specific clinical criteria agreed with WAST. This ensures sicker more acute patients are diverted to RGH or NHH if needed. All 3 hospitals have Minor Injuries Units (MIUs) where walk-in patients are treated for a range of minor ailments and illnesses. Following initial triage, patients are seen, treated and discharged or when necessary re-directed to in-hours GP's or GPOOH's for further follow-up or primary care assessment.

GPs also refer acutely unwell surgical and medical patients into Medical or Surgical Assessment Units (MAU/SAUs) for further assessment by Acute

Care Physicians and surgeons based at RGH & NHH. YYF provides MAU only. Having been assessed by consultants, patients either go on to be admitted to a specialty medical or surgical bed for further treatment (assessed-in) or are discharged (assessed-out) back into the care of their GP. Approximately 40% of GP referrals to MAU/SAU's are assessed-out within 24-48 hours.

The table below sets out the annual activity for each of these 3 units. As I said at the PAC session, we have been pleased to see the level of activity at YYF increase from around 20,000 per annum to approximately 28,000 per year through the change of the model and also the extension of the hours covered to a 24/7 basis.

	RGH	**NHH**	**YYF**
2012-13 attendances	82,845	45,790	27,655

We now only have two defined minor injury units in place locally. The largest is as outlined above in YYF, although the size and nature of the service means that we would see this as complementing significantly local A&E services.

The other Unit is located in Ysbyty Aneurin Bevan Hospital in Ebbw Vale, which opened 3 years ago. This unit currently sees around 2,825 patients per year. It has excellent facilities and is co-located with radiology facilities, but is open on a more limited basis in line with demand rather than on a 24.7 basis. It has had some difficulties in maintaining its daily level of activity that would allow it to ensure that staff were able to fully meet College of Emergency medicine standards. However, attendances have recently increased over the last 6 months with a concerted local campaign jointly taking place with the Health Board with the support of the community, local politicians and the Community Health Council. We have been very open about the ongoing need to balance access with levels of activity that keeps the services safe. We will be further reviewing this and continuing to work locally.

The Board had already made decisions locally to close 3 minor injury units back in 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.

The scope and configuration of services provided by the Emergency Department is summarised in the table overleaf:

Location	Services provided
RGH	Resus, majors, minors and paediatrics
NHH	Resus, majors, minors and paediatrics
YYF	ENP delivered minor injury service
YAB	ENP delivered minor injury service

Overview of GP OOHs Service

Our GP OOHs operates between the hours of 6.30pm and 8am Mon-Fri and all day Saturdays, Sundays and Bank Holidays and is coordinated for the whole of the Gwent area. The service has the following responsibilities:

- To identify immediate life threatening conditions.
- Identify patients who need in-patient care.
- To identify those whose treatment cannot wait.
- Defer those who can wait to see their own GP.
- Communicate effectively with patients and other healthcare professionals.

GP OOHs is divided into three discrete service domains:

- Call handling & triage.
- GP consultations in Primary Care Centres (PCCs).
- Home visiting.

Call Handling & Triage

Call handling and triage facilities are provided in 'Vantage Point House' (VPH) based in Cwmbran which is co-located with the Welsh Ambulance Service control centre. Call handling is undertaken by non-clinical staff using clinically based algorithms. Clinical triage is undertaken by a combination of nurses using a Telephone Assessment System (TAS) and GPs either in VPH or a Primary Care Centre (PCC) or via a remotely networked PC.

Primary Care Centres

Each PCC is staffed by GPs and where possible by supported Advanced Nurse Practitioner. Here, patients are seen and assessed face to face on an appointments only basis although a small number of patients self present.
There are three Primary Care Centres in ABHB situated in:

- St Woolos Hospital *(Outpatients Dept)*
- Ysbyty Ystrad Fawr *(YYF)*
- Nevill Hall Hospital *(Outpatient 2 Dept)*

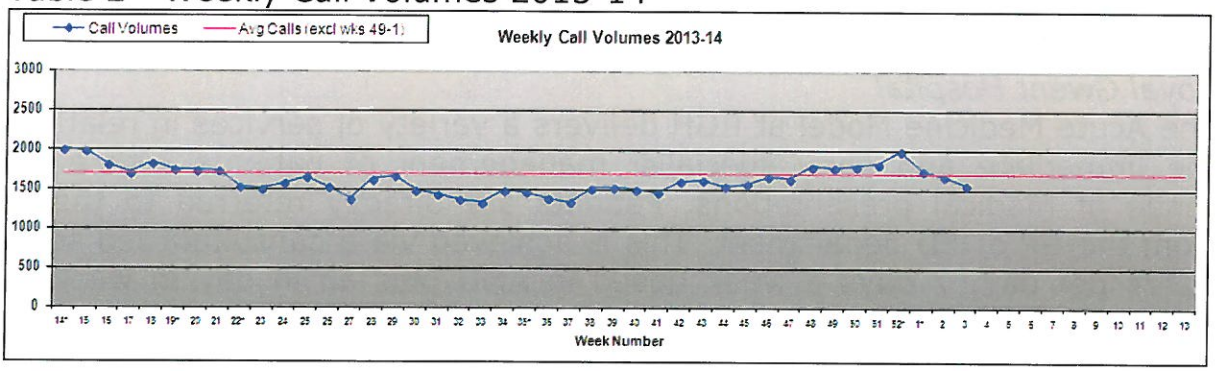
Home Visiting

The GPOOHs service also provides mobile GP home visiting for vulnerable patients and urgent cases that are unable to present to a PCC. Transport is provided by a fleet of 5 medic cars and a team of drivers.

Activity
Activity is derived from incoming calls that are clinically triaged resulting in patients being given telephone advice, offered a face to face assessment at a PCC or a home visit by a GP.

Call Volumes
Table 2 illustrates weekly call volumes for 2013-14 averaging approximately 1700 calls per week.

Table 2 - Weekly Call Volumes 2013-14



Call Disposal
Based on approximately 90,000 calls per year, around 33% receive advice; 43% attend the PCC and 15% receive a home visit, in the most serious of cases.

PCC Assessments & Home Visits
Calls from patients given telephone advice (approximately 33%) generally result in self-care or a deferral to be seen by the in-hours GP service. The remainder are triaged to receive a face to face assessment in a PCC or require a home visit by a GP. PCC appointments represent 43% of the total call disposal volume. Table 4 shows the distribution of appointments across the 3 PCC's, St Woolos being the busiest centre.

Table 3 – PCC Activity

Primary Care Centre Visits	**Total**	**%**
Nevill Hall	11065	23.49%
St Woolos	19655	41.73%
Ysbyty Ystrad Fawr	16382	34.78%
Grand Total	**47102**	

Home visits are provided by a team mobile GP deployed from the PCCs and Vantage Point House. Table 4 shows the distribution of home visits across the localities. Calls are mostly allocated on a geographical basis; however, some overlap exists dependent upon clinical priority, proximity and workload.

Table 4 – Locality Mobile Medic Activity

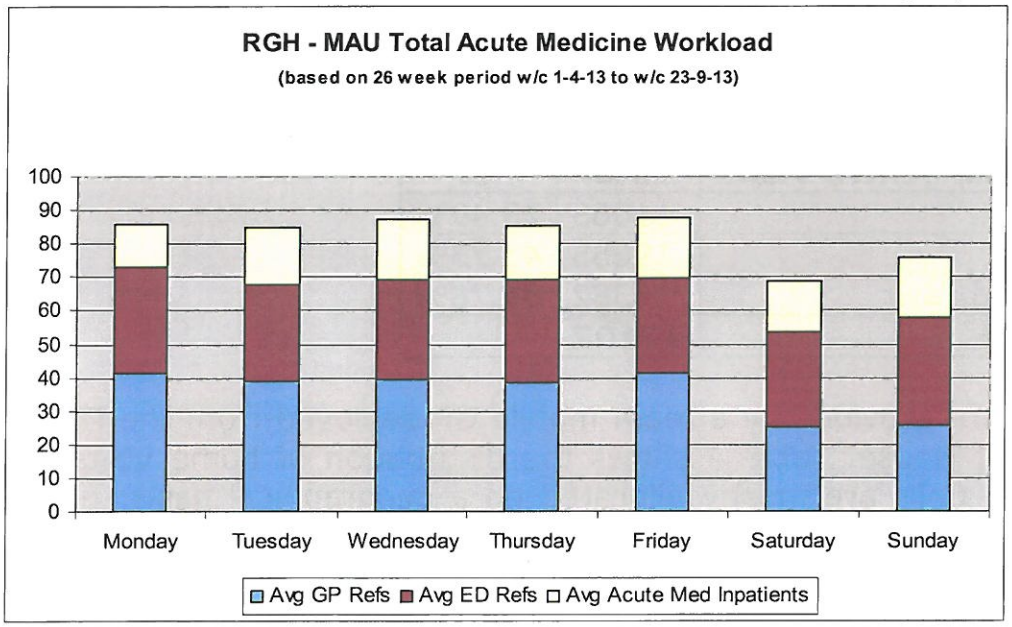
Mobile Medics	Total	%
Blaenau Gwent Medic	2093	17.37%
Monmouthshire Medic	1483	12.31%
Newport Medic	3337	27.69%
Torfaen Medic	2063	17.12%
Caerphilly Medic	3074	25.51%
Grand Total	**12050**	

Acute Medicine Service Configuration

Royal Gwent Hospital
The Acute Medicine Model at RGH delivers a variety of services in relation to the immediate and early specialist management of patients with a wide range of medical presentations. Patients are directly referred to the unit from the GP or ED department. This is achieved via a consultant led service 12hrs per day, 7 days a week based in AMU plus an in day in week ACP based in the ED. The ACP's have their own beds and are able to define patients to acute medicine under their name. In addition the unit also supports YYF and consultants rotate there on a rolling rota to provide in day cover. This medical model requires 39 sessions of Acute Medicine DCC's provided by 7 consultants.
Composition of the Unit:

- Assessment Trolleys: 15
- Pre-hospital Streaming Capacity: 12 trolleys
- Acute Medicine Beds: 12
- Ambulatory Area

The workload for Acute Medicine is demonstrated in the graph below:



Nevill Hall Hospital
The EAU at NHH comprises of 11 trolleys, 1 treatment area and 23 beds. Patients attend the MAU via GP referral, self presentation, Ambulance or transfer from the Emergency Department. There is a dedicated team comprising of 2 x ACPs and 1 Speciality Registrar who are supported by the on-call medical and ANP team. The assessed out rate runs at 43%. The service is currently looking to expand the level of ACP cover which will support further expansion of the working day and the ambulatory service.

The EAU is staffed by a dedicated nursing team. The Nursing resource has recently been reviewed and plans are in place to increase the establishment in line with the All Wales Principles to improve the level of nurse to patient ration whilst ensuring that appropriate resources are available to meet demand.

Ysbyty Ystrad Fawr
The MAU at YYF comprises of 10 trolleys and a 28 bedded assessment ward. Patients attend the MAU via GP referral, self presentation, Ambulance or transfer from the MIU.

There is a dedicated MAU team comprising of an ACP, ANP and dedicated Junior Doctor. Members of the Community Response Team attend the morning PTWR and more recently some dedicated Occupational Therapy resource has been identified.

The assessed out rate for MAU currently runs at 53% and work is progressing regarding the establishment of an Ambulatory Service.

The 10 trolleys are staffed by a dedicated nursing team, overseen by the Lead Advanced Nurse Practitioner. The Nursing resource is currently under review to ensure appropriate resource is available to meet demand. Since opening in November 2011 activity in MAU has increased by 74% compared to Caerphilly & District Miners Hospital.

Summary of overview

In summary, the information provided above reflects our current provision of front line unscheduled services across ABUHB. High level data has been included to provide context to activity, demand and patient flows. Whilst patient access is delivered within the constraints of the existing service configuration, the Health Board is actively engaged in significant strategic re-design of all services consistent with the Clinical Futures Programme and the South Wales Plan. This means that we will continue to look at the best practice models for these services – but driven by our local strategy publically approved and with CHC agreement to centralise our specialist A&E services at the Specialist Critical Care Centre site in 2018. This has been a feature of the South Wales programme also. This model will still ensure that

local A&E services remain available in other sites, where we can continue to provide good local access and expertise through nurse-delivered services.

- **Clarification of handover times for ambulances arriving at hospital**

It is important to note that there are two essential categories when looking at ambulance time at hospital. The first is the ambulance *'arrival to departure time'*. This is the time measured by the ambulance service and includes arrival at the A&E forecourt, time in the ambulance pre-decanting, unloading the patient and transporting them into ED, electronically notifying that the patient has arrived in ED, the handover process with the ED – including electronic notification of completed handover, equipment (trolley) cleaning, travel back to the ambulance and preparation before departure. This is known as the turnaround measure and is one of the suite of ambulance measures we monitor locally and will provide an understanding of delay across the system. The target time allowed for this process overall is 20 minutes. However within that 20 minutes, 15 minutes is the target for *'electronic notification to electronic handover'* complete element. This constitutes the *'15 minute handover'* ambulance internal target for hospitals which is more formally measured and reported. This means we are able to monitor both the arrival of vehicles and the internal transfer of patients and ensure that both act in the best interest of the patient. If ambulances have arrived on site but patients are delayed in their initial handover this will remain very visible not least the WAST and health live reporting systems.

- **Details of the financial programme for 'invest to save' within the Gwent locality**

The Gwent Frailty Programme was established in 2010-11 with the following partners:

- Aneurin Bevan University Health Board
- Blaenau Gwent Local Authority
- Caerphilly Local Authority
- Monmouthshire Local Authority
- Newport Local Authority
- Torfaen Local Authority

A joint invest to save proposal was developed to support the existing resources within Gwent to implement an innovative intermediate care model of 'community resource teams' and to equalise the resources available to each locality's population, to ensure the programme accelerated equal care for all patients across Gwent. However, the programme also allowed us as an organisation to align and bring together our existing services already focused on this group of patients/ users, for example, include response teams and reablement teams. The availability of invest to save funds was critical to consolidate the 6 organisations.

Financial Overview

A sum of £8.8m represents the original core contribution from all organisations, with an invest to save fund of £7.3m also agreed from Welsh Government, giving a pooled fund for the programme of £16.1m over a 3 year period.

The repayment profile for the £7.3m is spread over the period 2012/13 to 2017/18. During this period the Gwent organisations will have applied funding from historical service delivery models and applied them to recurrently resource the community resource teams.

The funding contributions made by each organisation as at 2013/14, reflecting the core nature of these services, are identified below:

Organisation Original Contributions	
	£000
ABHB	4,122
Blaenau Gwent	427
Caerphilly	1,693
Monmouthshire	960
Newport	1,162
Torfaen	440
Total	**8,804**

The Value of the invest to save spend incurred to date is outlined below and presents a programme forecast spend of £ 5.7m to year ending March 2014, further spend is anticipated into 2014/15 as we target the final pump-priming resources:

Invest to Save fund application				
	2010/11	**2011/12**	**2012/13**	**2013/14 F'cast**
	£000	£000	£000	£000
ABHB	11	1,538	1,324	782
Blaenau Gwent	-	-	-	-
Caerphilly	4	61	169	188
Monmouthshire	-	23	67	41
Newport	-	26	72	88
Torfaen	-	-	93	63
Central costs	203	671	139	169
Total Programme	**219**	**2,320**	**1,864**	**1,330**

The Invest to Save Payback profile is presented below. £1.375m has already been repaid:

Invest to Save Repayment Profile	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	£000	£000	£000	£000	£000	£000
ABHB	285	759	1,138	1,138	1,138	1,092
Blaenau Gwent	2	7	10	10	10	9
Caerphilly	22	58	87	87	87	83
Monmouthshire	14	38	57	57	57	55
Newport	34	90	136	136	136	130
Torfaen	18	49	73	73	73	70
Total Programme	375	1,000	1,500	1,500	1,500	1,439
Total Repayment						7,314

For 2013/14 a £3.8m budget will have been identified as Gwent organisations now re-applying funding from historical service delivery models and applying them to recurrently resource the community resource teams to maintain these services locally.

The latest forecast for 2013/14 presents that a Gwent wide programme budget of £14.8m has been identified, with a forecast spend of £13.4m anticipated, this is separate to the repayment of invest to save funding of £1m.

Future Financial Plans

An independent programme evaluation study is being procured and will influence the future model of the programme and ensure that we build on progress to date, but extend the impact and benefit of the frailty programme to more users. Extending joint partnership working and integration is being discussed, as these frameworks support a number of local ambitions about even closer working between health and social care, and is likely to be key to future service models. Frailty has been an enabler of these opportunities for better integration, even now extending to services such as mental health.

Local Commissioning Plans and Financial Plans for 2014/15 are being drafted and will be considered alongside the findings of the evaluation study and wider integration plans. I also indicated to the Assembly Members present that the use of the Intermediate Care Fund would also give a focus for the further development of such joint community-based services.

I have responded to the specific finance issue raised in respect of frailty not least on the profile of pay back to the invest to save fund, which is part of

the local contribution to services. There is a whole range of further information on experience, benefits, outcomes and impact which we continue to work through. I suggest that I will approach Jocelyn Davies personally alongside this to allow her to have some further understanding of the broader development of frailty and how it has contributed to local services.

I hope that I have been able to appropriately respond to the issues.

Yours sincerely

Dr Andrew Goodall
Prif Weithredwr/ Chief Executive