Dogfennau Ategol - Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Lleoliad:

Dyddiad: Dydd Iau, 29 Medi 2016

Amser: 09.00

I gael rhagor o wybodaeth cysylltwch a:

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Committee Clerk

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Noder bod y dogfennau a ganlyn yn ychwanegol i'r dogfennau a gyhoeddwyd yn y prif becyn Agenda ac Adroddiadau ar gyfer y cyfarfod hwn

Drafft - Inquiry intro winter preparedness 2017/17: Written responses

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Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016/17

Ymatebion i'r Ymgynghoriad

Medi 2016

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Health, Social Care and Sport Committee

Inquiry into winter preparedness 2016/17

Consultation Responses

September 2016

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WP 01
Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016
Inquiry into winter preparedness 2016/17
Ymateb gan: Coleg Brenhinol Meddygon Caeredin
Response from: Royal College of Physicians of Edinburgh

Inquiry into winter preparedness 2016/17

The Royal College of Physicians of Edinburgh is pleased to respond to the Health, Social Care and Sport Committee's inquiry into winter preparedness 2016/17 which recognises the importance of ensuring the Welsh NHS is equipped to deal with pressures on unscheduled care services during the coming winter.

Crucially, this inquiry should also ask organisations to consider the lessons it has learned (if any) from previous years to influence future responses.

Although the inquiry is themed around 'winter' our Fellows and Members report that difficulties accessing unscheduled care are a key concern for staff and patients year round. Therefore 'ensuring winter preparedness' may feel like a misnomer when many physicians and hospitals do not ever feel they exit this period of pressure.

The inquiry notes the importance of patient flow, and each part of the unscheduled care pathway plays a part in influencing urgent and emergency care performance. Focus needs to be on what aspects of that pathway can be improved to allow flow through the Emergency Department (ED) – either back into the community, or to the correct inpatient bed, at the right time, cared for by the right person.

The Acute Medicine Unit (AMU) and acute medicine teams can play a key role in keeping the system moving, although they too report pressure throughout the year. There is not a single solution to the pressures, but there are things within AMUs that can help maintain safe care:

- AMUs run by senior clinicians and staffed by dedicated multi-professional teams
- Ambulatory emergency care with extended opening hours and senior decision makers
- Early senior review of patients to enhance care and facilitate safe, early discharge
- In-reach to ED to reduce the workload burden on Emergency Physicians
- Championing 7-day services
- 'Discharge to assess' ethos being used by acute therapies teams

There are poor practices, however, which should be targeted:

- Moving patients from AMUs to general or specialty wards because there are no community beds available or social care provision at home for older patients to be discharged to.
- Moving patients to non-medical beds or beds in the wrong specialty ('boarding') because it is the only place where there is a bed. This practice increases length of stay and has an adverse effect on morbidity and mortality. Boarding, traditionally a winter feature, is now seen year round.
- Acute admission is the final default when patients have nowhere else to turn. Many patients present to the ED with conditions that should be managed in primary care, but people can't get in to see their GPs and community teams as

they are also stretched. Having co-located Urgent Care Clinics which are adequately staffed can help with this.

- There are inadequate services for vulnerable patient groups. Not just social care provision for older and frailer patients who are medically fit for discharge, but mental health services are also stretched and physicians commonly see patients with significant mental health conditions, and no acute medical problem, being cared for in an acute hospital bed.

WP 02
Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016
Inquiry into winter preparedness 2016/17
Ymateb gan: Coleg Nyrsio Brenhinol
Response from: Royal College of Nursing

Coleg Nyrsio Brenhinol Cymru
Royal College of Nursing Wales

INQUIRY INTO WINTER PREPAREDNESS 2016/17

Submission from the Royal College of Nursing Wales

Presented to the National Assembly for Wales Health, Social Care and Sport Committee

09/09/16

ABOUT THE ROYAL COLLEGE OF NURSING (RCN)

The RCN is the world's largest professional union of nurses, representing 430,000 nurses, midwives, health visitors, health care support workers and nursing students, including over 25,000 members in Wales. RCN members work in a variety of settings including the NHS and the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing.

INQUIRY INTO WINTER PREPAREDNESS 2016/17

Submission from the Royal College of Nursing Wales

1. RCN Wales believes the traditional pressure experienced by health services (particularly in emergency care) during the winter period from November to March has in recent years becomes an all year concern.

2. This change is symptomatic of the broader pressures facing health and social care services. Historically, the focus has been on the provision of Accident and Emergency services however the pressures are wide ranging and multi factorial. The outcome of these pressures result in significant risk to the quality of patient care, safety and increased morbidity and mortality rates[1].

The current pressures facing unscheduled care services

3. The key pressures facing unscheduled care services are staff shortages which are a result of inadequate workforce planning. This chronic shortage of staff brings additional staff stressors which result in increased sickness and problems with retention[2]. An additional factor is the retirement phenomenon where one third of the workforce is nearing retirement[3]

4. The rapid decline in District Nurses in recent years alongside the disinvestment in community Rapid Response Teams is increasing the pressures on other services[4]. This disinvestment of Primary and Community services in turn leads to unnecessary admissions to hospital which in turn leads to queues of ambulances outside of A&E departments and cancelled operations whilst delayed transfers of care affects the seamless transition between health and social care sectors.

5. Building better multidisciplinary care for people with complex needs would see a reduction in these unnecessary admissions[5]. In addition extended opening hours for GP surgeries[6] and better use of Triage by the best person with the right skills

[1] Royal College of Nursing (2013) RCN Labour Market Review: Safe Staffing Levels- A National Imperative. The UK Nursing Workforce Labour Market Review 2015. London: NMC.
[2] Royal College of Nursing (2013) Beyond Breaking Point: A Survey of RCN Members in Health Wellbeing and Stress. London: RCN.
[3] Institute for Employment Studies (2016) The Labour Market for Nurses in the UK and its relationship to the demand for and supply of International Nurses in the NHS. IES: Brighton.
[4] BBC News . 2016. *Royal College of Nursing concern over fall in district nurses in Wales*. [ONLINE] Available at: http://www.bbc.co.uk/news/uk-wales-36828072. [Accessed 18 August 2016].
[5] Edwards, N. (2014) Community Services: How They Can Transform Care. London. The Kings Fund.
[6] PULSE. 2013. *Longer GP opening hours needed to boost productivity*. [ONLINE] Available at: http://www.pulsetoday.co.uk/your-practice/regulation/longer-gp-opening-hours-needed-to-boost-productivity-says-monitor/20004689.fullarticle. [Accessed 18 August 2016].

would alleviate pressures, improve the patient journey and lead to better outcomes[7].

6. An additional pressure is the delay in the 'Go Live Dates' for the 111 service due to IT processes. The introduction of 111 was to amalgamate and streamline the current services of NHS Direct and the Out of Hours Service. The delay in implementation could potentially be adding to unscheduled care pressures due to lack of appropriate services and therefore patients being signposted to Accident and Emergency[8].

Has been sufficient progress in the Fourth Assembly?

7. The Royal College of Nursing Wales does not believe there has been sufficient progress in making the NHS system more robust and effective at dealing with these demands. Attached as an Annex1 to this evidence is the document Emergency Care - A Call for Action 2009. This is a set of recommendations presented by the Royal College of Nursing Wales to improve the emergency care service to the Welsh Government in September 2009. Regrettably most of these calls for action are still relevant. We draw the Committee's attention in particular to recommendations 9 and 10 which call for investment in primary and community care.

The actions needed to produce sustainable improvements

8. The RCN is holding a conference on the 26th September 2016 in Cardiff to examine some of these issues to utilise our member's expertise. Committee Members and Secretariat are invited to attend and we would be delighted to welcome you. Topics areas for discussion will be: Emergency Care for the People of Wales; Opportunities & Challenges; Patient Flow; A Modern Responsive Emergency Department; The contribution of nursing to emergency care triage.

9. We would be happy to send a short note sharing the outcome of this conference to the Committee.

10. In conclusion RCN Wales believes the following actions are needed to produce sustainable improvements to urgent and emergency care services, and the whole system, ensuring the Welsh NHS builds resilience to seasonal demand and to improve the position for the future.

[7] Department of Health (2015) Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values. DH: Williams Lea Publishers.
A mandate from the Government to Health Education England: April 2015 to March 2016
[8] The King Fund . 2016. *What's going on in A&E?* [ONLINE] Available at: http://www.kingsfund.org.uk/projects/urgent-emergency-care/urgent-and-emergency-care-mythbusters? [Accessed 18 August 2016].

- Improved workforce planning to address the shortages of nurses, this should consider increasing the numbers of pre-registration places, better coordination and management of clinical placements.

- Improved coordination and management in relation to recruiting and retaining international nurses.

- Development and deployment of enhanced skill mix including triage to ensure the right people deliver the right care in the right place at the right time.

- Greater investment in, and increased access to the primary care team (including nurse practitioners with independent prescribing).

- Greater investment in community healthcare services with a particular reference to the need to increase the numbers of District Nurses and Rapid Response teams;

- Emphasis on citizen engagement to ensure patients access the right services for example extensive publicity of the ‘Choose Well’ campaign.

WP 03
Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016
Inquiry into winter preparedness 2016/17
Ymateb gan: UNSAIN
Response from: UNISON

UNISON Cymru/Wales response: Inquiry into winter preparedness 2016/17

Introduction

1.1 UNISON Cymru/Wales is Wales' largest public sector trade union. UNISON has 100,000 members working in public services across Wales. We welcome the opportunity to feed into the National Assembly Wales inquiry into winter preparedness 2016/17.

1.2 We represent full-time and part-time staff who provide public services, although they may be employed in both the public and private sectors.

1.3 UNISON's health service group welcomes members employed or contracted by the NHS in all four UK countries. Our members are from all non-medical occupational groups including: nurses and health care assistants; midwives; health visitors; administrative, finance and HR staff; ambulance staff including paramedics, technicians, control room and maintenance staff, therapy and healthcare science staff; estates and housekeeping staff; technicians and maintenance staff; commissioning staff; allied health professionals; scientific staff; healthcare managers

Access to Services

2.1 Improved access to GP and dental surgeries outside of 'normal' working hours would take pressure off emergency services. People are reluctant to use out-of-hours services as these are often not easily accessible and patients frequently turn up at Emergency Departments.

2.2 GP services should be available 24/7 in Emergency Departments to allow for the patient to be directed immediately to a GP rather than taking the time of an emergency doctor.

2.3 This could work in conjunction with the proposed 111 services.

Choose Well

3.1 There is rising demand on emergency care, including 999 and emergency departments. We believe that the committee could consider the Welsh Government's approach to educating people about the misuse of emergency services, or the alternative services that are available. Anecdotal evidence suggests that GP practices and nursing homes are amongst those who use emergency services inappropriately.

3.2 The Choose Well campaign has been given very limited funding and we are concerned at the ability to produce an effective, far-reaching campaign with such limited resource.

3.3 An effective campaign could alleviate the pressures on services during the Winter period.

Ambulance

4.1 UNISON has received reports from our ambulance staff members that they are already seeing waits outside emergency departments.

4.2 This has a negative impact on both patients and on the staff who overrun their shifts to continue care for patients.

4.3 The agreement that allows fresh crews to take over and relieve crews at the end of their shifts is a positive measure; however this only works where resources are available. We have reports that this is a particular issue in rural areas where shifts regularly continue to overrun. There are health, wellbeing and family implications for the workforce in this scenario.

Handover to Emergency Departments

5.1 Historically, it was not uncommon for altercations to occur between ambulance and emergency staff due to the high pressured environment and pressures being faced by both parties.

5.2 Local Health Boards and Welsh Ambulance Services need to be working seamlessly and in partnership. Improvements have been made since the establishment of the Ambulance Services Special Committee, but increasing pressures ~~on~~ in the run up to and during Winter could undo some of this good work.

5.3 Ultimately, Welsh Ambulance and Local Health Board staff work tirelessly to provide high quality and efficient health services. Decent organisation and effective resources must be in place to allow this to happen.

Staff Absence

6.1 Whilst staff absence is obviously unplanned, it can often be predictable in nature when there are episodes of contagious illnesses.

6.2 Contingency plans must be in place to overcome the challenge of staff absence as a part of the Winter preparedness strategy.

6.3 The workforce should be protected from infectious illnesses where possible through available vaccines in order to minimise absence.

Conclusion

7.1 UNISON Cymru/Wales welcomes the opportunity to feed into this inquiry on Winter preparedness.

7.2 The ultimate aim of the Winter Preparedness plans should be to ensure that patients are provided with the right care, at the right place, by the right person, at the right time. By delivering this effectively, the heightened Winter demand on services will be more manageable.

7.3 UNISON would welcome the opportunity to further input into this inquiry as appropriate.

WP 04

Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016

Inquiry into winter preparedness 2016/17

Ymateb gan: Age Cymru

Response from: Age Cymru

Consultation Response

Winter preparedness

September 2016

Introduction

Age Cymru is the leading charity working to improve the lives of all older people in Wales. We believe older people should be able to lead healthy and fulfilled lives, have adequate income, access to high quality services and the opportunity to shape their own future. We seek to provide a strong voice for all older people in Wales and to raise awareness of the issues of importance to them.

We are pleased to respond to the Health, Social Care and Sport Committee's inquiry into winter preparedness in Wales. We welcome the committee's decision to look immediately at the issues of winter preparedness. The issue of excess winter mortality disproportionately affects older people, for example through avoidable slips, trips and falls or due to cutting back on heating out of fear of the cost.

General comments

- Prevention in the community: Whilst we acknowledge that much of the focus of this inquiry will be concentrated upon the preparedness of the Local Health Boards and the Welsh Ambulance Service Trust for winter 2016-17, we would like to stress the importance of preventative measures in the community in order to minimise the number of older people who end up requiring treatment from the NHS.

  Older people are at higher risk of unscheduled admission. Avoiding unscheduled admission to hospital is a major concern for the NHS because of the impact on the individual admitted, the high cost of emergency admissions, and the disruption that can be caused to elective care.

  Through its Healthy Ageing Initiative, Age Cymru is involved in supporting both the Choose Well and Beat Flu promotions by strengthening the messages underpinning its own Spread the Warmth campaign, working with our local Age Cymru partners and our high street retail presence. Age Cymru also produces a Winter Wrapped Up guide for older people which covers topics such as keeping warm (inside and out), flu vaccination and advice on financial entitlements.

- Influenza vaccinations (the 'flu jab): Flu can be more serious for some groups of people, including older adults, even if they are fit and healthy. These groups are more prone to complications that can arise from being infected with flu. To this end, promoting the importance of the free jab for older people is essential. It is important that older people are informed that their free vaccination may be available from a local community pharmacy as an alternative to making an appointment at their GP surgery.

Those working with older people, including health and social care professionals should also be vaccinated in order to minimise the risk of passing on the illness to the older people for whom they care. It is therefore worrying that take-up rates by these staff groups have been relatively low in the past. It is also important that carers of older people are vaccinated and we would recommend that carers should be eligible for a free vaccine in order to protect the vulnerable people for whom they care. It is important that these groups, as well as older people, understand that the vaccination only protects them from a year and keep their vaccinations up to date.

- Slips, trips and falls: Falls prevention is an important issue for the work of Age Cymru. Through our Healthy Ageing Initiative, we are engaged in the work on falls prevention through the Ageing Well in Wales expert advisory group on falls and are in collaboration with 1000 Lives Plus to establish a national falls prevention taskforce. As part of this work, Age Cymru and other partners, led by the Older People's Commissioner for Wales, will be promoting a new campaign 'Steady on…Stay safe' from February next year.

  The Ageing Well in Wales programme has identified the importance of reducing the impact and number of falls as a national issue that requires a coherent response. The Strategy for Older People[1] recognises that fear of falling is reported as a key concern for older people and a major contributing factor to their social isolation. In 2015, the Chartered Society of Physiotherapy (CSP) estimated that nearly 15,000 falls in Wales could be avoided through the use of physiotherapy-led preventative interventions[2]. The risk of slipping and/or falling, resulting in injury is aggravated during poor winter weather conditions.

  Falling – and the fear of falling – can have a major impact on older people. The physical aspects and injuries are obvious but potentially more damaging is the less obvious impact that falls can have on confidence. Older people tell us that anxiety about falling, even if they have never fallen, preys on their mind. A lack of confidence can lead to people limiting what they do, resulting in a higher chance of social isolation and loneliness and the additional associated health risks. People may, however, be reluctant to seek help and advice in case relatives or care professionals think they are no longer able to cope independently.

  Prevention of falls is vital. We should not focus solely on post-fall interventions. Age Cymru produces an 'Avoiding slips, trips and falls' guide for older people which covers issues such as eye tests, foot care and medicines management as well as some of the more obvious risks. This guide has been, and is being, used by many hospitals across Wales, which is great for older people. However, this throws up questions about sustainability as Age Cymru struggles to find the resources to produce a sufficient number of copies to reach demand in the absence of external contributions.

  We believe there needs to be a more consistent approach to falls prevention across Wales and a national mandatory minimum standard of support that all older people receive. This should comprise:
  - Access to information

[1] Welsh Government (2013): *The Strategy for Older People 2013-2023*
[2] CSP (2015): Physiotherapy could prevent 14,600 serious falls in Wales every year (Available at: http://www.csp.org.uk/news/2015/01/20/physiotherapy-could-prevent-14600-serious-falls-wales-every-year)

- Preventative interventions
- Care
- And signposting to other services or support.

Whilst slips and falls may occur disproportionately during the winter months due to adverse weather conditions, an effective approach to falls prevention can benefit older people all year round.

- Fuel poverty: Fuel poverty has been highlighted in the past by Public Health Wales as a key contributing factor to winter demand as people struggle to keep their homes warm. Public Health Wales has found that people at higher risk of the health effects of cold are also at higher risk of fuel poverty[3]

  Fuel poverty is a significant problem for many older people in Wales. In Wales, fuel poverty is defined as needing to spend 10 per cent or more of household income on fuel to maintain a heating regime adequate to safeguard comfort and health. Around 386,000 households were estimated to be in fuel poverty in 2012, equivalent to around 30 per cent of all households in Wales. Older people are the group most likely to suffer from fuel poverty. On average there are around 1,600 excess winter deaths each year in Wales, the vast majority of whom were older people. At the root of many winter deaths are cold, badly insulated homes.

  The Welsh Government has targets to eradicate fuel poverty which were set out in the Welsh Fuel Poverty Strategy in 2003 and reiterated by the Fuel Poverty Strategy 2010. Unfortunately the first two targets – to eradicate fuel poverty amongst all vulnerable households in Wales by 2010 and social housing by 2012 – were missed and there is no realistic prospect of achieving the final target of eradicating fuel poverty completely by 2018. In addition, many of the mechanisms and measures contained within the 2010 Fuel Poverty Strategy are out of date or no longer applicable. The Welsh Government's continued commitment to funding an energy efficiency programme specifically aimed at reaching fuel poor households has been extremely welcome. However, the relatively small size of the Nest annual budget means that the overall reach of the scheme has been small. We are keen to see a renewed approach to tackling fuel poverty that will provide a clear programme of support that vulnerable households are able to access.

- Appropriate hospital discharge: if older people do end up being admitted to hospital during the winter, it is essential for both the older person and the hospital that the older person is discharged appropriately to ensure hospital flow is maintained as best as possible.

  Too many older people are stuck waiting in hospital beds for much longer than necessary, often during complex discussions between different agencies over who should fund a long-term care package. We regularly hear of cases of older people waiting in hospital for a care package, without knowledge of why they are waiting, or any information as to their options and rights in this process. We hear from our local Age Cymru partners that the majority of older people they speak to do not even know that there is a discharge planning process, let alone that they have a right to be involved in it from the point of admission.

[3] Dyfed Wyn Hughes et al (June 2013): *External Factors ('Drivers') affecting long-term trends and recent 'pressures' on unscheduled care use and performance in Wales* (Public Health Wales)

At the other extreme, older people are sometimes discharged without appropriate measures taken to ensure that they will be safe and cared for whilst they recover at home. One person told us: “You can be discharged the day after surgery even if you live alone. There was no discussion about who would look after me, how far my family lived from me or if my house was suitable for me…how did they know it was safe for me to go home?” Discharges may also take place at inappropriate times, such as at night, causing unnecessary stress and anxiety for those being discharged. There have been a number of projects funded under the Intermediate Care Fund to improve discharge outcomes, for example the Extended Hospital Service in Gwent. In order to maintain and improve flow through hospitals, those pilot schemes that have been effective should be extended across Wales and adapted to local circumstances as appropriate.

We hope these comments are useful and would be more than happy to provide further information if required.

WP 05
Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016
Inquiry into winter preparedness 2016/17
Ymateb gan: Fferylliaeth Gymunedol Cymru
Response from: Community Pharmacy Wales

Community Pharmacy Wales
Fferylliaeth Gymunedol Cymru

A Response

Health, Social Care & Sport Committee's inquiry into the winter preparedness 2016/17

9 September 2016

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CPW agrees that the content of this response can be made public. CPW are happy to provide further information as required by the Committee either by additional written or oral evidence or to facilitate a Committee visit to a community pharmacy. CPW welcomes communication in either English or Welsh.

Part 1: Introduction

1. CPW is the only organisation that represents all 716 community pharmacy contractors in Wales. It works with Government and its agencies, such as local Health Boards, to help protect and develop high quality community pharmacy based NHS services and to shape the NHS Community Pharmacy Contractual Framework (CPCF) and its associated regulations. It is the body recognised by the Welsh Assembly Government in accordance with *Sections 83 and 85 National Health Service (Wales) Act 2006* as 'representative of persons providing pharmaceutical services'.

2. CPW represents a network of of community pharmacies across Wales which provide essential and highly valued health and social care services at the heart of local communities. Community pharmacies operate in almost every community across Wales, including in rural communities, urban deprived areas and large metropolitan centres. It is currently estimated that on an average day the network of community pharmacies across Wales will, between them, deal with more than 50,000 individual patients.

Part 2: Considerations for the Committee

Role of Community Pharmacy in reducing Unscheduled Care

3. Primary Care contractors have a significant role to play in reducing the pressures facing unscheduled care services. CPW believes that community pharmacies have a major role in helping to maintain a sustainable health service going forward. For community pharmacies to be able to successfully do this, there is a need for the development of core services to be available from every community pharmacy in Wales in order to increase the awareness and confidence of the general public in relation to the full range of community pharmacy based services in order to reduce pressures elsewhere in the primary and secondary care sectors.

4. CPW welcomes the national implementation of the Choose Pharmacy IT application across Wales following the successful pilot of the platform across 46 community pharmacies in Gwynedd, the Cynon Valley and Cardiff; and the opportunities that the platform will provide for pharmacies in delivering services for the general public and releasing capacity in general practice. However, CPW believes that the roll out of the platform currently proposed for 400 pharmacies needs to be extended to all 716 community pharmacies in Wales as soon as is practicable, as the implementation is an essential step in moving towards a cohesive, electronic and fully integrated healthcare system enabling consistent sharing of patient information across sectors to not only deliver seamless and safer patient care, but to allow pertinent information to follow the patient wherever care is provided.

5. Up to 18% of general practice workload and 8% of emergency department consultations are estimated to relate to minor ailments, reducing the time spent by GPs on managing minor ailments by the use of a community pharmacy based Common ailments service would enable them to focus on more complex cases and could reduce patient waiting times. The Choose Pharmacy application provides community pharmacies with the ability to deliver the Common Ailments service; however the service currently requires local commissioning by Health Boards, CPW would like to see the Common Ailments Service available as a national service available through all community pharmacies.

6. Up to 30% of calls to NHS Out of Hours services on a Saturday are for urgent requests for repeat medication. A third of those calls are referred directly to GP OOH services for an appointment to arrange a prescription. Other patients may attend A&E departments for a request for a repeat prescription which represents significant inefficient use of NHS resources. In some areas of Wales there is also a significant pressure on GPs to prescribe for temporary residents visiting an area who have failed to bring their medication with them. The development of the community pharmacy Emergency Medicines Service has significantly reduced this burden, however commissioning is variable across the Health Boards and CPW would ask the Committee to review this as part of their inquiry. Emergency Medicines Service is also a module planned to be added to the Choose Pharmacy platform which will provide community pharmacies in Wales with access to a summary of the Welsh GP Record (WGPR) reducing the need to refer any patient's back to other, less appropriate NHS services because a patient's medication cannot be verified, as well as improving patient safety.

7. The workload of some hospital based services and GP services could also benefit from using the capacity of the community pharmacy network to triage and signpost patients to the most appropriate health care professional. Making community pharmacies the first port of call for patients accessing NHS services would make a massive contribution to the delivery of a prudent healthcare regime

Prevention and Self Care

8. Community pharmacies have been commissioned to provide NHS flu vaccination for several years, however there is variability in commissioning and CPW would like the service to be available to all community pharmacies across Wales. Community pharmacy should be included in the flu planning proposals for all LHBs at an early stage to allow community pharmacy contractors enough notice to ensure that pharmacists are trained and vaccines are available to deliver the service. Community pharmacies would also like the opportunity through the primary care clusters to work with GP colleagues to target those patients that do not routinely attend for vaccination.

9. Community pharmacies are pivotal to both the delivery of the Public Health agenda nationally in Wales and at local primary care cluster level. The ability of the NHS to cope with future demands on its resources is

heavily dependent on the Governments ability to tackle diseases and illnesses related to lifestyle choices. The community pharmacy network arranged as 716 High Street Healthy Living Centres as the channel for organised public health campaigns and offering the full range of services aimed at changing lifestyles and improving public health would make a substantial contribution to achieving existing Government targets

Supporting Discharge

10. CPW believes that hospital discharge and outpatient services could benefit from the dispensing of related hospital prescriptions in a community pharmacy. This could make a significant contribution to releasing capacity in hospital based pharmacy services as well as leading to significant improvements in releasing hospital beds and in the overall patient experience.

11. The Discharge Medicines Review Service (DMR) provides for a patient's community pharmacy to undertake medicines reconciliation of a patient's medicines at discharge with those prescribed by their GP and for them to identify and resolve any unintended discrepancies. An evaluation of the service found that for each £1 invested £3 was saved by NHS Wales through avoided A&E attendances, hospital admissions and reduced medicines waste. However despite the service being launched in 2011, there has been issues in relation to patient identification as community pharmacies are not routinely informed when patient's have been in hospital. CPW welcome the inclusion of DMR within the Choose Pharmacy application as this will allow for electronic discharge information to be transferred from hospitals using the Medicines Transcribing and e-Discharge (MTeD) system to a patient's nominated community pharmacy and for the pharmacy to undertake an electronic DMR, however CPW would like the Committee to review the use of MTeD in hospitals across Wales to ensure that this valuable information can be shared electronically with both GPs and community pharmacies for all Welsh patients.

Integration with Primary Care Clusters

12. CPW understands the importance that primary care clusters have in transforming primary care. CPW would like to see the role of all primary care contractors become an integral part of primary care cluster working. Community pharmacy contractors can significantly support the primary care agenda helping to support the long-term sustainability of primary care by using pharmacists' skills and abilities according to the prudent healthcare principles and releasing capacity in GP practices and in A&E departments. Community pharmacies have the largest daily footfall of all the stakeholders within a primary care cluster and as such should have a significant role to play in relation to supporting the health and wellbeing needs of the local community they serve. However, to date the integration of community pharmacy within the 64 primary care clusters across Wales has been variable and in the majority of cases is unfortunately so far non-existent

Part 3: Conclusion

In conclusion CPW believes that the community pharmacy network across Wales is a hugely under-exploited healthcare asset which could help to support the Welsh NHS in dealing with winter pressures in particular by reviewing:

- The roll-out of Choose Pharmacy across Wales
- The commissioning of NHS community pharmacy enhanced services by Health Boards
- The potential role of community pharmacy within the Public Health agenda in relation to prevention and self care
- The role of community pharmacy in supporting discharge
- The role of all primary care contractors within Primary care clusters and planning for winter pressures.

WP 06
Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016
Inquiry into winter preparedness 2016/17
Ymateb gan: Coleg Brenhinol y Meddygon (Cymru)
Response from: Royal College of Physicians (Wales)

Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

Ymchwiliad i barodrwydd am y gaeaf 2016/17

Ymateb RCP Cymru

Pwyntiau allweddol

- Mae'r sialensiau sy'n wynebu byrddau iechyd wrth iddynt baratoi am y gaeaf yn gymhleth. Maent yn adlewyrchu'r pwysau ehangach ar y GIG ac ar ofal cymdeithasol.
- Mae byrddau iechyd yn gweithio mewn cyd-destun o ddiffyg cyllid, diffyg meddygon a cheisio ei dal hi ymhob man. Mae hyn yn arwain at bwysau cynyddol ar ysbytai.
- Yn ôl gwaith ymchwil diweddar gan y RCP ni chafodd 40% o swyddi am feddygon ymgynghorol a hysbysebwyd y llynedd yng Nghymru eu llenwi; gan amlaf, oherwydd nad oedd neb wedi ymgeisio. Mae hyn yn cael effaith ddifrifol ar allu meddygon i ddarparu gofal o ansawdd uchel i gleifion.
- Mae system gofal cymdeithasol sydd dan bwysau, diffyg staffio a diffyg gwelyau mewn ysbytai i gyd yn cyfrannu at oedi gyda throsglwyddo gofal.
- Mae'r RCP, drwy ei Raglen Ysbytai'r Dyfodol a'n gwaith gydag ysbytai yng Nghymru, yn ymchwilio i ffyrdd newydd ac arloesol o ddarparu gofal.
- Mae hyn yn cynnwys cydlynu gofal a thriniaeth i gleifion yn well fel nad oes angen eu derbyn yn ddiangen i'r ysbyty, a'u helpu i adael yr ysbyty mor fuan â phosib. Rydyn ni hefyd yn datblygu prosiectau tele-iechyd yng ngogledd Cymru ac yn annog ysbytai a gwasanaethau cymunedol i weithio mewn partneriaeth.

Am fwy o wybodaeth, cysylltwch gyda:

Lowri Jackson
Uwch gynghorydd polisi a materion cyhoeddus RCP yng Nghymru
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From the RCP vice president for Wales
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From the RCP registrar
Gan Gofrestrydd yr RCP
Dr Andrew Goddard FRCP
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09 Medi 2016

Annwyl gydweithiwr,

Ymchwiliad i barodrwydd am y gaeaf 2016/17

1. Diolch i chi am y cyfle i ymateb i'ch ymgynghoriad ar ymchwiliad pwyllgor y Cynulliad i barodrwydd am y gaeaf 2016/17. Mae ein hymateb yn seiliedig ar brofiadau ein cymrodyr a'n haelodau a chymerwyd pob dyfyniad, oni nodir fel arall, o gyflwyniadau tystiolaeth a dderbyniwyd gennym gan gymrodyr ac aelodau'r RCP.

2. Mae Coleg Brenhinol y Meddygon (RCP) eisiau gwella gofal cleifion a lleihau salwch, yn y Deyrnas Unedig ac ar draws y byd. Sefydliad claf-ganolog wedi'i arwain yn glinigol ydyn ni. Mae ein 33,000 o aelodau ar draws y byd, gan gynnwys 1,100 yng Nghymru, yn gweithio mewn ysbytai ac yn y gymuned ar draws 30 o wahanol arbenigeddau meddygol, yn rhoi diagnosis ac yn trin miliynau o gleifion gydag ystod eang dros ben o gyflyrau meddygol.

3. Mae nifer o rwystrau sy'n atal ysbytai rhag delio'n effeithiol â'r pwysau gofal annisgwyl a ddaw yn y gaeaf. Mae'r rhwystrau'n cynnwys oedi gyda throsglwyddo gofal sy'n arwain at reoli'r llif cleifion yn aneffeithiol. Yn ôl astudiaethau o Loegr, awgrymir bod gymaint â 40% o gleifion sy'n marw yn yr ysbyty heb yr anghenion meddygol a fyddai'n ofynnol iddynt fod yno[1]. Ar ben hynny, mae o leiaf 25% o welyau mewn ysbytai'n cael eu meddiannu gan bobl gyda dementia a llawer ohonynt yn debygol o aros ddwywaith gymaint yn yr ysbyty na chleifion eraill dros 65 oed[2]. Yn aml, y rheswm am hyn yw diffyg gofal yn y gymuned ar eu cyfer. Gwaethygir y sefyllfa gan yr amgylchiadau ariannol anodd y mae'r GIG yn gweithio ynddynt.

4. Mae rheoli'r llif cleifion rhwng yr adran frys, yr uned feddygol aciwt a'r wardiau arbenigol yn dibynnu ar drosglwyddo gofal yn effeithiol a rhyddhau cleifion yn brydlon. Mae diffyg cyllid i ofal cymdeithasol, prinder gwelyau a phroblemau gyda recriwtio a chadw meddygon yn golygu bod ysbytai'n aml yn cael trafferth trosglwyddo cleifion yn effeithiol a chynnal ansawdd y gofal ar yr un pryd.

[1] Coleg Brenhinol y Meddygon 2014. National care of the dying audit for hospitals, Lloegr: Mai 2014
[2] Y Gymdeithas Alzheimer. *Fix Dementia Care in Hospitals*. 2016

Nid wyf yn meddwl bod unrhyw gynllunio o ddifrif yn digwydd. Yr hyn sydd ei angen yw mwy o gapasiti. Dyna'r wers sydd angen ei dysgu ac nid yw hynny wedi digwydd.

[Meddyg ymgynghorol yng Nghymru]

5. Mae ein haelodau a'n cymrodyr yn gweithio mewn gwasanaeth iechyd o ddiffyg cyllid, diffyg meddygon a than ormod o bwysau. Mae'r galw gan gleifion ynghyd â bylchau mawr yn y gweithlu'n ei gwneud yn anodd gofalu am gleifion. Yn 2014-2015 dywedodd 21% o feddygon ymgynghorol y DU fod 'bylchau sylweddol yn rotâu staff meddygol dan hyfforddiant a gofal cleifion yn dioddef o'r herwydd'[3]. Mae'r ffigurau hyn yn destun pryder oherwydd yr arbenigeddau sydd fwyaf cysylltiedig ag ysgafnu'r pwysau ar ofal annisgwyl yn y gaeaf sy'n gweld y bylchau staffio mwyaf, gyda meddygaeth aciwt a geriatrig yn adrodd y nifer fwyaf o apwyntiadau ymgynghorol wedi eu canslo neu wedi methu.

Argyfwng gweithlu sy'n gwaethygu

6. Mae'r argyfwng staffio hwn yn cael effaith fawr ar allu meddygon i asesu cleifion yn sydyn ar ôl iddynt fynychu adrannau brys, i deilwrio eu cynlluniau gofal ac i drosglwyddo eu gofal yn ddiogel a phrydlon. Gall hyn gael effaith negyddol ar brofiad y claf a golygu nad yw wardiau'n gallu ysgafnu'r pwysau ar adrannau brys. Mae targedau'n anodd eu cyrraedd oni bai fod digon o staff i drin cleifion neu i'w trosglwyddo i ofal cymdeithasol mewn da bryd.

7. Ar hyn o bryd nid oes unrhyw ddull strategol cenedlaethol o gynllunio'r gweithlu meddygol yng Nghymru. Dros y blynyddoedd, mae hyn wedi cyfrannu at drafferthion gyda recriwtio a chadw'r gweithlu meddygol, yn enwedig meddygon dan hyfforddiant. **Rydym yn gryf o blaid datblygu strategaeth genedlaethol glinigol ar gyfer hyfforddiant a'r gweithlu meddygol yng Nghymru.** Mae gan Gymru gyfle gwirioneddol i ddatblygu model arloesol a phwyswn dros roi arweinyddiaeth glinigol wrth galon y broses honno.

8. Mae'n greiddiol bwysig hefyd bod Cymru'n gwneud ymdrech fwy cydweithredol i ddenu ei myfyrwyr ei hun i'r ysgolion meddygol yng Nghaerdydd ac Abertawe. Gallai'r myfyrwyr hyn fod yn fwy tebygol o aros yng Nghymru ar gyfer eu hyfforddiant ôl-radd, ac os ydynt yn gadael maen nhw'n fwy tebygol o ddod yn ôl adref wedyn. Dim ond 30% o fyfyrwyr yn ysgolion meddygol Cymru sy'n dod o Gymru. Mae hyn cymharu gyda 55% yn yr Alban, 80% yn Lloegr a 85% yng Ngogledd Iwerddon.[4] **Rhaid i ysgolion meddygol gynnig mwy o leoedd israddedig i fyfyrwyr o Gymru er mwyn datblygu a chadw gweithlu 'cartref'** a dylent fuddsoddi mewn rhaglenni allgymorth sy'n annog ceisiadau gan gymunedau gwledig, anghysbell a Chymraeg eu hiaith.

Prinder gwelyau a diffyg capasiti

9. Mae prinder gwelyau mewn ysbytai hefyd yn gwaethygu problemau gyda llif cleifion. Gan y DU y mae'r ail nifer isaf o welyau ysbyty am bob mil o'r boblogaeth ymhlith 23 o wledydd Ewrop. Dywed ein haelodau a'n cymrodyr yn aml fod symud cleifion o unedau meddygol aciwt i wardiau cyffredinol neu arbenigol yn broblem oherwydd nad oes gwelyau ar gael. Cleifion hŷn yw'r rhain y credir eu bod yn ddigon da i dderbyn gofal yn y gymuned ond ni ellir eu trosglwyddo oherwydd bod diffyg gwasanaethau yn y gymuned.

[3] Ffederasiwn Coleg Brenhinol Meddygon y Deyrnas Unedig. *Census of consultant physicians and higher specialty trainees in the UK 2014-15.* Llundain: Coleg Brenhinol y Meddygon, 2016.
[4] NHS Education for Scotland. *Domicile of UK undergraduate medical students*. Mawrth 2013

10. Mae tystiolaeth glir fod unedau meddygol aciwt (AMU) sy'n cael eu rhedeg yn dda'n helpu i leihau lefelau marwolaeth, hyd yr arhosiad a lefelau ail-dderbyn i'r ysbyty[5]. Mae gan unedau AMU sydd wedi'u staffio gan dimau amlddisgyblaethol a'u harwain gan feddygon gofal aciwt botensial i wella ansawdd a diogelwch y gofal i gyfran fawr o gleifion gyda chyflyrau aciwt. Pwyswn ar y byrddau iechyd i fuddsoddi yn eu gweithlu meddygol cyffredinol ac mewn unedau AMU fel bod ysbytai'n gallu ymateb yn fwy effeithiol a diogel i'r galwadau cynyddol gymhleth a roddir ar ysbytai o ran gofal meddygol aciwt.

Ailddylunio'r system gofal diwrnod hwnnw

11. Mae rhai timau clinigol, gan gynnwys rhai ym Mwrdd Iechyd Prifysgol Abertawe Bro Morgannwg a Bwrdd Iechyd Prifysgol Cwm Taf wedi cydnabod bod angen dull newydd o weithio i ddelio â'r pwysau trwm sydd ar adrannau brys, ac wedi llwyddo i ail-ddylunio eu systemau i weithredu gofal brys diwrnod hwnnw (AEC) fel rhan o'r ateb[6]. Gofal clinigol yw gofal diwrnod hwnnw, sy'n gallu cynnwys diagnosis, arsylwi, triniaeth ac adsefydlu, gofal nad yw'n cael ei ddarparu drwy'r system gwelyau ysbyty draddodiadol neu fel rhan o wasanaethau cleifion allanol traddodiadol[7].

12. Mae gweithredu AEC yn sicrhau, lle bo hynny'n briodol, bod cleifion brys sy'n cyrraedd yr ysbyty i gael eu derbyn yn cael eu hasesu'n gyflym a'u ffrydio i AEC i dderbyn diagnosis a thriniaeth y diwrnod hwnnw, gyda gofal clinigol parhaus wedyn. Mae prosesau'n cael eu cyflymu, gan gynnwys adolygiad gan ymgynghorydd, mynediad amserol at wasanaethau diagnostig a thriniaethau, i gyd o fewn un diwrnod gwaith. Mae hyn wedi gwella'r canlyniadau clinigol a phrofiad y claf, ac wedi lleihau costau. Mae timau clinigol sy'n gweithredu'r dull hwn yn adrodd y medrant reoli nifer sylweddol o gleifion brys yn gyflym, heb fod angen eu derbyn yn llawn, ac yn troi o leiaf 20-30% o achosion brys at ofal AEC[8].

13. Gall AEC fod yn arbennig o werthfawr i asesu a rheoli cleifion hŷn, eiddil a reolir drwy lwybrau a gefnogir gan dîm amlddisgyblaethol gyda chysylltiadau da i wasanaethau gofal sylfaenol, cymunedol ac awdurdod lleol. Gall y cysylltiadau hyn gynnig asesiadau ac ymyriadau chwim i bobl hŷn, ac osgoi arhosiad mewn ysbyty. I bobl hŷn, mae mynediad at y gwasanaethau hyn yn bwysig fel y medrant aros yn eu cartrefi eu hunain ac osgoi cael eu hail-dderbyn yn ddiangen.

> *Yn fy mwrdd iechyd i, yr agweddau cadarnhaol gwirioneddol ar gynllunio ar gyfer y gaeaf yw'r hyfforddiant gwella ansawdd sydd wedi'i roi i staff cartrefi gofal (a'r cynllunio gofal rhagflaenorol o ganlyniad), y pwyslais ar gynllunio gofal rhagweithiol i bobl gyda mwy nag un cyflwr neu sy'n eiddil, a gweithio'n integredig â'r cyngor a'r trydydd sector.*
>
> [Meddyg dan hyfforddiant yng Nghymru]

Datblygu modelau gofal newydd i atal derbyn cleifion i'r ysbyty

14. Mae'r RCP hefyd yn gweithio gyda thimau clinigol lleol drwy ein Rhaglen Ysbytai'r Dyfodol (FHP) flaenllaw ar ddatblygu modelau gofal arloesol i helpu i ateb anghenion cleifion yn defnyddio

[5] Scott, I; Vaughan, L; Bell, D. Effectiveness of acute medical units in hospitals: a systematic review. *International Journal for Quality in Health Care,* 2009; Cyfrol 21, Rhif 6: tud. 397 –407.
[6] Coleg Brenhinol y Meddygon. Acute Care Toolkit 10. Ambulatory Emergency Care. Hydref 2014
[7] Coleg Brenhinol y Meddygon. *Acute medical care: The right person, in the right setting – first time. Report of the Acute Medical Task Force.* Llundain: RCP, 2007: p xxi. Wedi'i gymeradwyo gan y Coleg Meddygaeth Frys, 2012.
[8] Blunt I. *Focus on preventable admissions: Trends in emergency admissions for ambulatory care sensitive conditions, 2001 to 2013.* Llundain: Y Sefydliad Iechyd ac Ymddiriedolaeth Nuffield, 2013.

adnoddau presennol[9]. Mae un safle Ysbyty'r Dyfodol yng ngogledd Cymru ac wedi bod yn treialu sesiynau ymgynghorol tele-iechyd cleifion dros gyswllt fideo rhwng timau gofal iechyd cymunedol ac arbenigwyr ysbyty.[10] Fodd bynnag, mae dau safle Ysbyty'r Dyfodol RCP yn Lloegr yn gweithio'n benodol i sicrhau bod llai o gleifion yn cael eu derbyn i'r ysbyty a'u bod yn derbyn gofal yn y gymuned, sef Mid Yorkshire NHS Hospital Trust ac East Lancashire Hospitals Trust.

15. Mae Mid Yorkshire NHS Hospitals Trust wedi sefydlu Tîm Gofal Asesiad Chwim o'r Henoed (REACT) yn yr uned dderbyn aciwt yn Ysbyty Pinderfields yn Wakefield. Tîm amlddisgyblaethol yw REACT sy'n cynnwys ymgynghorwyr geriatrig, nyrsys a therapyddion arbenigol sy'n gweithio gyda'i gilydd i asesu cleifion 80+ oed, neu gleifion 65+ oed sy'n byw mewn cartrefi gofal, o fewn 24 awr iddynt gyrraedd yr ysbyty. Mae'r tîm yn cwrdd yn ddyddiol i gydlynu'r gofal a'r triniaethau i gleifion fel y medrant adael yr ysbyty mor fuan â phosib ac fel nad oes raid eu derbyn yn ddiangen i'r ysbyty. Mae natur amlddisgyblaethol y tîm yn golygu y medrant gynnig gofal person-ganolog drwy ddarparu'r gwasanaethau iechyd a therapiwtig sydd ei angen ar bobl.

16. Ers sefydlu'r tîm REACT yn 2014, mae Ysbyty Pinderfields wedi gweld gwelliant mawr yn nifer y cleifion sy'n derbyn gofal yn y gymuned yn hytrach na chael eu derbyn i'r ysbyty. Wrth gymharu data rhwng 2014 a 2015, mae cynnydd o 24% wedi bod yn nifer y bobl eiddil sy'n cael eu trosglwyddo i ofal yn y gymuned yn hytrach na chael eu symud i ward mewn ysbyty. Dros yr un cyfnod rhwng 2014 a 2015, roedd gostyngiad o 14% hefyd yng nghyfanswm y cleifion 80+ oed oedd yn cael eu derbyn i wardiau ysbyty. Mae'r asesiad sydyn hwn gan dîm amlddisgyblaethol wrth ddrws ffrynt yr ysbyty'n sicrhau bod cleifion yn derbyn y gofal mwyaf addas i'w hangen ac yn ysgafnu peth o'r pwysau sydd ar staff yng ngweddill yr ysbyty.

17. Mae'r tîm REACT yn Ysbyty Pinderfields hefyd wedi bod yn gweithio'n agos â darparwyr trydydd sector i wella'r broses o drosglwyddo gofal o'r ysbyty i'r gymuned. Mae Age UK yn dod i'r uned asesu aciwt yn yr ysbyty'n gyson i drosglwyddo gofal cleifion yn ddiogel i'r gymuned[11]; maen nhw'n cynnig gwasanaeth cludo a siopa negesau fel nad yw pobl hŷn agored i niwed yn cael eu rhyddhau heb gymorth digonol. Drwy weithio'n gydweithredol gyda gweithwyr iechyd a gofal cymdeithasol y tu allan i'r ysbyty, mae pobl hŷn eiddil yn gallu derbyn gofal wedi'i bersonoleiddio fel y medrant aros yn annibynnol a pheidio gorfod cael eu haildderbyn.

18. Mae safle datblygu FHP arall yn East Lancashire Hospitals Trust yn ceisio adnabod cleifion hŷn eiddil sydd ar gael i'w rhyddhau'r un diwrnod ar ôl iddynt gyrraedd yr ysbyty. Mae'r nyrs yn yr uned asesu meddygol (MAU) yn monitro lefel dderbyn aciwt y cleifion hŷn eiddil er mwyn adnabod y rhai sy'n addas i'w rhyddhau'n gyflym, yn trefnu iddynt dderbyn asesiad geriatrig cynhwysfawr ac yn cysylltu â gweithwyr gofal eilaidd a gofal cymdeithasol i gynllunio ar gyfer eu rhyddhau'n ddiogel yr un diwrnod.

19. Mae data rhagarweiniol gan East Lancashire Hospitals Trust yn awgrymu y llwyddwyd i osgoi 59% rhag cael eu derbyn i'r ysbyty'n defnyddio'r model gofal hwn ers i'r prosiect ddechrau yn 2014[12]. Os gellir osgoi derbyn cleifion i'r ysbyty drwy gyflymu siwrne'r claf o'r MAU trwodd at ofal cymdeithasol, gellir helpu pobl hŷn eiddil i adael yr ysbyty'n gynt a byw'n annibynnol yn y gymuned.

[9] RCP Rhaglen Ysbytai'r Dyfodol
[10] RCP Future Hospital development site: Betsi Cadwaladr University Health Board
[11] Age UK. *Frailty in secondary care*.
[12] Temple, M; Dytham, L; Bristow, H. *Action learning at the Future Hospital development sites.* Future Hospital Journal 2016 Vol 3, No 1: 13–5

20. Yn y ddwy astudiaeth achos hon, mae gweithio mewn partneriaeth rhwng yr ysbytai a'r gwasanaethau cymunedol wedi lleihau'r oedi gyda rhyddhau. Mae gofal eilaidd a gofal cymdeithasol integredig i bobl hŷn yn gallu arwain at lai o ddefnydd o welyau ac yn ôl Cronfa'r Brenin mae ysbytai sy'n gweithio mewn ffordd integredig hefyd yn tueddu i fod â chyfraddau derbyn is sy'n rhoi profiad gwell i'r claf.[13]

21. Mae'r problemau sy'n wynebu adrannau brys, yn enwedig yn ystod y gaeaf, yn gymhleth ac ni ellir eu datrys gydag un ateb. Bydd lleihau nifer yr achosion oedi gyda throsglwyddo gofal yn gwneud rhywfaint i ysgafnu'r pwysau ar adrannau brys. Mae effaith y diffyg cyllid ar gyfer y system gofal cymdeithasol yn ychwanegu at y pwysau mewn ysbytai, gyda chleifion yn aros yn hirach nag sydd angen yn yr ysbyty oherwydd diffyg gwasanaethau yn y gymuned. Ar ben hyn mae taer angen cynyddol i ganfod ateb cenedlaethol i'r problemau o recriwtio a chadw meddygon. Heb ddigon o feddygon ar y ddaear, bydd gofal cleifion yn dioddef.

22. Fel y mae timau'r prosiect FHP yn ei ddangos, mae gweithio'n effeithiol yn amlddisgyblaethol ac integreiddio gwasanaethau gofal iechyd yn arwain at ganlyniadau a phrofiadau gwell i gleifion ac yn ysgafnu'r pwysau dros y gaeaf. Dyna pam y mae'r RCP yn credu bod angen symud i ffwrdd o fodel gofal lle buddsoddwn naill ai mewn gofal sylfaenol neu eilaidd, a thuag at weithio'n integredig fel tîm lle mae arbenigwyr ysbyty'n cynnal mwy o'u clinigau yn y gymuned a Meddygon Teulu'n treulio rhan o'u hamser yn gweithio gyda chydweithwyr wrth ddrws ffrynt yr ysbyty.

Mae angen model gofal iechyd newydd ac integredig

23. Byddem yn croesawu cael sgwrs aeddfed am ddyfodol dylunio gwasanaethau yng Nghymru, a'r weledigaeth sydd ei hangen ar lefel genedlaethol i ddatblygu ffordd newydd o weithio. Mae'n bwysig nad yw'r buddsoddiad yn y gwasanaeth iechyd yn y dyfodol yn ceisio cynnal hen system sydd wedi torri. Rhaid i Lywodraeth Cymru hyrwyddo modelau integreiddio arloesol a chyflwyno cyllidebau ar y cyd sy'n arwain at ganlyniadau ar y cyd ar draws y sector iechyd a gofal lleol. Ni fydd gwario ar y system bresennol yn newid unrhyw beth yn y tymor hir; rhaid i fyrddau iechyd fuddsoddi mewn atal a thrin cyflyrau cronig a gadael i glinigwyr arloesi.

24. Ni ddylid anghofio'r bobl hynny sy'n byw mewn ardaloedd gwledig ac anghysbell chwaith; yr ardaloedd hyn sy'n cael eu taro galetaf gan yr argyfwng mewn gofal sylfaenol, a lle mae gan fodel gofal newydd ac uchelgeisiol fwyaf o botensial. I gyflawni hyn oll, rhaid newid ein ffordd o feddwl yn llwyr, rhaid cael ymgysylltu ac arweinyddiaeth glinigol gryfach a chael y timau gofal sylfaenol, eilaidd, cymunedol a chymdeithasol i feddwl yn fwy cydgysylltiedig.

Am fwy o wybodaeth, cysylltwch os gwelwch yn dda gyda Lowri Jackson, uwch ymgynghorydd polisi a materion cyhoeddus RCP yng Nghymru, yn [redacted].

Gyda phob dymuniad da,

[13] Imison C, Poteliakhoff E, Thompson J. *Older people and emergency bed use. Exploring variation*. London: The King's Fund, 2012.

Dr Alan Rees
Is-lywydd Cymru'r RCP

Dr Andrew Goddard
Cofrestrydd y RCP

WP 07
Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016
Inquiry into winter preparedness 2016/17
Ymateb gan: Coleg Brenhinol yr Ymarferwyr Cyffredinol
Response from: Royal College of General Practitioners

RCGP Wales Response to Inquiry into Winter Preparedness 2016/17

The Royal College of GPs Wales represents GPs and junior doctors training to be GPs from across Wales. We welcome the chance to respond to this consultation on the pressures facing the Welsh NHS in relation to unscheduled care services during the coming winter 2016/17.

Winter brings increased incidence of respiratory infections, flu and flu type illnesses and other infections diseases. These acute illness can be more severe in those with long term conditions and cause additional debility in those who are already suffering from chronic conditions. This can make their care more complex or mean that they are ill for longer. Adverse weather condition may make provision of medical and /or social care more difficult, which may further affecting the health of those with chronic conditions particularly the elderly. People may have difficulty travelling either to care or to provide health or social care or even for friends and family to provide support. In addition adverse weather conditions may increase falls and injury particularly in the elderly or add to ill health due to isolation or cold. This increases the work of general practice and if there is no additional capacity in the system there is an increased attendance at AE.

GPs are involved in unscheduled care both in hours via their practices and also out of hours via dedicated out of hours services. In Wales there is a current shortage of GPs and recruitment both to practices and to OOH services is struggling. There are workload issues in practice at present and any increase in demand increases will have adverse affects on the care of patients in the community. This will on effect to the management of chronic conditions and preventative care, which can also result in more referrals secondary care for admission. As the hospitals become over crowded then patients are discharged with out allowed adequate recovery time or satisfactory after care planning. This can results in increased problems for both general practice and district nursing both of which may struggle to manage the patient and this results in further referrals for admission. Social services are often not able to respond quickly enough and do not work in an integrated fashion to prevent admissions or support discharges compounding some issues. There can often be protracted discussion about which patients should have social wand which health care.

Some of the LHB winter pressure plans look at getting general practice and primary care to increase work throughput, but if the systems are already at capacity or even over capacity in the summer months, this is not a viable plan. It is vital that general practice receives additional funding to ensure that they can both retain the current staff and also make provision for additional staff to support the extra winter workload. This also needs to ensure that there is training of the new staff to carry out these functions. Practices are learning to work in new ways with different types of health professionals e.g. paramedics, physiotherapists, pharmacists and also is some cases, social workers.

In some areas and for some purposes the additional resources can be targeted via the clusters. The clusters are however not working effectively in some areas and money may be slow to filter through for new cluster staff from LHBs. There needs to be new ways developed to ensure that the manpower is effective to provide staff to do both face to face and back room functions in the GP practices to support the anticipated surges in capacity expected during winter 2016-17. There also needs to be additional funding to support district nursing where it is struggling and acute social care.

In brief, to support the potential for winter unscheduled care pressures, RCGP Wales believes that the following should be given urgent consideration:

- additional funding to GP practices to employ clinical staff
- funding to set up training for staff such as nurses, paramedics, physiotherapists to work in general practice as opposed to their traditional roles or in secondary care

- improved integration of services between social care and health care to prevent duplicate visits or gaps in care
- ensure there are systems in place to support GPs and their staff from suffering burnout and stress due to excessive workload in addition to the current opening of Occupational Health services
- innovations to attract new doctors to work in Wales particularly as GPs and to reduce GPs from leaving the service early
- early setting up of practice nurse placements as part of nurse education and also specific post graduate training in general practice.

Preventative care should be provided in every surgery. In order to be able to respond to increased unscheduled care demand, there needs to be sufficient resources to enable there to be over capacity to prevent routine scheduled care to be continued with out extending waiting times for appointments. Currently most GPs and their staff are over stretched without the increase in demand.

WP 08
Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016
Inquiry into winter preparedness 2016/17
Ymateb gan: Coleg Brenhinol Pediatreg ac Iechyd Plant
Response from: Royal College of Paediatrics and Child Health

Royal College of Paediatrics and Child Health Submission to the Health, Social Care and Sport Committee's Inquiry into winter preparedness 2016/17 September 2016

1. Introduction

1.1 The Royal College of Paediatrics and Child Health (RCPCH) is pleased to contribute to the work of the Health, Social Care and Sport Committee and it's aims to understand and explore the winter preparedness of health and social care services in Wales.

1.2 The RCPCH works to transform child health through knowledge, innovation and expertise. We have over 550 members in Wales and over 17,000 worldwide. The RCPCH is responsible for training and examining paediatricians. We also advocate on behalf of our members, represent their views and draw upon their expertise to inform policy development and the maintenance of professional standards.

1.3 For further information please contact Gethin Jones, External Affairs Manager for Wales: [redacted] or [redacted].

2. The current pressures facing unscheduled care services, and how well prepared the Welsh NHS and social services are for winter 2016/17

2.1 While children's health has improved greatly in the UK over the last 30 years, the UK continues to lag behind much of Western Europe and performs poorly on several measures of child health and wellbeing, including mortality[1] [2]. The RCPCH's *Why Children Die* report[3] highlights a need to better manage sick children and recommends that measures are taken to improve recognition and management of serious illness across the healthcare service.

2.2 Infants, children and young people (ICYP) aged 0 to 18 make up around 20% of the UK population[4] and they are high users of healthcare services; accounting for around a quarter of a typical GP's workload[5] and more than a quarter of emergency department attendances.

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[1] Wolfe et al. Improving child health services in the UK: insights from Europe and their implications for the NHS reform. *BMJ* 2011; 342: d1277

[2] Wolfe et al. Health Services for Children in Western Europe. *The Lancet* 2013; 381 (9873): 1224-1234

[3] RCPCH, National Children's Bureau and British Association for Child and Adolescent Public Health. *Why Children Die: death in infants, children and young people in the UK.* 2014 http://www.rcpch.ac.uk/sites/default/files/page/Death%20in%20infants,%20children%20and%20young%20people%20in%20the%20UK.pdf

[4] 2011 Census, Office of National Statistics

[5] Hippisley-Cox J et al. Trends in consultation rates in general practice 1995 to 2006: analysis of QRESEARCH database 2007. Cited in Wolfe et al. Improving child health services in the UK: insights from Europe and their implications for the NHS reforms? *BMJ* 2011.

2.3 The vast majority of children's illnesses are minor, requiring little or no medical intervention and a significant number of these emergency attendances may be deemed unnecessary or inappropriate. Unnecessary attendances are distressing and disruptive to children and families and also a wasteful high-cost intervention in a resource-limited health service, putting additional pressure on the hospital.

2.4 As this winter and the bronchiolitis/flu season approaches, the same pressures as previous years exist with no mitigation. RCPCH members have expressed concerns that the total number of beds, the number of cubicles and the number of Paediatric High Dependency Unit (PHDU) and Paediatric Intensive Care Unit (PICU) beds are all insufficient. As in previous years, services will again face short term periods where they have to compromise care by placing infectious children in wards, not cubicles, manage HDU patients in temporary overflow HDU beds on wards and have to provide intensive care in a DGH setting without specialist staff or equipment as all the UK PICU beds are full.

2.5 The RCPCH has also continued to express serious concerns about the sustainability of the paediatric workforce and services across the UK and the latest data show that gaps on paediatric rotas are increasing[6]. Services are having to be sustained by existing junior doctors and consultants struggling to plug vacancies. 89% of paediatric clinical directors (across the UK) are concerned about how the service will cope in next six months; up from 78% last year.

2.6 From the data received to date from the 2015 Workforce Census[7] (two hospitals outstanding) we estimate that 11% of posts on tier 1 rotas in Wales (junior trainees) and 21% of posts on tier 2 rotas (usually more senior trainees) were vacant over the 2015/16 winter period. These figures are slightly higher than elsewhere in the UK.

2.7 From our previous census in 2013, we reported that there were 153 Whole Time Equivalent (WTE) paediatric consultants in Wales i.e. 27.5 per 100,000 children aged 0-15. This ratio was lower than that in Scotland, London and the North of England but higher than the ratios on Northern Ireland, South of England, Midlands and East of England. However, the RCPCH estimate that across the UK as a whole an additional 800-1000 WTE consultants are needed to meet the standards for acute care such as 12 hour consultant presence in hospital 7 days a week (RCPCH Facing the Future Standards) and British Association for Perinatal Medicine standards for neonatal care.

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[6] RCPCH. *Rota Vacancies and Compliance Survey.* 2016
http://www.rcpch.ac.uk/sites/default/files/user31401/Rota%20vacancies%20and%20compliance%20survey%20-%20FINAL.pdf

[7] RCPCH carries out a biennial census of the UK paediatric workforce and child health services, from which we produce figures for Wales. The latest report (our 2015 census) will be disseminated late in 2016. http://www.rcpch.ac.uk/census

3. **Whether there has been sufficient progress in the fourth Assembly in alleviating pressures on unscheduled care through integrated winter planning across health, social and ambulance services, and lessons learned**

3.1 The pressures on unscheduled care remain a daily concern for paediatricians working in hospitals day to day and for many patients using the services.

3.2 It is disappointing that many of the recommendations designed to ease the pressures have not been acted upon and we are not aware of any specific action taken in relation to children.

4. **The actions needed to produce sustainable improvements to urgent and emergency care services, and the whole system, ensuring the Welsh NHS builds resilience to seasonal demand and to improve the position for the future**

4.1 In the short term, an increase in paediatric trainee and consultant numbers is urgently needed along with better advanced planning of rotas to avoid the costly use of locums. Annualised job planning would allow more senior decision makers to be on the shop floor in winter to maximise chances for senior review and early discharge.

4.2 Figures from the Welsh Deanery show that there are currently (Summer 2016) 148 paediatric trainees in Wales, which represents a fall from an RCPCH estimate of 156 in 2015. Clearly a decline in the number of trainees will impact the number of new Certificate of Completion of Training (CCT) holders who qualify as future consultants. In 2014, only 13 doctors achieved CCT in paediatrics and its subspecialties in Wales.

4.3 Around half of paediatric consultants and over 75% of those recruited to training in recent years are women. As these proportions have grown, so inevitably has time out of programme due to maternity leave. Along with the relatively high rates of less than full time training in paediatrics, this has meant that participation rates are falling. These trends do not appear to have been taken fully into account by the Wales Deanery when determining training numbers. Better mapping of and additional training places are needed to cover expected rota gaps due to maternity leave and less than full time working.

4.4 In addition to an increase in paediatricians, we also need to break down barriers to multi-disciplinary working, an increase in children's nurses and immediate opportunities for our GP colleagues to access child health training. Less than half of GPs are given the opportunity to undertake a paediatric placement during their training. Primary care services must be better equipped to identify children with early signs of serious illness, enabling them to be appropriately managed at first point of contact and ensuring that all children receive the right care at the right time before the illness has the opportunity to escalate.

4.5 In the long term, the demand for beds for emergency admissions can only be managed by better self/family care with early recognition of illness and more care delivered in the community outside of hospital settings. This will require a move away from single institutions towards a systems-based approach with networks of organisations delivering pathways of care and active engagement of children, young people and their families to better understand their needs.

4.6 The RCPCH is clear that closer working between primary and secondary care services is required to ensure that ICYP are getting the right care, in the right place and at the right time. Providing high quality paediatric care in a community setting will also reduce pressure on acute services (throughout the year). We need to help ICYP and their families navigate the options available to them, including self-care at home, with better signposting and safety netting.

4.7 The RCPCH's *Facing the Future: Standards for Acute General Paediatric Services*[8] and *Facing the Future: Together for Child Health*[9] make the case for whole system change in paediatrics to meet the needs of ICYP. The model recommends fewer, larger inpatient units which provide consultant delivered care and are better equipped to provide safe and sustainable care. These units need to be supported by networked services and more care delivered closer to home through community children's nursing teams and better paediatric provision in primary care.

4.8 Where children do need to be cared for in a hospital setting we need to ensure that all those delivering urgent care are following consistent guidelines and make sure that all emergency departments have the appropriate skill mix and workforce to deliver safe, effective and efficient care. The RCPCH is currently revising the Intercollegiate *Standards for Children and Young People in Emergency Care Settings*[10] (last published in 2012) which provide healthcare professionals, providers and service planners with measurable and auditable standards of care applicable to all urgent and emergency care settings.

[8] RCPCH. *Facing the Future: Standards for Acute General Paediatric Services*. 2015 www.rcpch.ac.uk/facingthefuture
[9] RCPCH,RCN, RCGP. *Facing the Future: Together for Child Health.* 2015 www.rcpch.ac.uk/togetherforchildhealth
[10] *Intercollegiate Standards for Children and Young People in Emergency Care Settings*. 2012 http://www.rcpch.ac.uk/sites/default/files/page/Intercollegiate%20Emegency%20Standards%202012%20FINAL%20WEB.pdf

WP 09
Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016
Inquiry into winter preparedness 2016/17
Ymateb gan: Lloyds Pharmacy
Response from: Lloyds Pharmacy

National Assembly for Wales - Health Social Care and Sport Committee

Inquiry into winter preparedness 2016/17

LloydsPharmacy's submission

Introduction

LloydsPharmacy welcomes the opportunity to respond to the Health Social Care and Sport Committee's inquiry into winter preparedness 2016/17.

Over the decades of working locally in Wales, we have seen communities evolve and families grow. LloydsPharmacy is placed in 83 pharmacies across Wales, where over 450 health-trained staff have a proven track record in delivering innovative and quality pharmacy services - located where people live, and across 7 Local Health Boards. Community pharmacies are located in the hearts of communities and span the boundaries of health and social care.

We strongly believe that community pharmacy can play a key role in supporting and furthering NHS Wales's priorities as part of an integrated strategy to combat increasing pressures on demand, such as enabling more capacity in GP surgeries or preventing people being admitted to hospital –especially during the winter months when susceptibility to illness is high and services can come under considerable strain.

Role of Community Pharmacy

Community Pharmacy in Wales is ideally placed to provide an extensive range of additional services, which can not only provide much needed support to primary care and other healthcare services, but also increase access to healthcare for communities.

Alongside GPs, the community pharmacy is often the first port of call, and is the most frequent touch point people have with NHS services. There are around 35 million visits to community pharmacy in Wales every year, providing a vast number of opportunities to offer support and engage people through health related conversations.

Part of the NHS family

It is increasingly said that there is a decline in the GP workforce numbers in Wales. Community pharmacy can support local neighbourhoods by providing essential access to NHS services as well as supporting the GP practice network.

Whilst pharmacists being located in general practice is advocated in the RCGP Wales publication Strengthening General Practice – Actions for a brighter future for patients in Wales -

Cryfhau Ymarfer Cyffredinol - Creu gwell dyfodol i gleifion yng Nghymru; the ready-made network of community pharmacists and their teams can, and already do, deliver a range of services which not only widen access but deliver outcomes for patients. We have highlighted a number of areas where this is already happening but there is scope for more.

We welcome the recent recognition by Welsh Government that independent contractors provide valuable NHS services in our communities and the window stickers which define that NHS services are available in premises such as pharmacy, dentists and optometrists clearly indicates that we are part of the NHS family in Wales.

As in our recent response to the Committee's consultation on future priorities, we would encourage the Committee to review and build on the work undertaken by the Health and Social Care Committee in the fourth Assembly through its inquiry into the contribution of community pharmacy to NHS services in Wales.

We believe it would be of interest to the Committee and the National Assembly to review the range of services currently available and explore how they can be maximised to support the plan for primary care for Wales as set out by the Welsh Government. The inquiry could also explore further initiatives which utilise community pharmacies unique position and skills to support the health of the communities in Wales and the sustainability of the NHS.

Supporting the right care in the right place at the right time

The evaluation of the pathfinder Common Ailments Service in Cynon Valley and Gwynedd demonstrated the impact, economic benefit and positive return on investment in the two pathfinder areas.

We welcome the support of the Welsh Government in the 'Choose Pharmacy' initiative which includes the investment of £750,000 to implement the community pharmacy IT platform across 400 pharmacies, which will support the extended delivery of the Common Ailments Service.

Whilst this is positive in furthering the role of community pharmacy, we encourage Welsh Government to continue their support by backing the rapid roll out of the Choose Pharmacy platform to the whole community pharmacy network in Wales. This will not only further cement the role of community pharmacy as part of the NHS in Wales, it will help to provide people with a clear route of access to the most appropriate healthcare setting for their needs.

To have the biggest impact and to support a positive change in behaviour – where people do choose pharmacy – we call on the Welsh Government and the NHS to support full coverage of the Common Ailments Scheme across the country – to make this a universally accessible service from all community pharmacies. This will require Health Boards to commit to funding with a consistent and long term outlook.

Although support for self-care and treatment for common ailments is a core element of the community pharmacy offer, our reach and capability goes far beyond, and there are a range of opportunities for other Choose Pharmacy services to alleviate system pressures. These include Emergency Hormonal Contraception service, Emergency Medication Supply and Discharge

Medication Review – all of which, when underpinned by access to the GP record can have a high impact on supporting primary care and help build capacity.

We look forward to being able to deliver the whole range of Choose Pharmacy services once the platform is available and to working with Welsh Government and our local primary care colleagues to promote the care available with a view to encouraging people to access the right service, at the right time in the right place.

Making the best use of medicines

Research shows that up to 50% of patients fail to take their medicines as prescribed, which can lead to sub-optimal treatment, potentially resulting in exacerbations of their condition, avoidable interventions or even hospital admission. It is estimated that this costs NHS Wales around £10million every year and is a contributory factor when looking at winter pressure on the NHS.

Community pharmacy services, such as Medicines Use Review are pivotal in ensuring that people understand their medications as well as identifying any potential issues with the regime.

By engaging pharmacy more in supporting medicines optimisation for patients, such as the responsibility for the NHS Repeat Dispensing Service, and eventually more independent prescribing by pharmacists in the community, we envisage better outcomes for patients and the NHS, and an increase in capacity in General Practice.

We call on Welsh Government and NHS stakeholders to support the extension of the Repeat Dispensing Service, which helps to remove administrative task from General Practice, as well as supporting regular and consistent contact between pharmacy and patients. We believe that this is the building block which supports the future development of services in pharmacy – such as supporting patients with long term conditions.

Supporting discharge from hospital

Bed blocking is a phrase which is widely used by the media especially in winter months, but which does not convey the complex needs of patients who are unable to leave hospital immediately after their treatment is concluded, potentially due to arrangements around their medication. However, through the Discharge Medication Review Service (DMR), patients can be supported through their discharge from hospital by their local community pharmacy, thus allowing safe transition from one setting to another. The service ensures that the patient receives their intended medication and that they or their carer understands how to get the best from their medicine to manage their ongoing needs. This can help to free up resources more effectively and allow people to return home at the earliest opportunity, particularly at a time of the year when the pressures on the system are at their greatest.

We would welcome the planned expansion of the Medicines Transcribing and e-Discharge (mTED) system throughout hospitals in Wales which will allows the production of the Electronic Discharge Advice Letter (eDAL) via the Choose Pharmacy platform. This will enable the community pharmacy the deliver the valuable DMR to all patients where this is appropriate when transferring between care settings.

Prevention

Community pharmacy plays a significant role in the prevention of ill health, from supporting patients diagnosed with a long term condition to manage their conditions, to providing lifestyle advice and information to avoid people developing conditions in the first place. Examples of this could be through stop smoking services, asthma inhaler technique checks, diabetes screening and blood pressure measurement services.

Recently, community pharmacy has also been commissioned to provide the NHS Flu vaccination service, which is again maximising the levels of patient access and expertise in this setting. This works best in conjunction with GP practice – where collaborative working can increase overall rates of immunisation for communities, preventing those most at risk from developing flu and helping to avoid potentially serious complications and avoidable hospital admissions.

We ask that the full roll out of the pharmacy flu vaccinations service is undertaken, to ensure that the opportunity for improving access and therefore, increasing uptake is realised. We also welcome in enhanced communication through the planned introduction of the Choose Pharmacy platform to provide a more seamless service and reduce bureaucracy.

Conclusion

We do believe it would be of interest to the Committee and the National Assembly to review the range of services currently available through community pharmacy and explore how they can be maximised to support the plan for primary care for Wales as set out by the Welsh Government.

LloydsPharmacy looks forward to being able to deliver the whole range of Choose Pharmacy services once the platform is available and would welcome the opportunity to work with Welsh Government and our local primary care colleagues to promote the care available which encourages people to access the right service, at the right time in the right place.

We call on the Welsh Government and the NHS to support full coverage of Choose Pharmacy platform and the Common Ailments Scheme – to make this a universally accessible service through community pharmacy. As we already mentioned, this will require Health Boards to fully commit to funding with a consistent and long term outlook, which will ultimately help to change behaviour around how people access NHS services.

We also believe that one of the key elements to enabling and enhancing pharmacy's role in supporting primary care to be the extension of the Repeat Dispensing Service and we welcome the opportunity to work with the Health, Social care and Sport Committee, the Welsh Government and Community Pharmacy Wales in further developing this and the role of community pharmacy to support the health of people in Wales, and the future sustainability of the NHS.

WP 10

Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016

Inquiry into winter preparedness 2016/17

Ymateb gan: Conffederasiwn GIG Cymru

Response from: Welsh NHS Confederation

	The Welsh NHS Confederation response to the Health, Social Care and Sport Committee Inquiry into winter preparedness 2016/17.
Contact:	Nesta Lloyd – Jones, Policy and Public Affairs Manager, the Welsh NHS Confederation. [redacted] Tel: [redacted]
Date:	8 September 2016

Introduction

1. The Welsh NHS Confederation represents the seven Health Boards and three NHS Trusts in Wales. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

2. We welcome the opportunity to contribute to the Health, Social Care and Sport Committee inquiry into winter preparedness. Operational planning processes need to be in place all year round however experience demonstrates that the winter months pose particular challenges for health and care organisations. Unscheduled care services face further pressures during the winter months and it is an area which impacts on how patients and the public experience health and care services. The reasons for the year-round pressures on unscheduled care services are well known.

3. The unscheduled care system is faced with increasing activity and patient acuity and is compounded by workforce supply pressures during the winter. However when the Committee considers these pressures and challenges it is vital that the whole health and care service, and not only the acute hospital services, are considered. Unscheduled care performance is a whole-system issue that is significantly affected by community, social care, primary care and preventative care services.

i. The current pressures facing unscheduled care services, and how well prepared the Welsh NHS and social services are for winter 2016/17;

4. There are a number of significant pressures facing unscheduled care services in Wales, however Local Health Boards and Trusts, through their Integrated Medium Term Plan (IMTP) processes and winter plans, are ensuring that they are prepared for this year's winter. Winter plans cover the period between October 2016 to May 2017.

a) Pressures facing unscheduled care services

Rising demand

5. Changes in how people live their lives and the success of the NHS in keeping people alive for longer means demand for care is rapidly rising. An ageing population, combined with more people having increasingly complex needs, means that demand for health and social care services is predicted to grow rapidly in coming years. Wales currently has the highest rates of long-term limiting illness in the UK. Between 2001-02 and 2010-11 the number of people with a chronic or long-term condition in Wales increased from 105,000 to 142,000.[i] All these factors affect people's health and increases demand on health and care services.

6. The ageing population has a significant impact on demand for health and social care services all year round, but particularly during winter months. The ageing population, accompanied by increasing co-morbidity, medicalisation, frailty and social isolation, is a long term driver of unscheduled care demand. As people live longer but have fewer children, there is an increased proportion of the population who are dependent on care. On average, older people have lower baseline functions, greater frailty and lower resilience. This leads to greater need for support for the activities of daily living, tipping over into acute ill health at a lower threshold, and slower recovery from illness, which places increased demand on health and social care services.

7. While attendance at Emergency Departments (ED) remains generally static, the complexity of patient need and other influencing factors have resulted in performance not improving despite numerous initiatives focussed on ED efficiency. The complexity and severity of conditions of those admitted places a huge strain across ED. The most significant issue is not the numbers of people presenting at ED but the ability to provide alternatives to admission alongside the ability to transfer patients safely and quickly from hospital to their place of residence and to prevent readmission.

8. In addition to ED, the pressures on critical care units can increase during the winter. Critical care provides specialist support for patients with acute life-threatening injuries and illnesses, often when one or more organs have failed. As highlighted within the Annual Report 2016 for the Critically Ill,[ii] critical care beds are not always used appropriately due to problems with patient flow through the hospital. For example, not all patients in critical care beds require that level of care but some might be awaiting discharge to hospital wards and this delay to hospital wards can increase during the winter months. This then has a knock on effect and can result in cancelled operations or patients who require critical care being transferred to other hospitals who have a critical care unit.

Seasonal factors and respiratory infections

9. Hot and cold weather are both associated with increased demand for unscheduled care services. Respiratory illnesses have a distinct seasonal pattern, with an increase in winter largely due to influenza infection leading to hospital admission and excess winter mortality. Other viral infections, such as noro virus, are also common in the winter. Both viruses can place significant short term strain on unscheduled care services.

10. Seasonal influenza and other respiratory virus infections can significantly affect demand for unscheduled care in the winter. Fortunately, in recent winters seasonal influenza has not reached the “higher than average activity” threshold but primary and secondary care systems still need to ensure that they have the surge capacity to respond to such increase in demand as they are likely to occur every few years.

Workforce

11. The NHS ability to respond to winter challenges is constrained by a number of factors, including the NHS workforce. Recruitment issues exist within all staff groups and core medical, nursing and therapy workforce capacity impacts on the NHS ability to find the increase in the workforce required during the winter. In some Health Boards workforce capacity remains fragile in areas such as ED, Acute Medical Services and District Nursing, despite proactive recruitment at home and overseas, and introducing changes to workforce models to provide sustainability.

12. While workforce strategies, including overseas recruitment for nursing/therapies, are in place recruitment and employment processes have been, and continue to be, challenging. For example

nursing and senior nurse cover are co-ordinated to ensure robust arrangements are in place, however this is always challenged by sickness and vacancy impacts, and can lead to an increased use of agency and bank staff. The availability of bank and agency staff can be limited during peak holiday periods and experience has proven that the reliability of agency staff attending for their shifts can be problematic for some Health Boards.

Infrastructure constraints

13. One key aspect of winter planning for this year is the ability to manage surges in activity from the heralded emergency caseload whilst maintaining levels of elective activity. Most hospitals in Wales have very few surge areas available to them during the winter. This limits both the creation of additional bed capacity for winter and the options for managing infection prevention and control outbreaks.

14. Within acute services, difficulties can be encountered with the number of acute emergency admissions presenting and as a consequence the ability to accommodate this caseload alongside planned elective activity. Furthermore, available bed capacity often becomes compromised by bed closures resulting from infections, particularly of a viral gastrointestinal nature.

Delayed transfer of care

15. In order to ensure a smooth flow of people through the care system (primary, community and acute health and social care), it is imperative that all patients are able to be transferred or discharged in a timely fashion when their episode of care is complete. One way of measuring flow efficiency, particularly between various parts of the care system, is to measure delayed transfers of care. While there are still some significant issues around delayed transfer of care, and Health Boards are fully aware they need to be reduced further, a number of initiatives are happening across Wales which is improving delayed transfer of care.

16. Across Health Boards there is a focus on patients who are medically fit, ensuring the assessment and discharge process is timely and any delays are escalated and dealt with at a senior level. Discharge standards are in place across community and Local Authorities to ensure patients are assessed and discharged within agreed timeframes. Collaborative working between community and acute managers is now a routine way of working across Health Boards to ensure appropriate levels of discharge is maintained. Examples where this is done include;

- ‘Bullet rounds’ – daily multidisciplinary rounds to discuss progress of patient recovery and plan interventions to support discharge;
- Weekly meeting and teleconference calls to monitor discharge planning of complex patients against Estimated Date for Discharge (EDD);
- Weekly multi-agency review meetings held with each ward manager; and
- Daily reports shared across health and social care identifying patients on the Discharge Working list.

Changes in non-NHS service provision

17. A range of community services are under pressure and are providing less support in the community, leading to backward pressure on the discharge of patients from high intensity inpatient care. There has been pressure on social services budgets over a number of years with changes in the threshold at which individuals receive access to support. In some demographic groups there are incentives to look after the frail elderly at home to avoid the high cost of residential or nursing home costs. The timescales at which assessment progresses for residential or nursing home care are widely recognised as a factor contributing to delayed discharges from hospital care.

Fragility of the private sector domiciliary care market

18. A recent exploratory analysis undertaken by the Welsh Government suggests that there has been a fall in private sector residential and nursing home beds in Wales[iii] which can impact on delayed discharges from hospital care. Some areas are also reporting a reduction in home care packages. These factors reduce the overall pool of resource available and contribute to increased backward pressure on NHS inpatient services.

19. Last winter a number of domiciliary care providers across a number of Health Boards handed back packages of care. This impacted on capacity within Health Boards community resource teams and their ability to take on new hospital discharges, as well as supporting patients in their own homes. A careful balance has to be struck between releasing community capacity to help reduce delayed transfers of care from hospitals, whilst not saturating available capacity in the community. This issue has continued through the year with a number of private providers leaving the market, but this is not just a winter issue.

b) How well prepared is the Welsh NHS.

20. Health Boards and Trusts, as part of their IMTP process, review previous winter plans and performance each year and then develop plans for the forthcoming winter period. As part of this process Health Boards implement their unscheduled and urgent care improvement plans and consider the priorities that have been confirmed as part of their individual IMTP process for 2016/17. The Health Boards also consider guidance that has been issued by Welsh Government and once completed winter plans have to be submitted to the Welsh Government. The Welsh Ambulance Services NHS Trust (WAST) also has robust winter plans in place at strategic, operational and tactical levels. More information on this can be found in the evidence from the WAST, which is the subject of a separate submission to this inquiry.

21. Health Boards continue to develop a whole system view of urgent care that allows them to take early decision making across the patient pathway, knowing that pressures often manifest early in their primary care services prior to the surge in secondary care. When developing their winter plans Health Boards consider the demand through mapping against the previous years, however this needs to take into account significant events e.g. prolonged snow/cold weather and outbreaks of the norovirus, especially as last year was a mild winter with no significant outbreaks of norovirus.

22. In order to provide assurance to their Executive Boards, likely demand is mapped against previous years and a number of bed modelling scenarios undertaken to deliver the capacity required for unscheduled care. While demand is mapped against previous years the most difficult part of planning for winter is the scale of variation in demand from one winter to the next, particularly in relation to medical bed capacity. For some Health Boards the range can be an additional 10 beds or an additional 100 beds. Given the financial, workforce and infrastructure limitations it is not always possible to prepare for all eventualities and the NHS can usually only plan for a typical winter rather than the extremes.

23. When managing winter pressures a suite of integrated plans are produced and implemented by Health Boards, including;

- Seasonal Pressures Plan: Cold weather plans to ensure that services are maintained in the event of adverse weather conditions;
- Escalation and Capacity Plan;
- Community Hospital Capacity Management Plan;

- Hospital Discharge Policy and Procedure;
- Immunisation Plan, to increase the uptake for staff and vulnerable patients;
- Demand Management (5 Step Care Pathway);
- Capacity Management;
- Escalation Management; and
- Infection control: Enhancing support in relation to infection control/ respiratory equipment which sees a peak in demand during the winter months.

24. The main aims of the plans are to implement actions in order to manage surges and variation in demand, enable improved flow across the system and maintain service levels in all areas to improve access for patients.

25. As previously highlighted, when developing their plans Health Boards review and evaluate last year's performance over the winter period and put in place actions to improve responses to winter pressures this year. Some of the key priorities highlighted by Health Boards to be taken forward this year include;

- Full implementation of discharge improvement plans;
- Right sizing community and core services capacity;
- Implementing new processes and pathways that reduce ambulance conveyance to Emergency Departments;
- Implementation of the 111 service in Abertawe Bro Morgannwg University Health Board;
- Maintain patient flow improvements and ward processes;
- Redesigning front door services/ models of care;
- Improving escalation processes;
- Unscheduled Care Programme established to ensure improvements are made to the unscheduled care system looking at 5 key areas; informatics, in hospital flow, discharge, locality development and workforce to build resilience for the future;
- Primary and Community Out Of Hours services need to be enhanced to avoid increases in attendances and referrals to hospital services;
- Further development of ambulatory care pathways can reduce the pressure on both admissions and Emergency Departments;
- Improved discharge planning for complex care patients is vital if length of stay is to be managed and delays to discharge minimised;
- Dedicated site management improves flow and the Health Boards ability to de-escalate; and
- A specific plan for March and Easter needs to be developed as winter continues.

26. Health Boards are also using information to drive their decision making with tools that allow them to predict speciality requirements month on month. The challenges that Health Boards have rest on the ability to change their workforce requirements to meet the type of demand, particularly in difficult to recruit groups of staff. Health Boards capacity to meet demand is focused more on the teams who care for patients as opposed to the place where they care for patients (beds, trolleys, clinics etc). Therefore Health Boards are developing a range of options that will be dependent on the staffing resource models available.

27. The provision of an integrated seasonal plan is seen as one element of Health Boards system wide approach to improving unscheduled care and urgent care services and cannot be viewed in isolation, albeit that the winter presents some different challenges to the all-year-round system demands. To ensure the production of a single integrated winter plan, Health Boards develop their plans in conjunction with the Welsh Ambulance Services NHS Trust (WAST), primary care

colleagues, Local Authorities, voluntary and the independent sector. This highlights the whole system approach to the management of unscheduled care which maximises the contribution of every service, with the aim of caring for patients in the right place, at the right time and by the right care team. It is part of a three year rolling IMTP, which has been prepared against the background of the NHS Wales vision for unscheduled care.

28. Finally, many Health Board plans, as in previous years, have been underpinned by significant investment in their unscheduled care services. This includes additional staff appointments, extended day working and the introduction of new models of care. The unscheduled care improvement plan is also being supported using a service improvement approach to developing sustainable change going forward.

ii. Whether there has been sufficient progress in the fourth Assembly in alleviating pressures on unscheduled care through integrated winter planning across health, social and ambulance services, and lessons learned;

29. Overall there has been sufficient progress in the fourth Assembly in alleviating some of the pressures on unscheduled care. A number of initiatives and policies have been introduced and implemented during the fourth Assembly. The NHS works with partners in their local areas to manage the pressures facing health and social care during winter, with collaborative working taking place throughout the year to enhance joint activities to support and improve service delivery and reduce system pressures. While progress has been made a number of challenges still exist which will be responded to by the NHS in Wales.

Unscheduled Care Reports and Tools

30. A number of unscheduled care reports and tools have been introduced over recent years to support the NHS in Wales to respond to and alleviate the unscheduled care pressures that they face. These have included:
    - **A Toolbox of Actions to Address Pressures in Unscheduled Care (January 2015):** This document forms a concise reference guide for NHS Managers in Wales. It lists thirty actions which might be used to address pressures in the unscheduled care services in NHS Wales.
    - **What Drives Demand for Unscheduled Care Services in Wales? (January 2015):** This report describes a wide range of important 'drivers' which contribute towards the growing gap between demand and supply in unscheduled care.
    - **Atlas of Variation in Unscheduled Care (November 2014):** This interactive atlas presents indicators from across the unscheduled care system in Wales, relating to both the need for services and their utilisation. The web resource, introduced by the Public Health Wales Observatory, aims to stimulate discussion, improve understanding and inform decision-makers on local factors and their influence on the unscheduled care system.
    - **External Factors Affecting Long Term Trends and Recent 'Pressures' on Unscheduled Care Use and Performance in Wales (June 2013):** This report examined the external factors affecting long-term trends and pressures affecting the unscheduled care and performance in Wales, especially for major A&E departments during the winter and spring of 2012/13.
    - **Unscheduled Care Analyses (March 2013):** The Public Health Wales Observatory has published a series of analyses for health boards which have emergency departments (EDs) within their boundaries. The analyses include information from the Emergency Department Data Set (EDDS).

Programme for Unscheduled Care

31. The NHS Wales Programme for Unscheduled Care has supported the NHS to alleviate some of the pressures on unscheduled care. The Programme sets out a 10 step patient pathway that recognises that actions taken outside of an emergency facility can have a major impact for the demand for, and use of, such a facility. This reflects the approach that Health Boards have adopted in recent years where their Unscheduled Care Improvement Plan has successfully focussed on:

- Providing services that reduce unscheduled care demand in the first place, especially for emergency care; and
- Ensuring that once an acute episode of care is complete, the transfer back to the community is timely and safe.

32. Increased collaboration has also been key to ensure improvements. Overall, Health Boards have a positive track record of joint working to manage the pressures facing health and social care during winter, with collaborative working taking place throughout the year to enhance joint activities to support and improve service delivery and reduce system pressures. Through working collaboratively Health Boards have ensured that actions within the plans are implemented in order to manage surges and variation in demand, enable improved flow across the system and maintain service levels in all areas to improve access for patients.

Prudent healthcare

33. Informed by the work of the Bevan Commission and others around the world, the NHS in Wales has taken on the principles of prudent healthcare as it responds to the growing challenges it faces. The prudent healthcare principles were introduced in 2014 and puts NHS Wales at the front of a growing international effort to get greater value from healthcare systems for patients. As part of prudent healthcare the NHS in Wales is ensuring that people access care at the right level for their needs; right care; right time; right place; right people. As part of this principle healthcare is provided to fit the needs and circumstances of patients and avoids wasteful care. This includes keeping people healthy and living independently in their own homes and communities as much as possible, thus reducing inappropriate demand on more acute healthcare services, and returning people back to their communities from acute care as quickly as safety allows, thus improving the flow through the healthcare system.

Supporting those at highest risk

34. Health Boards are identifying those patients at high risk of admission and are particularly focusing on the frail elderly. To support this, within primary care, some Health Boards have purchased a software package to risk stratify patients who will then be discussed at primary care Multi-Disciplinary Team (MDTs) meetings. These MDTs proactively develop management plans to reduce the risk of avoidable hospital admissions.

35. Community Services play a significant role in maintaining patients at home and avoiding unnecessary hospital admissions. Health Boards have identified resources and services to address the surges in activity experienced during the winter months when levels of patient acuity can increase. There is a focus on providing re-ablement, rapid response domiciliary care service and step up facilities to avoid hospital admissions. This is supported by the development of roles to focus on and develop community resilience with the third sector. Through funding from the Intermediate Care Fund, IMTP and Cluster Networks, community teams have been strengthened.

36. National pathways have been developed with the WAST which includes Falls, resolved Hypoglycaemia and resolved Epilepsy. Further pathways are being developed with the implementation of 111 service in 2016 in Abertawe Bro Morgannwg University Health Board. In

addition, there are a number of more local pathways, a good example of which is that for mental health in Cardiff and the Vale University Health Board. The Frailty Pathway is also being developed across a number of hospital sites to provide timely elderly assessment to avoid admissions. Frequent hospital attenders are also reviewed jointly between Health Boards and the WAST and management plans are put in place to avoid hospital conveyance and admission where appropriate. Again, there is more detail about this in the separate evidence submission from the WAST.

Choose Well campaign

37. The Choose Well campaign was developed in 2011 to give people more information and to help them make the right decision on which services they choose based on their symptoms. This helps people access the right treatment and professional advice when they need it. Health Boards and Trusts are working to educate their local population in regards to the provision and availability of alternative services. The Choose Well campaign is promoted at every opportunity by the NHS in Wales, including in any public engagement events and through social media.

38. In addition to the Choose Well campaign the Welsh Government has introduced Choose Pharmacy. Originally it was piloted in 32 pharmacies, 19 pharmacies in the Betsi Cadwaladr University Health Board and 13 in the Cwm Taf University Health Board area in October 2014. It provides patients access to free treatment for a rage of common ailments from the pharmacy rather than them having to make an appointment to see the GP. In March 2016 Choose Pharmacy was extended to cover the whole of Wales and the scheme should help to free up GP time to deal with people with more complex needs – up to 18% of GPs' workload and 8% of emergency department consultations are estimated to relate to minor ailments,[iv] such as coughs, colds, ear ache, hay fever, conjunctivitis and head lice. A review[v] into Choose Pharmacy has already highlighted several positive outcomes, including improved patient access, better use of pharmacists' skills and resources, and improved public understanding of the support available at their local pharmacy.

Joint working with Public Health Wales NHS Trust

39. There has been a significant amount of work between Health Boards and Public Health Wales NHS Trust to plan for the flu campaign. This has executive director leadership and senior management support in many Health Boards. Flu champions are identified within nursing teams and community nurses have undergone training to immunise patients on their caseloads.

40. There has been collaborative working between Health Boards and Public Health Wales NHS Trust in relation to adverse weather forecast and anticipatory planning to support anticipatory management of respiratory conditions. Also Public Health Wales NHS Trust provide intelligence in terms of any impact specific issues can have e.g. norovirus impacting on nearby Health Boards to enable early warning triggers.

iii. The actions needed to produce sustainable improvements to urgent and emergency care services, and the whole system, ensuring the Welsh NHS builds resilience to seasonal demand and to improve the position for the future.

Vision for NHS Wales

41. There is a huge degree of consensus across health and care organisations on the key challenges facing the health and care system as a whole. If we are to better meet people's needs and ensure taxpayers get the best possible value from the money we put into health and care services then

change will be necessary. Recognising the need for action, the Welsh NHS Confederation is calling on the Welsh Government to develop a long term vision and ten year strategy for sustainable health and care services in Wales**.** The development of an explicit vision and strategy for health and care would help NHS organisations to develop and implement new service delivery models and transformational change with greater pace and scale. It will provide a strong strategic context for change that is understood and supported by politicians, partners and the public.

Integration

42. Integration across health and social care is key. The health and well-being of the population is not the sole responsibility of the NHS - everyone must come together to play their part. To provide patient-centred care, collaborative working is vital. Integration needs to happen, both within and outside the health service. The NHS will not be able to rise to the challenges it faces without the help of our colleagues in other sectors, including housing, education and, in particular, those in social services. The new Public Service Boards, introduced as part of the Well-being of Future Generations (Wales) Act 2015, will enable public services to commission and plan collaboratively, ensuring that services are integrated and that care and support provided improves health and well-being outcomes for the local population. The Act should help drive collective decision making models within national and regional priorities, especially around service reconfiguration.

Prevention

43. Prevention and early intervention to improve population health is a national priority for the NHS in Wales. We all recognise that it is the key to improving the health and well-being of the whole population, while helping to manage demand on secondary care. Wales faces a significant number of public health challenges, including high levels of obesity, drinking above the guidelines, smoking and poor levels of physical activity. The impact of such behaviours on our health is resulting in significant demand being placed on the health service. Bold decisions are now required to make industrial scale change in our services and shift the funding to support people to make better lifestyle choices.

Self-care

44. The vision for unscheduled care in Wales is that people should be supported to remain as independent as possible, that it should be easy to get the right help when needed and that no one should have to wait unnecessarily for the care they need, or wait to go back to their place of residence. The NHS in Wales will achieve this by working with patients and carers as equal partners to provide prudent care.

45. Self-care plays an important role in helping to reduce demand on over-stretched primary care and emergency departments during periods of increased demand. Self-care can prevent ill-health in the long-term, and can help reduce the burden on general practice in the winter. Furthermore there is a need for an open and honest conversation with the public about what the NHS can provide in the future. While the NHS is free at the point of contact, it is not free of obligation, and the public will need to be supported in taking more responsibility for their own health. Patients need to become partners in managing and improving their health, rather than passive recipients of healthcare. However, increased use of self-care and its promotion should only be one of many measures taken to increase the resilience of the NHS to beat the effects of winter pressures.

Service change

46. With increase demand it is clear that the NHS needs to transform and adapt when it comes to the way it approaches care and treatment for people. For the sustainability of the NHS to be secured, and for it to continue to deliver high quality care, it cannot do things in the same way. This trend

is likely to continue unless system change is addressed and a way of funding across pathways of care can ensure parity of resources aimed at primary and community based services, which are proven to keep people out of hospital settings.

47. While social care is an important part of the solution, improvements and substitution of services will not manage all the pressures on the system. There is also a need to remove some of the complexity of different services that has been built into the system which can confuse the public. However, in the absence of accurate data outside hospital, fostering a better understanding of the way that local systems work will not be easy.

The role of primary care

48. The OECD Review of Health Care Quality UK, raising standards,[vi] recommended that Wales should "Put Primary Care front and centre as a force for dynamic system change". It proposes that this requires the continued growth and support of primary care clusters and their activities as well as fostering new models of care delivery, incentivising innovation and new ways of working. This reinforces the work that is already underway and requires a sharpening of focus and increase in pace of delivery.

49. Implementation of 'Our plan for a Primary Care service for Wales up to March 2018',[vii] has progressed over the last 12 months, supported by additional funding for Cluster Networks and pacesetters. However, significant progress will only be made if equal priority is given at both individual Health Board and national level to improving primary, community and social care alongside secondary care. This will require the development of a balanced approach at Health Board level to core funding of areas where real evidence demonstrates benefits accruing to the whole system.

Conclusion

50. The NHS in Wales continues to work in an integrated and planned way to alleviate the pressures and challenges that it faces, especially during the winter period. In order to adequately respond to the pressures that health and care services are facing, it is vital that there is sufficient capacity across the entire health and social care system, including accident and emergency departments, general practice and social care provision.

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[i] Nuffield Trust, June 2014. A Decade of Austerity in Wales? The funding pressures facing the NHS in Wales to 2025/26.
[ii] Welsh Government, August 2016. Together for Health: Annual Report 2016 for the Critically Ill
[iii] Health statistics Wales 2014, Summary results, Table 15.2 and Chapter 16, Table 16.1, Welsh Government.
[iv] Pharmacy Research UK, January 2014. Community Pharmacy Management of Minor Illnesses (MINA Study).
[v] Welsh Government, July 2015. Evaluation of the Choose Pharmacy common ailments service.
[vi] OECD, February 2016. Reviews of Health Care Quality: United Kingdom 2016.
[vii] Welsh Government, February 2015. Our plan for a Primary Care service for Wales up to March 2018.

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Cymru Wales

WP 11

Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016
Inquiry into winter preparedness 2016/17

Ymateb gan: Y Gymdeithas Feddygol Brydeinig Cymru Wales

Response from: British Medical Association Cymru Wales

BMA

WINTER PREPAREDNESS 2016-17

Inquiry by the National Assembly for Wales Health, Social Care and Sport Committee

Response from BMA Cymru Wales

9 September 2016

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the Health, Social Care and Sport Committee's inquiry into winter preparedness 2016-17.

The British Medical Association (BMA) is an independent professional association and trade union representing doctors and medical students from all branches of medicine all over the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 160,000, which continues to grow every year. BMA Cymru Wales represents over 7,500 members in Wales from every branch of the medical profession.

RESPONSE

Executive Summary

- There is an ever increasing demand for health services across the NHS which is exacerbated during winter months. Demand within the health service is now so great that hospitals are full all year round, preventing the system from coping with a seasonal spike in demand.

- In order to adequately respond to these pressures, BMA Cymru Wales believes that it is vital that there is sufficient capacity across the entire health and social care system, including accident and emergency departments, general practice and social care provision. BMA Cymru Wales is particularly concerned that a lack of investment and capacity in social care is increasingly impacting on the provision of healthcare, particularly during times of peak demand.

- The short-termism associated with the need to make efficiency savings in NHS Wales can prevent longer term, better value savings being made. This in turn hinders progress in tackling the underlying structural issues which allow winter pressures to present serious problems. Permanent funding solutions across the entire NHS needs to be implemented, and investment must keep up with demand in every part of the system.

- In order to ensure effective planning for winter pressures within the health system it is also necessary to tackle wider public health issues, such as keeping vulnerable people warm in winter and ensuring that older people, and those with co-morbidities, are adequately cared for in the community

Causes of winter pressures

Winter pressures are caused by the interplay between seasonal increases in morbidity and structural problems within the healthcare system. An increase in winter mortality and morbidity does not just occur during extremely cold weather, but also on relatively mild winter days, which are more frequent. The cold weather mainly affects the health of older people, the very young and those with long term conditions. This, combined with the dangers associated with snow and ice and the sheer scale of the annual influenza vaccination campaign, leads to increased pressures on the health service during the winter season.

The exact pattern of winter pressures is largely unpredictable, mostly because it is impossible to predict the severity of winter weather or of any flu outbreak. As a result of this, the health and care system must have adequate capacity and plan appropriately to be sufficiently robust to react to these necessarily variable demands. However, NHS Wales is already stretched to its limits and increasingly unable to respond to additional pressures.

Unfortunately, these public health pressures impact significantly on emergency departments, generating severe challenges in bed access throughout hospitals. The declining number of hospital beds, workforce shortages and patient flow must all be addressed if emergency departments are to have sufficient capacity to cope with winter pressures.

The surge in morbidity during the winter months also has a major impact on primary care. General practice is going through an unprecedented crisis and must be given the resourcing and support needed to respond flexibly to the needs of patients. This includes further promotion of self-care, which can help reduce demand on over-stretched practices. Emergency departments are also under resourced. Combined, these pressures put the healthcare system under huge strain, reducing its ability to absorb spikes in demand during the winter months. Emergency departments must also not be considered in isolation – there needs to be greater collaboration, coordination and integration between all areas of the health and care system.

While there will always be winter pressures, it is possible to create a health system that is sufficiently robust to react to the inevitable but variable additional demands placed on services during winter. However, there is no quick fix solution to the current crisis in healthcare provision. Longer term investments need to be made to adequately tackle the problems, and the financial challenges facing the NHS in Wales must not detract from these.

The complete solution is even broader. In order to truly manage winter pressures, we will need to tackle wider public health issues – such as keeping our older and vulnerable population warm in winter, keeping them well fed, keeping them mobile, and ensuring timely access to adequate social care.

Planning for winter pressures and developing resilience within the system

The Welsh Government holds quarterly, seasonal planning meetings with the NHS, local authorities and the third sector. Health boards, local authorities and the ambulance service have also developed joint winter plans over the last two winters.[1] Through the Environment (Wales) Act 2016 and a focus on energy efficiency, coupled with Warm Homes programmes including NEST and Arbed, progress has been made in tackling some of the root causes of health problems in winter that are related to or exacerbate by living in cold conditions.[2] 'Flu vaccination programmes aimed at particularly vulnerable groups have been proactive and had a reasonable take up (although under the Welsh Government target).[3] However, despite these interventions, the number of excess winter deaths has increased significantly in the last decade, and this year on year decline shows little sign of stopping.

In Wales there are on average between 50,000 and 70,000 attendances at A&E departments in any given month.[4] During winter months there is usually an increase in emergency admissions which places the health service under significant strain. Emergency admissions primarily increase because of a rise in the number of respiratory infections, which mainly affect the very young, elderly and those with co-morbidities. Problems can also derive from the length of time patients with these complex and severe conditions stay in hospital.

An increase in emergency admissions puts pressure on hospital services, and adds to the existing challenges within the NHS in Wales. One of the most pressing challenges with regard to coping with

[1] http://gov.wales/about/cabinet/cabinetstatements/previous-administration/2014/winterpreparednes/?lang=en
[2] http://gov.wales/topics/environmentcountryside/energy/efficiency/warm-homes/?lang=en
[3] http://www.wales.nhs.uk/sites3/page.cfm?orgid=457&pid=55714
[4] http://www.infoandstats.wales.nhs.uk/page.cfm?orgid=869&pid=62956

winter pressures is the gradual decline of the number of available hospital beds, as a consequence of an increase in the number of day case admissions and an increasing tendency to try to treat patients in a primary or community care setting. The decline in available beds impacts on patient care within hospitals, particularly during winter, and is counterproductive to the provision of optimal care.

BMA Cymru Wales has raised concerns about the steady decline in the number of available beds over the last decade and the impact this may have on the safety and quality of patient care. We would like to see this policy urgently re-evaluated. The lack of availability of appropriate hospital beds can result in patients being admitted to any available bed, not necessarily within the ward they need. Data from StatsWales clearly shows that the number of available beds has decreased year on year from almost 20,000 in 1999 to around 11,000 in 2015.[5]

At the same time, our members report that demand has increased and this has pushed the more efficient use of fewer beds beyond the limits of safety – with higher bed occupancy rates, increased bed use factor, reducing length of stay and reducing turnover interval. These factors adversely affect patient cross-infection rates and reduce staff to patient ratios resulting, in our view, in avoidable harm and increased staff sickness.

For some decades now, this downward trend in bed capacity has exceeded the level which might have been safely removed from the system due to the demonstrable increases in efficiency that have taken place. As a result, the NHS in Wales is now provisioned in terms of bed capacity for a slightly-better-than-average day but not for an average winter's day. There is therefore no longer any potential resilience within the system for a worse than average day, or series of days

Social care and delays in the transfer of care

Wales' aging population has a significant impact on demand for health and social care services all year round, but particularly during winter. Generally we know that the number of elective and non-elective hospital admissions for older people has increased. During winter the number of emergency admissions increases further. The complexity and severity of conditions of those who are admitted places a huge strain across emergency departments.

In order to better cope with increased demand it is vital that social care services also have sufficient capacity and investment. BMA Cymru Wales is concerned that a lack of funding and capacity within social care is increasingly impacting on the provision of healthcare, with patients presenting at healthcare settings due to gaps in social care provision. This also manifests itself in delays in the transfer of care from hospital settings for older patients which can result in significant financial strain on the NHS and exacerbate problems at times of increased demand.

We are aware of cases where GPs may wish to refer patients for nursing care rather than admission to hospital but, because it may not be possible for suitable care to be arranged in a timely manner, GPs have had no alternative but to arrange for their patients to be admitted to hospital. This adds to pressures on the availability of hospital beds which in turn leads to delays for patients who need to be admitted to those beds following presentation at emergency departments.

Good collaboration between health and social care services is important to avoid this happening. Hospital discharge should be a timely, planned and co-ordinated process and communication with families, patients and carers is of fundamental importance throughout. This is especially important during winter months when, due to the weather, patients with co-morbidities will be more vulnerable.

Medical workforce

In order for the health system to be sufficiently robust to react to seasonal pressures, there must be sufficient recruitment to all specialties within the NHS in Wales. We have concerns that there are a

[5] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/NHS-Beds/nhsbedssummarydata-by-year

significant number of trainee vacancies within Wales although there is insufficient data to fully understand such workforce issues.

There are many areas where there is a paucity of data available compared to that available in England. For example, there is a distinct lack of collection and publication of meaningful data on workforce vacancies. This has not been routinely published in Wales since 2011. Insufficient data evidently hinders effective workforce planning.

The Welsh Government often focusses on the fact that the total number of GPs in Wales has risen over the last few years. These figures only relate to a headcount of GPs working in Wales. A more accurate figure would be the number of whole-time equivalent GPs but this information is not collected. It is evident that an increase in the number of GPs does not necessarily mean more capacity within the workforce or more appointments available to patients, as so many GPs now work part time due to the pressures and stresses they are facing after years of inadequate resourcing of general practice.

The small increase in headcount also fails to reflect the significant changes in working patterns for GPs that have taken place over the last 12 years. This has led to a level of workload that is becoming increasingly unsustainable across Wales, with even more acute problems in certain areas.
It is vital for the quality and sustainability of the service that simple measures such as a headcount are avoided as they do not accurately reflect the complex factors affecting the stability and appropriate skill mix of the workforce.

Most patients enter the healthcare system through general practice, which has seen an unprecedented increase in demand in recent years alongside significant, and growing, workforce shortages.
Given the significant challenges we are faced within Wales, BMA Cymru Wales welcomes recent announcements from the new Welsh Government of plans to increase the number of GPs and primary healthcare workers in Wales through training and recruitment. However, we believe there is still much to do to address the current crisis in general practice, the effects of which will be exacerbated during winter.

Based on figures from 2013, we know that GPs in Wales carry out in excess of 19 million consultations with patients per year. On the basis of studies undertaken within the NHS in England, through which it has been generally accepted that around a third of GP consultations are unscheduled, this means that GPs in Wales undertake more than 6.5million unscheduled consultations a year – significantly more than those dealt with through accident and emergency departments.

In order to ensure patient safety, and to protect GPs against burnout, it is crucial that action is taken to provide for both an increase in recruitment and put in place appropriate support and safe working guidelines to prevent unsafe practices. Unmanageable demand for primary care will inevitably lead to patients presenting at accident and emergency departments, adding to existing pressures.

Self-care
Self-care plays an important role in helping to reduce demand on over-stretched primary care and emergency departments during periods of increased demand. Self-care can prevent ill-health in the long-term, and can help reduce the burden on general practice in winter. However, increased use of self-care and its promotion should only be one of many measures taken to increase the resilience of NHS Wales to beat the effects of winter pressures. Self-care alone is not sufficient to address the problems experienced by the NHS in Wales in winter.

Further to this, there is a distinct need for a public education programme to support people to make appropriate choices as to how and when they access healthcare. It is important that people understand when it is appropriate to access unscheduled care through either their GP or their local accident and emergency department. More work needs to be done to understand behaviour patterns and to work with groups who are more likely to access care inappropriately.

WP 12
Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016
Inquiry into winter preparedness 2016/17
Ymateb gan: Cymdeithas Siartredig Ffisiotherapi
Response from: Chartered Society of Physiotherapy

CHARTERED SOCIETY OF PHYSIOTHERAPY
CYMDEITHAS SIARTREDIG FFISIOTHERAPI

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Dear Chair and Committee Members

Inquiry into winter preparedness

The Chartered Society of Physiotherapy (CSP) in Wales is pleased to provide a written contribution to this review.

General introduction

Physiotherapists and their support staff working in the hospital and community environments will be affected by the winter pressures as demand for services increases at this time.

Physiotherapy has a role to play in terms of managing and treating patients with acute respiratory problems who may require respiratory physiotherapy but also in providing rehabilitation services in a hospital setting to help patients recover after illness or surgery and return home. In a community setting physiotherapists, as part of multi-disciplinary teams, work hard with patients to try and prevent admission to hospital.

Physiotherapy is therefore important with regard to the need for throughput of patients through the system, helping to release hospital beds as patients are discharged home and preventing admission to hospital from within the community.

Key points from the Chartered Society of Physiotherapy

Feedback from members appears to be that in most areas the physiotherapy profession has been asked to provide a physiotherapy perspective within high level plans being worked upon by Health Boards during the summer months looking ahead to, and planning for, the winter pressures.

In one of the Health Boards, the manager reports that they regularly attend a series of winter readiness meetings each autumn and the profession is fairly integral to the local planning to ensure as a service physiotherapy is able to respond to any increase in demand and the profession is in no way slowing up patient discharge from hospital. In some cases, locum cover has been provided to ensure that physiotherapy services can be maintained.

Concluding comment

The CSP hopes the committee finds these points useful and looks forward to following the progress of the review. Please contact the CSP if you require further information.

Philippa Ford MBE MCSP
CSP Public Affairs and Policy Manager for Wales

[redacted]

About the CSP and Physiotherapy

The Chartered Society of Physiotherapy is the professional, educational and trade union body for the UK's 54,530 chartered physiotherapists, physiotherapy students and support workers. The CSP represents over 2,300 members in Wales.

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity. Physiotherapists and their teams work with a wide range of population groups (including children, those of working age and older people); across sectors; and in hospital, community and workplace settings. Physiotherapists facilitate early intervention, support self management and promote independence, helping to prevent episodes of ill health and disability developing into chronic conditions.

Physiotherapy delivers high quality, innovative services in accessible, responsive and timely ways. It is founded on an increasingly strong evidence base, an evolving scope of practice, clinical leadership and person centred professionalism. As an adaptable, engaged workforce, physiotherapy teams have the skills to address healthcare priorities, meet individual needs and to develop and deliver services in clinically and cost-effective ways. With a focus on quality and productivity, physiotherapy puts meeting patient and population needs, optimising clinical outcomes and the patient experience at the centre of all it does.

Philippa Ford MBE MCSP
CSP Public Affairs and Policy Manager for Wales
[redacted]

WP 13

Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016

Inquiry into winter preparedness 2016/17

Ymateb gan: Fforwn Gofal Cymru

Response from: Care Forum Wales

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Consultation response –
Inquiry into winter preparedness 2016/17

Care Forum Wales is a membership organisation for Health and Social Care Providers in Wales representing over 450. Care homes and domiciliary care provision run by our members is a key component in keeping people out of hospital and supporting them when they are discharged from hospital. We believe the Regional Partnership Boards created during the fourth Assembly should become a key component in bringing statutory and non-statutory partners together to deal with complex issues such as winter preparedness.

Such partnership working is at very early stages and our members still see problems which could be dealt with by better co-ordination and recognition of the work of the sector. In some areas we see blockages in the system with patients waiting for assessments by health professionals or social workers before discharge.

Improved joint working could ensure that providers are willing to take on the care of new people, for example, on Fridays, rather than be concerned that the support networks, medical supplies or case notes will not be available and there will not be sufficient community support to take on care safely over the weekend.

Independent providers have capacity to be used to provide step up, step down or reablement services which are not currently being used but could release pressure on the hospital system.

Such partnership working requires better relationships to be built up together with mutual trust between the statutory and non-statutory sectors in terms of what can be provided.

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WP 14
Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016
Inquiry into winter preparedness 2016/17
Ymateb gan: Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Response from: Welsh Ambulance Services NHS Trust

Welsh Ambulance Services NHS Trust: Submission to Health, Social Care and Sport Committee Inquiry into Winter Preparedness September 29, 2016

Introduction

1. The Welsh Ambulance Service welcomes the opportunity to submit evidence to the National Assembly for Wales' Health, Social Care and Sport Committee in support of its inquiry into winter preparedness.

2. The challenges faced by the Welsh NHS in managing the demands of the winter season have been well-documented in recent years. An older and increasingly unwell and frail population, the seasonal impact of potentially adverse weather and higher levels of sickness, both within the community and among NHS staff, coupled with long-standing system issues, can inhibit the ability of patients to be cared for in the community. This is often because of pressures on community-based health and social care services, which combine to affect detrimentally the quality and timeliness of services provided to patients.

3. What has become apparent more recently is that system pressures now persist across the year to a greater or lesser extent and, while planning for the winter is clearly a key element of the Welsh Ambulance Service's annual planning cycle, the need to think in a more integrated and innovative way about managing demand is something which has become a feature of the Trust's work throughout the year.

4. This is, in part, why the Welsh Ambulance Service has taken a more integrated approach to planning for the winter season this year, ensuring that plans developed at local level are more closely aligned with health board planning, while developing a multi-level, Wales-wide organisational plan that covers strategic, tactical and operational issues.

Background

5. Following a protracted period of poor performance, poor employee relations and intense public and political scrutiny, the Welsh Ambulance Service has been on a journey of recovery and improvement since the autumn of 2014.

6. Under the leadership of a largely new Board and Executive Management Team, the organisation has made measurable progress on its journey of improvement to tackle some of its long-standing organisational issues, working closely with its staff and trade union partners to deliver a step change in performance and in outlook.

7. The introduction of commissioning arrangements through the Emergency Ambulance Services Committee and the Chief Ambulance Services Commissioner has also provided a strong national focus on care standards and improvement, through a collaborative commissioning and delivery approach involving all health boards and the ambulance service.

8. The standards required of the Welsh Ambulance Service are set out in the Commissioning and Quality Delivery Framework, which sets out a Five-Step Ambulance Care Pathway. This details the steps in the delivery of emergency ambulance services in NHS Wales. The Ambulance Care Pathway encourages a focus on the way patients flow through the unscheduled care system as a whole and covers the journey from helping patients choose the right service for them (Step 1), to taking very ill patients to hospital or another place of care (Step 5).

9. The advent of a new Clinical Model in October 2015, for an initial pilot period of 12 months, has further improved performance and has firmly repositioned the Welsh Ambulance Service as a clinically-led and quality driven service.

10. However, the impact of seasonal pressures on performance, and on the quality of service provided to patients, is something of which the Welsh Ambulance Service has been very aware in its 2016/17 planning. Detailed below is an indication of the approach adopted and some of the interventions proposed to ensure that both quality and timeliness of service are maintained during the 2016/17 winter period.

Planning for Winter: Assumptions and Previous Learning

11. In developing its Winter Plan, the ambulance service has been cognisant of the need both to learn from its experiences, particularly of last winter, and to balance this learning with a set of strategic and operational assumptions.

12. An over-riding assumption in that planning has been that the new Clinical Model, which the Welsh Ambulance Service has been piloting for a 12-month period from October 1, 2015, would continue for the duration of the plan. This has now been confirmed with Welsh Government's recent notification of an extension of the model until March 2017. This is welcomed.

13. Similarly, the Winter Plan contains some critical elements which are not resource neutral and require additional funding in order to realise. At the time of writing, this funding has yet to be secured through the commissioning process, although discussions are continuing.

14. Historically, winter planning at the Welsh Ambulance Service has not sufficiently balanced strategic imperatives and operational requirements. This year, an approach has been adopted which attempts to do this, while also ensuring the plan is underpinned by more tactical plans to address specific pinch points, for example the Christmas and New Year period.

15. The introduction of Ambulance Quality Indicators (AQIs) means that there is an agreed data set to review patient flow and performance over the 2015/16 winter period and also to predict patient flow for the coming winter.

16. For the purposes of clarity, the Welsh Ambulance Service's Winter Plan has been presented using the Five-Step Ambulance Care Pathway as a template.

Figure 1: Five-Step Ambulance Care Pathway

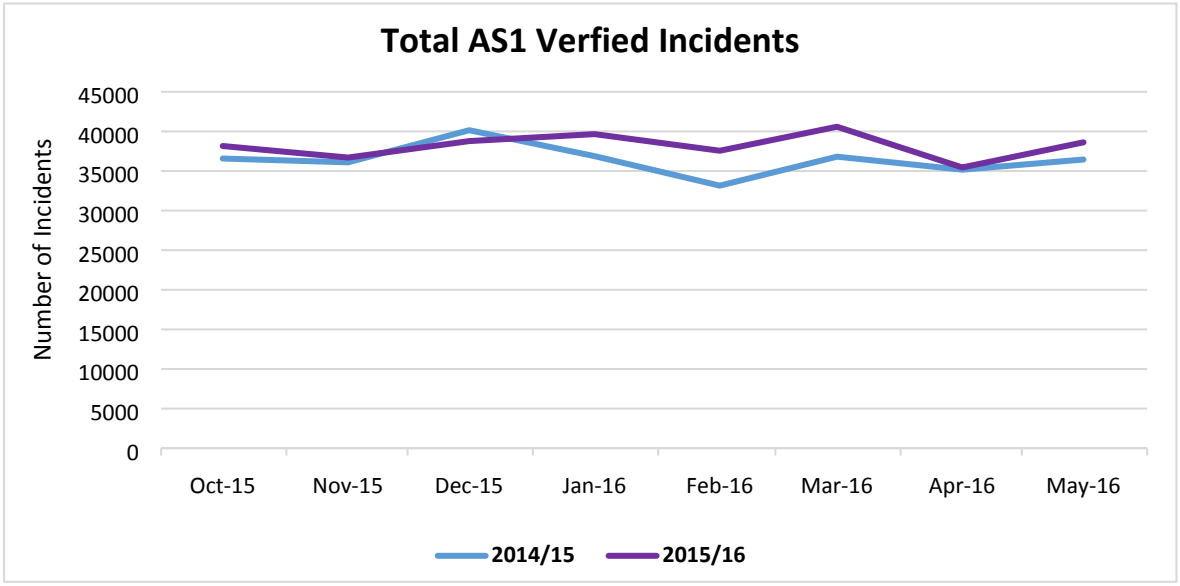
17. In developing a Winter Plan for 2016/17, the experience of winter 2015/16 has been reviewed in detail, looking at four determinants of patient flow and performance, namely:

- prevention;
- "hear and treat";
- patients treated at scene or referred to more appropriate healthcare providers and
- maintaining response capacity during the winter period, e.g. actual hours, handover delays.

18. In reviewing the 2015/16 winter period, a number of issues stood out:

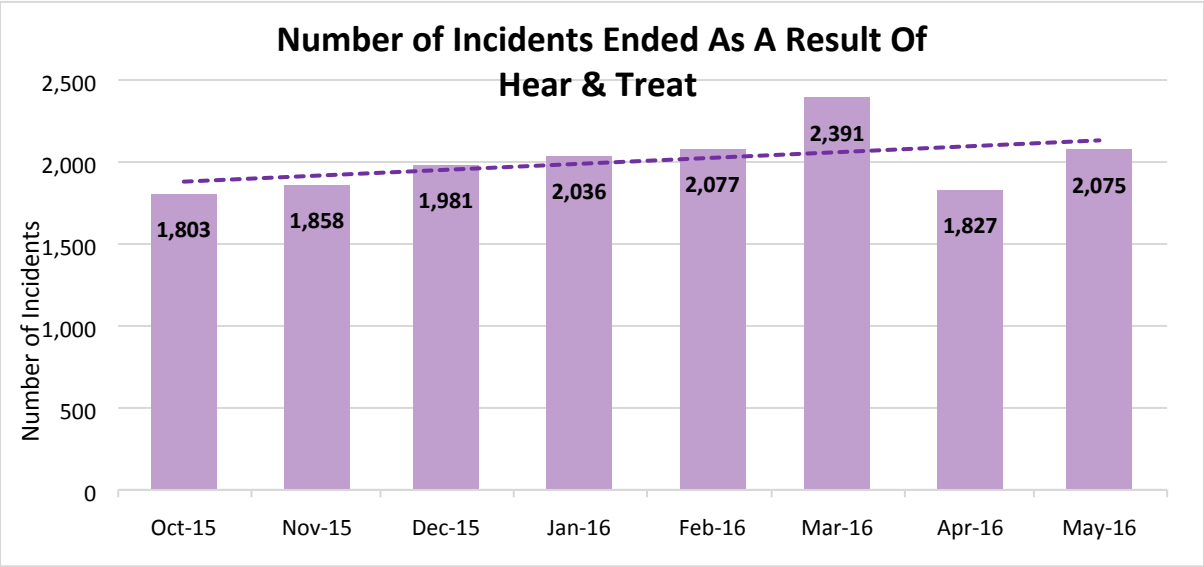
- Demand continued to increase at a rate of 4.89% year-on-year. An increase of approximately 4% is the norm across ambulance services, both in the UK and worldwide and may reflect a variety of factors: 24/7 culture, ageing populations with increasing clinical acuity, access to primary care. Whatever the cause, it is reasonable to assume that this increase in demand will continue through the 2016/17 winter period.

Figure 2



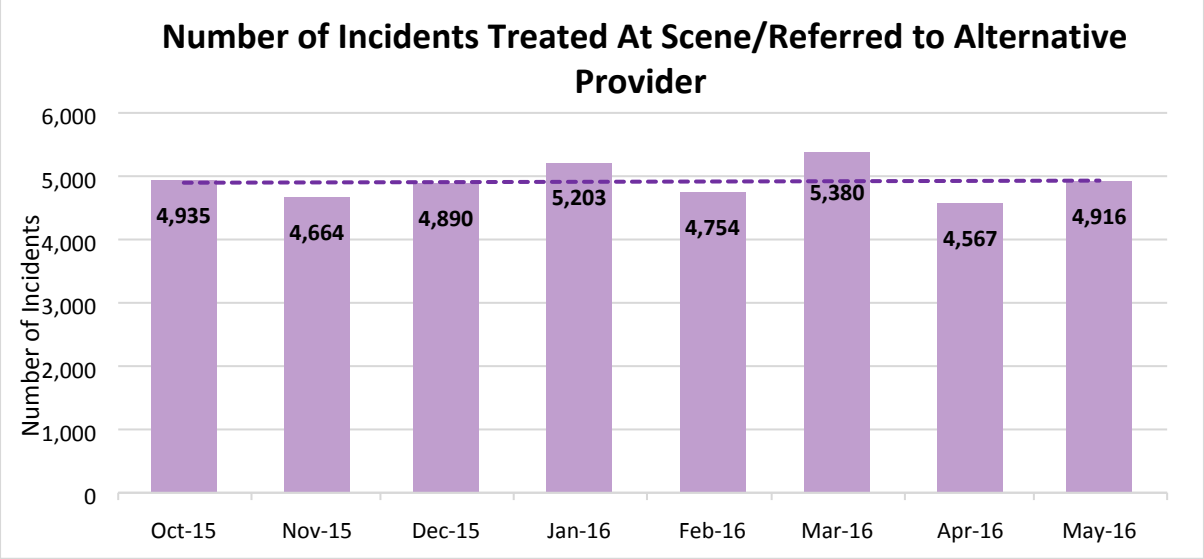
- Incidents ended as a result of "hear and treat" via the Welsh Ambulance Service's Clinical Desk showed an improving trend

Figure 3



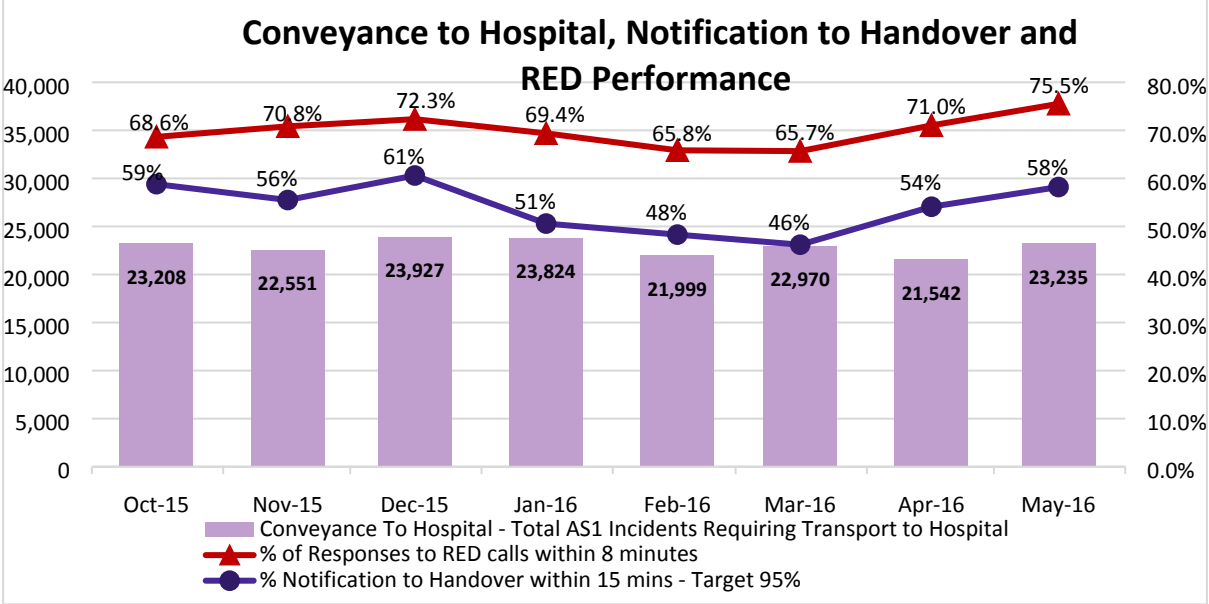
- incidents treated at scene/referred to alternative healthcare providers showed no discernible improvement

Figure 4



- significantly, while conveyance numbers into hospital peaked in December 2015, with levels before and after Christmas not significantly different, handover delays and, therefore, ambulance hours lost to them, were significantly higher in the new year, with a drop in RED performance (calls identified as life-threatening) and AMBER patients having to wait longer.

Figure 5



19. Of critical significance is the impact of protracted delays and system issues on patient experience and outcome. During the winter period of 2015/16, there was a marked increase in the number of Serious Adverse Incidents reported to Welsh Government, with 12 SAIs reported in February 2016 alone attributed to handover delays as a contributory factor.

20. What is less well recognised is the risk posed to patients in the community who need intervention from the Welsh Ambulance Service but for whom no resource is available because of ambulances delayed outside Emergency Units.

21. While the number of patients adversely affected in terms of outcome is less easy to quantify (SAI notifications provide one mechanism), there is always the clear and present risk that a patient who is the subject of a RED call in particular will come to significant harm if there are insufficient available ambulance resources. There is a direct correlation between handover delays, the availability of emergency ambulances and risk to patients, therefore.

22. In addition, the impact on staff morale and wellbeing is also adversely affected by such system problems, which in turn can have a detrimental impact on sickness levels within the Welsh Ambulance Service, compounding an already difficult problem.

23. It is with all these factors and evidence in mind that the Welsh Ambulance Service has approached its planning for winter 2016/17.

Winter Plan 2016/17

24. The key tenet of the Welsh Ambulance Service's Winter Plan 2016/17 is to ensure the safe delivery of care to patients. This has meant looking at more innovative measures than in previous years to ensure that high standards of care and availability of emergency ambulances can be maintained.

25. It has also meant ensuring that planning is integrated with that of health boards at a local level to ensure the system works in a cohesive and effective way.

26. The Plan has been modelled using the Five Step Ambulance Care Pathway and a flavour of some of the proposed actions contained therein is detailed below.

Step 1 – Help Me Choose

27. There will be an increased focus on public and patient engagement through NHSDW/111 and the Trust's Communications and Engagement Teams.

28. Planned rosters will reflect winter demand patterns and the use of bank staff will also be planned. There will be reduced levels of annual leave over the festive period and managers will undertake calls for 20% of their time.

29. The work which has been undertaken successfully on managing frequent callers more effectively will be extended to focus on locations like nursing homes and hostels which generate a high volume of calls.

30. Recognising the volume of incidents which relate to non-injury fallers, there will be focused used of Community First Responders (volunteers) to respond to these calls, thus freeing up emergency ambulance resources.

Step 2 – Answer My Call

31. The Welsh Ambulance Service has developed a service change initiative for Enhanced Hear and Treat, which would see the recruitment of an additional 12 whole time equivalent members of staff to support the Trust's clinical desk. This development has been supported by the Emergency Ambulance Services Committee (EASC) via its Quality Assurance Improvement Panel (QAIP) but funding is still awaited at the time of writing.

32. As an interim measure, pending confirmation of funding, the Welsh Ambulance Service has committed to resourcing four members of staff at its Clinical Control Centre in Llanfairfechan in North Wales to provide Clinical Desk cover and support calls for clinical assistance received from the police force.

33. An increase in Hear and Treat rates does not feed directly through into reduced conveyance to hospitals, as a patient may still be conveyed by private motor vehicle or taxi; however, it does mean fewer ambulances are deployed to scene and fewer patients are conveyed to hospital in ambulances, which means there is increased capacity to respond.

34. The Trust has also recently reviewed its escalation arrangements and agreed a Combined Escalation Toolkit. The toolkit includes a Resource Escalation Action Plan (REAP) which includes trigger points split into levels with pre-planned actions for each level of escalation.

35. The Clinical Contact Centres (CCC) have a CCC Demand Management Plan, with specific planned actions to support each stage of the REAP including a Logistics Desk to be deployed during Winter pressures, using the triggers and actions within REAP and Local Escalation Action Plans (LEAPs) to escalate and manage delayed resources, with a particular focus on handover delays. These plans include the use of clinical staff to support the Clinical Desk and the use of support function administrative staff to support the CCCs.

Step 3 – Come to See Me

36. The main focus in this step is on the targeted use of WAST's resources to boost capacity to respond through the winter months, for example:

    - the Trust is planning to recruit 162 front line staff (including Non-Emergency Patient Transport Service staff) during the period October 2016 to May 2017.

    - the Trust has introduced a new process of proactively managing and tracking use of private ambulance providers and St John. This has resulted in a reduced spend on these during the first half of the year, with a profile of planned spend developed to cover the winter period where planned increase is accounted for within the current financial plan.

    - a more pro-active and pre-planned use of bank staff to match identified periods of high demand.

    - the Trust is also planning to pre-plan the use of Locality Managers, Medical Directorate managers and secondees into the winter rosters (one shift per week 01 November 2016 to 31 March 2017).

    - the pro-active and pre-planned management of Community First Responders (CFRs) to encourage them to take shifts during known demand peaks, for example, in the festive season. There has been investment in new mobile, handheld technology making it easier for CFRs to be alerted to, and respond to, appropriate calls in their community.

    - Three "community paramedic" trials are planned for the winter period in Powys, the Vale of Glamorgan and the Rhondda. Community Paramedics will operate in these geographical areas and will attend 999 calls, as well as working with primary care and Out-of-Hours services to undertake appropriate domiciliary visits.

Step 4 – Give Me Treatment

37. The focus of this step is on delivering treatment at scene and referral to alternative providers, much of which is reflected in the local plans developed on an LHB level, contingent on available care pathways, for example.

38. Each WAST LHB Winter Plan includes an action to maximise the use of existing pathways i.e. referral to alternative providers during the winter months, with Cardiff and Vale providing a good example of working closely with the Cardiff Mental Health Crisis Team on providing additional hours during periods of high demand.

39. Each WAST LHB Winter Plan also includes specific actions on pathways around diarrhoea and vomiting and flu, which the Welsh Ambulance Service is working on with LHBs to deliver.

Step 5 – Take Me to Hospital

40. The Welsh Ambulance Service's conveyance rates are largely in line with the average for UK ambulance services. In June 2016, 17,278 patients (69.8%) who called 999 were conveyed to hospital following a face-to-face assessment.

41. This notwithstanding, the Service recognises that identifying alternatives to conveyance and admission, where clinically appropriate, are important elements in managing demand.

42. The Trust has introduced Paramedic Pathfinder as a clinical decision support tool for paramedics, while work continues with health boards to develop alternative care pathways which avoid admission to busy Emergency Units. It is fair to say that the availability of such pathways across Wales is not uniform and models are varied, although national pathways are now in place for falls, resolved hypoglycaemia and resolved epilepsy.

43. The Welsh Ambulance Service's Director of Operations and Medical Director will be working with staff in advance of the winter 2016 period to communicate about safely managing risk, recognising that the Trust continues to develop the mentoring, clinical review and supervision mechanisms necessary to provide additional support and assurance for staff in their clinical decision-making.

44. For those patients who are conveyed to hospital, the management of handovers is critical, both for reasons of patient safety and quality of experience, as well as the availability of ambulance resources in the community.

45. The Welsh Ambulance Service is working closely with LHBs on the provision of Hospital Ambulance Liaison Officers (HALOs) by LHBs to support this important issue. WAST will provide training to support the implementation of the HALO model.

46. Another key action will be the regular monitoring of Welsh Circular /2016/029 NHS Wales Hospital Handover Guidance v2, with appropriate escalation to NHS Wales/Welsh Government when required.

47. The WAST National Winter Plan also includes the targeted use of Pre-triage Assessment Vehicles (PtAV) outside major hospitals, during high periods of escalation. This element of the plan will be progressed through further discussion with a range of stakeholders, as well as being subject to a full risk assessment.

Enabling Actions

48. The WAST National Winter Plan (and supporting WAST LHB Operational Plans) are SMART, i.e. the actions contained therein are specific, measurable, achievable, realistic and time-bound, with the template designed to enable active performance management of the agreed actions.

49. The Plan also includes a lessons learnt element and evaluation of the effectiveness of this approach to winter planning to help develop and embed this key process in the future.

50. Other actions in the national plan include the boosting of capacity to respond to concerns during busy periods and seasonal flu campaigning, among others.

Welsh Ambulance Service Winter Plans at LHB Level

51. The Welsh Ambulance Service organises its teams around Local Health Board boundaries. Each area is led by a Head of Operations who works closely with LHB colleagues throughout the year.

52. In terms of winter planning, local teams have been collaborating with health boards on local plans, making sure that the plans of individual organisations "chime" and have synergy, to ensure the system works together to deliver improvements for patients.

53. Examples of good practice in these plans include:

    - Fixed site alcohol treatment centres (ATCs) and the use of Non-Emergency Patient Transport (NEPTS) ambulances to provide additional mobile capacity and transport for inebriated patients during identified high demand periods;

    - Rapid handover Paramedic Pathfinder Framework to be implemented in Ysbyty Gwynedd and Ysbyty Glan Clywd emergency departments;

    - Targeted use of a six person cycle response team in Cardiff City Centre and Cardiff Bay (and other centres) during identified periods of high demand, including Christmas shopping period;

    - Pre-period liaison and forward planning with Swansea City Centre Rangers who act as city centre CFRs to match identified periods of high demand;

    - Additional recruitment of Emergency Medical Technician/paramedic staff for deployment in 2016

    - Accelerating the use of Armed Forces Medics as bank workers for WAST by undertaking a gap analysis for training needs and other army staff to respond as CFRs from their Brecon base.

54. Every plan includes a focus on maximising unit hours production on the agreed roster through forward planning of annual leave and time off in lieu (TOIL), the active management of sickness absence and support to self-roster.

Christmas and New Year Tactical Plan

55. Christmas and New Year present a variety of challenges to the Trust, with particular spikes in demand caused by the festive calendar, which is compounded by trying to maintain actual hours during a period when staff also wish to take leave.

56. Work is currently underway on a tactical plan for the period 23 December 2016 to 04 January 2017 which will assess the alignment between predicted demand and estimated actual hours.

Predicted Performance

57. Given the number of variables involved, predicting performance is complex. At this stage, the Trust's view is that it can achieve the 65% RED pan-Wales target throughout the period of its plan; however, significant lost hours as a result of handover delays will manifest itself on AMBER performance levels. The Trust's current focus is on working with experts on a Demand and Capacity Review, which will test the impact of these variables on performance.

Financial, Staff and Resourcing Assumptions

58. There are a number of financial and resourcing assumptions which underpin the Winter Plan. The need to secure the funding for initiatives such as the additional Hear and Treat capacity, well as support from health boards for the HALO concept, remains a priority.

59. Other aspects of investment in the plan will need to be supported from within the existing resource envelope.

60. The support of our staff and their representatives will be fundamental to the success of the plan and the plan has been developed in partnership with trade unions to ensure that this is the case. As further iterations and developments are identified, these elements will also be tested with trade union colleagues.

Resilience of the Wider Unscheduled Care System

61. There can be no doubt that the resilience of the unscheduled care system is something which requires constant vigilance and innovative approaches to render it sustainable in the medium to long term.

62. However, it would be wrong to assume that the answer to sustainability lies exclusively in further investment in the NHS. Many of the issues with which the unscheduled care system grapples, throughout the year, are societal and lie in the need to recognise the importance of developing social and domiciliary care, working closely with local government, the third sector and private sector providers, as well as in the need to educate the wider population on both responsible use of the unscheduled care system and on adopting healthier lifestyles, to reduce future demand on the NHS more broadly.

63. It is recognised that much work is underway across the health and social care system on all these issues, and that the Well-being of Future Generations Act, and the creation of public service boards, provide helpful vehicles for progressing these important agenda.

64. The role of the public in playing their part cannot be overstated and it is important that the sustainability of the NHS is seen as a collective and social responsibility, rather than one that lies exclusively with NHS organisations and/or government to resolve.

65. Without doubt, further development of both primary and community services will be important in supporting patients to be cared for safely at home, reducing the need for ambulance conveyance to hospital and subsequent admission. The Welsh Ambulance Service is actively working with primary care clusters to develop new models of care, based on the community paramedic model, to support this agenda.

66. On a positive note, there is more integrated planning taking place across organisations and sectors than ever before, which gives the system the best chance it is had in some time to develop long term, sustainable solutions to the challenges it faces. That is not to say that problems are easily or rapidly resolved, but there is a collective recognition that the situation that has pertained for a number of years cannot do so in the future.

Closing Observations

67. From a Welsh Ambulance Service perspective, there is a clear need for the organisation to manage its own resources and people effectively over the winter period, and this will be a matter of great focus for the Trust.

68. Similarly, it is important that LHB plans "hold up" and that there is positive and regular dialogue and communication between partner organisations to identify potential pressure points as early as possible and to find mutually helpful solutions.

69. Finally, it is important that the wider public recognises the part it has to play in reducing pressure on the ambulance service, and the unscheduled care system as a whole, by recognising that there is a difference between "unexpected" and "emergency" and that misuse of the system puts the lives of others in danger.

70. It is the role of government, the NHS, the third sector and all those involved in civil society to help inform and educate the public about their responsibilities, as it is wrong to "blame" patients for using a system which, for many, has become complex to navigate and confusing.

71. The advent of the 111 pathfinder project in the Abertawe Bro Morgannwg University Health Board area during the late autumn of 2016 provides an excellent opportunity to simplify the system for local residents and will be an important step in helping the public identify the right service to meet their needs, building on the excellent work undertaken by NHS Direct Wales.

72. The fact that the Welsh Ambulance Service is hosting the 111 service means there is positive synergy with the organisation's preventive and advisory role, as well as its emergency and non-urgent response models.

73. The 2016/17 winter period will be something of a test bed for many of these new approaches, and it will be important to evaluate their success in order to establish them as intrinsic to future planning.

Ends/EVH/Sept16

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WP 15

Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016

Inquiry into winter preparedness 2016/17

Ymateb gan: Coleg Brenhinol Meddygaeth Frys

Response from: Royal College of Emergency Medicine

Welsh Assembly Health Social Care and Sport Committee

Inquiry into Winter Preparedness 2016/17

12 September 2016

Written evidence submitted on behalf of the RCEM Wales

RCEM Wales is the single authoritative body for Emergency Medicine in the Wales. RCEM Wales works to ensure high quality care by setting and monitoring standards of care, and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

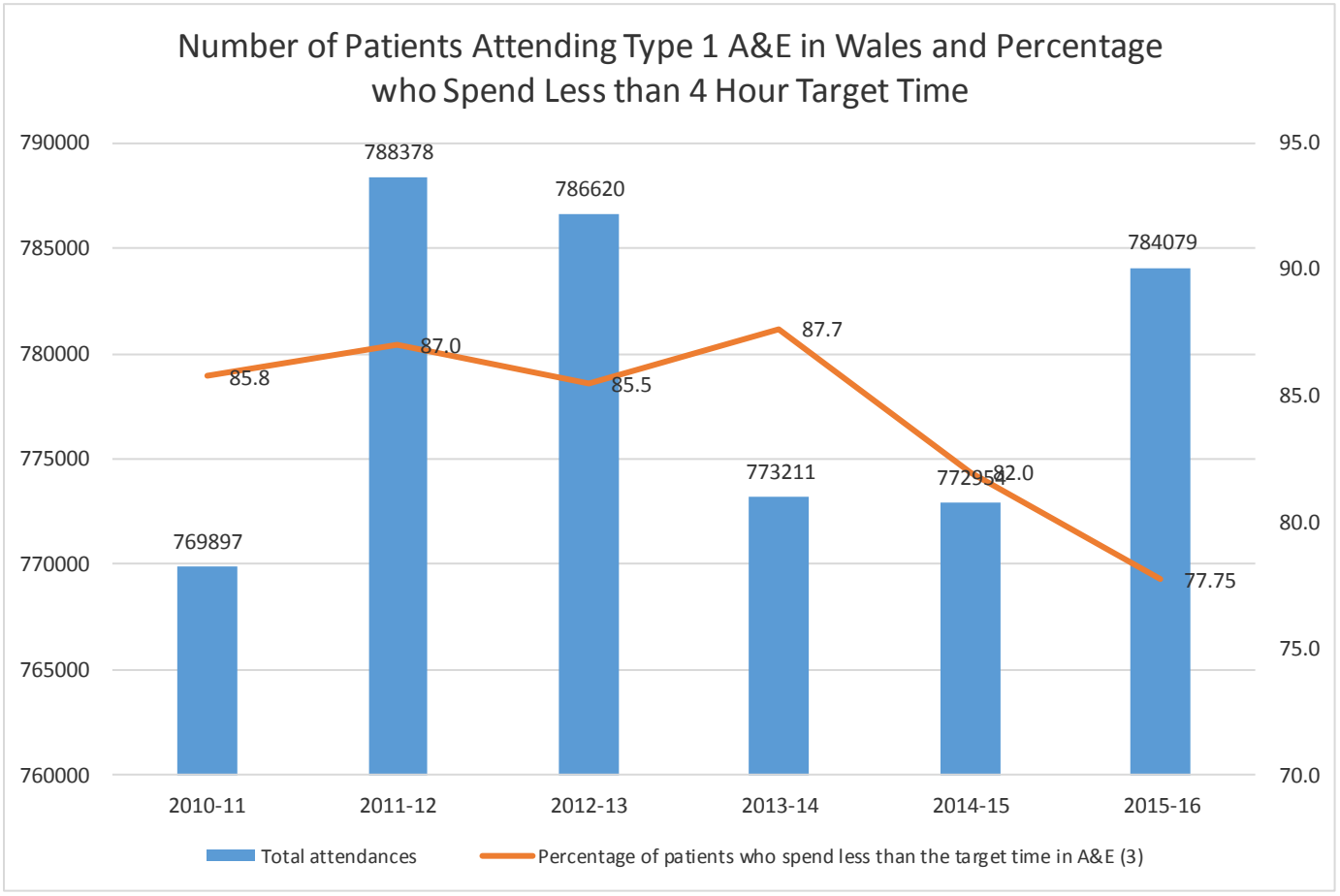
Question: Is the Welsh NHS equipped to deal with the pressures of unscheduled care services during the coming winter?

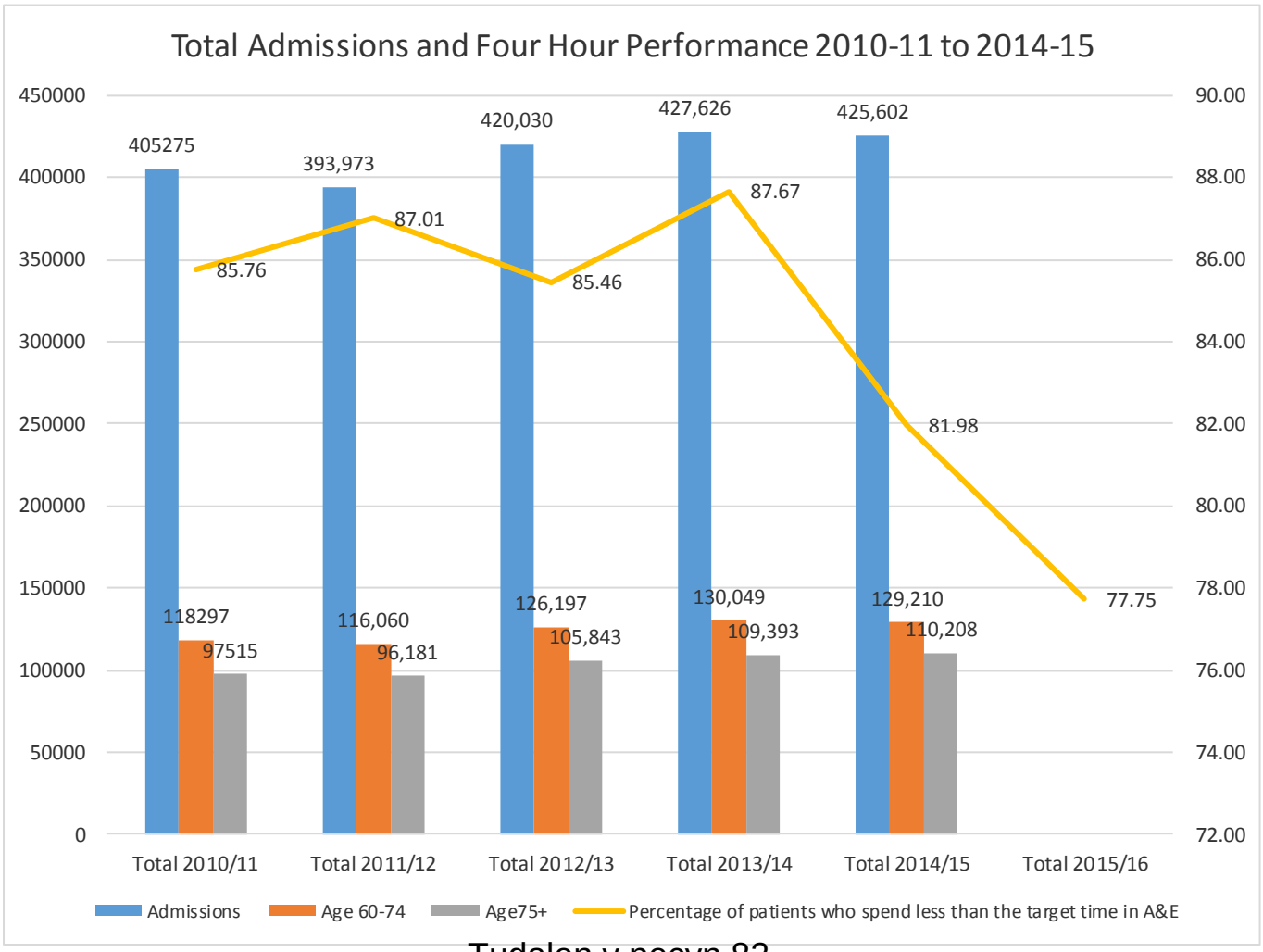
1. The NHS in Wales faces a significant challenge to meet the health needs of an aging population with increasingly complex needs. The number of people over 65 years of age is predicted to grow by 292,000 by 2039. This is an increase of 44%.[1] Moreover, compared to 2011 there are already an additional 86,634 people aged over 65 alive today.[2]

2. While these changes are significant when considered on their own, they are compounded that elderly populations changing attitude to their own health. Analysis of both Disability Free Life Expectancy[3] and Healthy Life Expectancy[4] data released by the Office for National Statistics has shown that while life expectancies are increasing those same people's assessments of their remaining life expectancy in good health are decreasing.

3. This in turn is reflected in an increasing propensity to access health services. As the King's Fund has recently shown, demand from this age group has grown and continues to grow considerably beyond mere demographic change, and has resulted in rising numbers of GP appointments both in person and over the phone.[5]

[1] Welsh Government National Population Projections
[2] Stats Wales National Level Population Estimates by Year
[3] ONS Changes in Disability Free Life Expectancy
[4] ONS Health Life Expectancy
[5] King's Fund Understanding Pressures in General Practice The data referred to here is from England but is taken as broadly indicative.

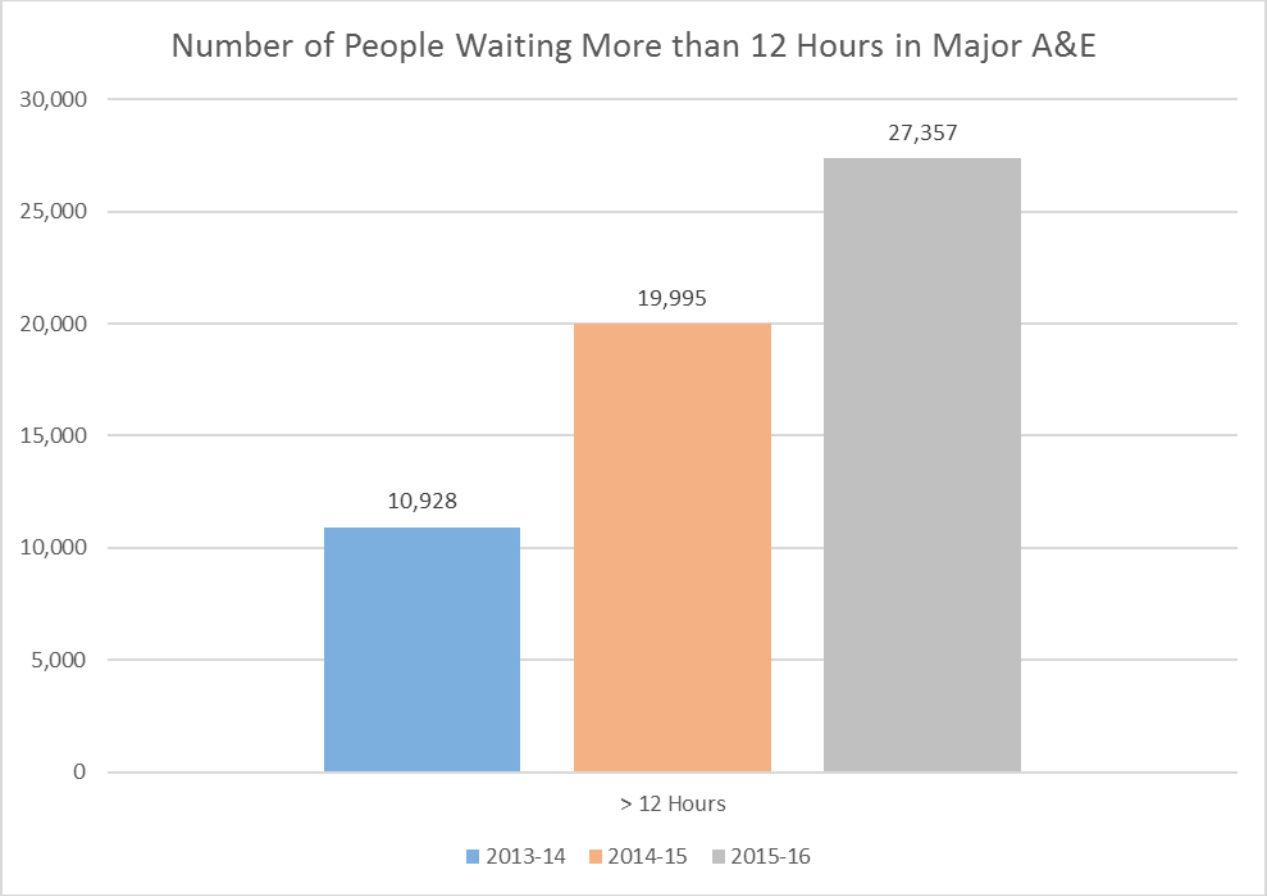

Number of Patients Attending Type 1 A&E in Wales and Percentage who Spend Less than 4 Hour Target Time
790000
785000
780000
775000
770000
765000
760000
95.0
90.0
85.0
80.0
75.0
70.0
769897
788378
786620
773211
772954
784079
85.8
87.0
85.5
87.7
82.0
77.75
2010-11
2011-12
2012-13
2013-14
2014-15
2015-16
Total attendances
Percentage of patients who spend less than the target time in A&E (3)


Total Admissions and Four Hour Performance 2010-11 to 2014-15
450000
400000
350000
300000
250000
200000
150000
100000
50000
0
90.00
88.00
86.00
84.00
82.00
80.00
78.00
76.00
74.00
72.00
405275
393,973
420,030
427,626
425,602
85.76
87.01
85.46
87.67
81.98
77.75
118297
97515
116,060
96,181
126,197
105,843
130,049
109,393
129,210
110,208
Total 2010/11
Total 2011/12
Total 2012/13
Total 2013/14
Total 2014/15
Total 2015/16
Admissions
Age 60-74
Age75+
Percentage of patients who spend less than the target time in A&E

4. As the Danish physicist Neils Bohr once remarked, it is difficult to make predictions especially about the future. As since 2010 the picture in Welsh Emergency Medicine has not been entirely negative. The percentage of patients spending less than the 4 hour target time in major A&Es reached a peak in 2013 of 87.7% although since then performance has been in decline.[6]

5. Moreover the data that has so far been published by the NHS Wales Informatics Service indicates that this decline has continued into 2016/17.[7] Four hour performance has so far been worse in each month of 2016/17 compared with the same period in the previous year while attendances have risen by 1.6%.

6. The data for patients waiting more than 12 hours is equally concerning.[8] Since 2013-14 the number of patients subject to these delays in major A&E centres has grown from 10,928 to 27,357 in 2015-16. This is an increase of 150.33%.



7. So in order to answer this question we need to ask whether there has been any material changes in the facts on the ground for the NHS in Wales since 2013 which would suggest that the situation was about to improve, rather than continue to deteriorate.

[6] Stats Wales Performance against 4 hour waiting times target by major hospital
[7] NHS Wales Informatics Service Monthly Accident and Emergency Report - After April 2013
[8] Stats Wales Performance againt 12 hour waiting times

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NHS Funding

8. The figures given below are from Stats Wales and detail NHS expenditure per head.[9]

Category	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
Total NHS Funding (£)	1721.31	1755.77	1759.10	1765.57	1803.82	1876.47
Social care needs (£)	15.78	14.45	13.99	14.69	15.93	16.18

9. Although these numbers are not adjusted for inflation, there are part of this picture that are quite positive. Social care funding has increased by 9.2% since 2013 – something which cannot be said in England – and overall NHS funding has increased by 5.9% or just under 2% per year. This again compares favourably with the situation in England where the rate of increase has been around 0.7% since 2010.[10]

10. However, considered more closely a different picture emerges. The Nuffield Trust after adjusting for the fact that older populations have higher health needs and associated costs, Wales is now the lowest spending UK nation on its Health Service.[11] Moreover, since its foundation in 1948 the NHS has spending increases of around 3.7% per annum in real terms.[12] This suggests that while recent spending increases are welcome, increases of around 2% before accounting for inflation are unlikely to arrest declines in performance.

[9] Stats Wales NHS expenditure per head by budget category and year
[10] The Health Foundation Hospital finances and productivity: In critical condition?
[11] Nuffield Trust NHS In Numbers & Health Spending Across UK Nations
[12] The Health Foundation Hospital finances and productivity: In critical condition?

A&E Staffing

11. The figures given below are from Stats Wales and give details about changes to the emergency medicine workforce since 2010.[13]

Staff Category	2010	2011	2012	2013	2014	2015	% Change since 2010	% Change since 2013
	260.19	274.29	263.42	287.28	286.03	288.08	9.68	0.28
Consultant	49.00	53.50	54.60	61.20	66.80	63.20	22.47	3.16
Specialty Doctor	28.30	36.45	43.20	39.30	45.60	47.85	40.86	17.87
Staff Grade	3.10	2.10	1.00	1.00	1.00	1.00	-210.00	0.00
Associate Specialist	20.72	17.52	17.50	15.86	12.50	11.50	-80.18	-37.94
Specialist Registrar	76.20	86.60	67.00	85.80	73.01	93.71	18.68	8.44
Senior House Officer	10.00	13.00	13.00	19.00	16.00	5.00	-100.00	-280.00
Foundation House Officer 2	55.00	51.00	51.00	52.00	58.00	50.00	-10.00	-4.00
Foundation House Officer 1	14.00	12.00	15.00	12.00	12.00	14.00	0.00	14.29

Year	Total attendances	Percentage of patients who spend less than the target time in A&E	Number of Consultants	Consultant Per Attendance
2010-11	769897	85.76	53.50	14390.60
2011-12	788378	87.01	54.60	14439.16
2012-13	786620	85.46	61.20	12853.27
2013-14	773211	87.67	66.80	11575.01
2014-15	772954	81.98	63.20	12230.28

12. Questions of staffing are complex, but the point to notice is that although there were considerable increases in the A&E workforce between 2010 and 2013 – when as we have seen A&E actually improved – since 2013 that progress has stalled.

13. Moreover from 2013-14 the number of consultants per attendance has deteriorated. This has gone from one to every 11,575 attendance in 2013-14 to one to every 12,230 in 2014-15. This echoes our wider concerns about on-going difficulty recruiting staff to support the speciality in Wales. These difficulties are aggravated by the placement of major trauma centres throughout the principality and the continued attractions of more lucrative work in other countries such as Australia.

14. Between 2013 and 2015 the workforce expanded by no more than 0.28%. One could argue that this is a reflection of the fact that from 2013 to 2015 attendances at major A&E's were broadly stable. However – as we shall see further below – this does not account the increasingly elderly profile of the Welsh population. This means that the casemix in Welsh A&E is becoming more complex, and more demanding, and requires a workforce of sufficient size and with the necessary number of senior decision makers to treat them effectively.

15. Unfortunately, more current workforce data is not yet available centrally. However, between 2014-15 and 2015-16 attendances at major A&Es in Wales increased by 11,125 or 1.41%.[14] Furthermore, the data so far published for 2016/17 shows that up to this point

[13] Stats Wales Medical and dental staff by grade and year

[14] Stats Wales Performance against 4 hour waiting times target by Major Hospital

attendances have been higher than last year.[15] Either for financial reasons or otherwise, if decisions about the recruitment and retention of A&E do not accurately reflect the nature of demand then performance cannot reasonably be expected to improve.

[15] NHS Wales Informatics Service Monthly Accident and Emergency Publication - After April 2013

Bed Availability and Occupancy

16. The figures given below are from Stats Wales and show bed availability and bed occupancy in the Welsh NHS.[16]

Year	Average daily available beds	Average daily occupied beds	Percentage occupancy
2010-11	12149.33	10294.16	84.73
2011-12	11809.69	10062.42	85.21
2012-13	11497.02	9923.24	86.31
2013-14	11241.49	9653.17	85.87
2014-15	11061.52	9588.74	86.69

17. What these figures show is that there has been a 9.83% decrease in bed availability since 2010 and a 3.93% decrease since 2013. The number of daily occupied beds has decreased by slightly less, at 7.38% and 3.49% respectively.

18. While this does something to indicate that the available bed stock is being used more efficiently, gains has nonetheless failed to prevent an increase in bed occupancy to levels greater than 2013.

19. As was the case for staffing data, more contemporaneous bed availability data is not yet available. Although it is not possible to be certain, it seems highly likely that the number of available beds has continued to decline into 2016/17 and that bed occupancy rates have continued to increase. This is because this would represent the continuation of a trend seen in Wales and the wider UK NHS for at least the last 20 years.[17]

20. This being the case, we have evidence to suggest that there are higher levels of demand, whilst staffing levels that have stagnated, and there continuing declines in hospital bed capacity. Or to put it in more simple terms, the system has more patients to deal with and less facility with which to do so in a timely fashion. In these circumstances it is unrealistic to expect that the percentage of patients is going to get better.

Aging Population and Delayed Transfers

21. The figures given below are from Stats Wales collated from the Office of National Statistics.[18]

Year	Population
Mid 2013 All ages	3082412
Mid 2013 Aged 65 and over	600630
Mid 2014 All ages	3092036
Mid 2014 Aged 65 and over	614747
Mid 2015 All ages	3099086
Mid 2015 Aged 65 and over	624773

22. What these figures show is that the population of Wales – which already had considerable needs centred around an aging population – has continued to become more elderly. From mid 2013 to mid 2015 the population of those over 65 year of age increased by 3.86%. In the same time period, the populations as a whole increased by no more than 0.54%.

[16] Stats Wales NHS Bed Summary Data By Year
[17] Stats Wales NHS Bed Summary Data By Year
[18] Stats Wales National Level Population Estimates by Year

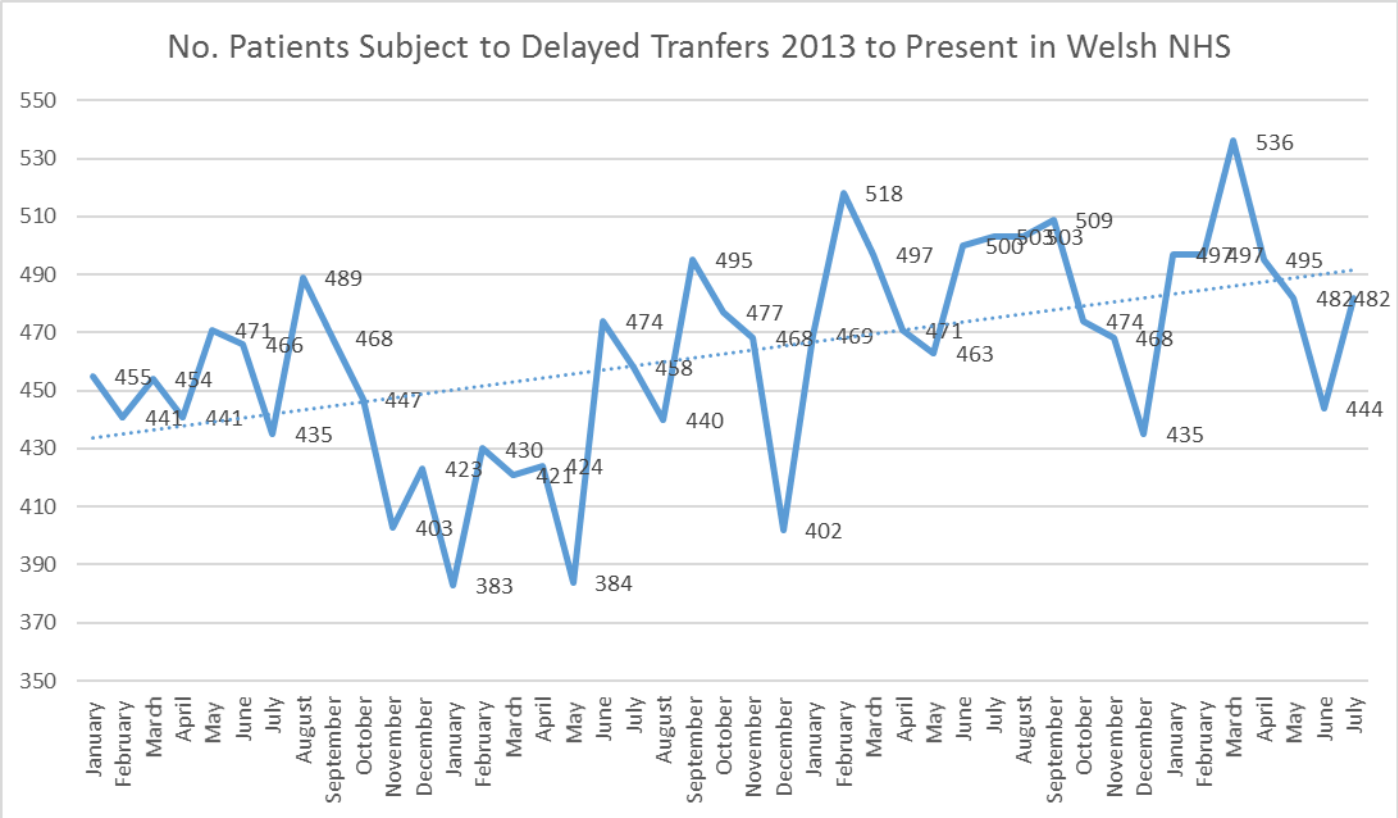
23. It is within this context that the Royal College of Emergency Medicine takes the view that ED have struggle in the face of rising demand, not because success is impossible, but because we continue to systematically under-resource emergency departments in the forlorn hope that the next redirection strategy will succeed where all others have demonstrably failed.

24. Instead A&E should be resourced to practice an advanced model of care where the focus is on safe and effective assessment, treatment and onward care. While it is essential to manage demand on A&Es, this should not detract from building capacity to deal with the demand faced, rather than the demand that is hoped-for.

25. If this rate of growth has continued, then by mid 2016 we can expect there to have been 632,821. This would represent an increase of 32,190 since 2013. If these figures are reflected in the age and volumes of patients seen in Welsh A&E departments, then the casemix and time and resources necessary to change them can be expected to have increased. Since – as we have seen – the resources necessary to do so have not been supplied then the situation can be expected to become more adverse.

26. One aspect of an aging population is that more of those patients who enter hospital are more likely to need some kind of care package in place before they can leave. When this cannot be supplied in a timely fashion then those patients are subject to Delayed Transfers of Care.

27. The chart given below shows the numbers of patients subject to Delayed Transfers of Care in Welsh hospitals since 2013.[19]



28. What this shows is from at least 2014 the trend is clearly upwards and the existing data for 2016 suggests that this will continue. For example the mean average number of patients delayed per month in 2015 was 484. The average number of delays per month thus far is 490. This would result in 5885 delays for the whole of 2016 rather than 5810 for 2015.

[19] Stats Wales Delayed Transfers of Care by Organisation

29. This is important because the more patients are subject to delayed transfers of care – and the data does not specific how long each of these delays lasted – the fewer beds are available within hospitals to treat patients who arrive at A&E requiring treatment. Logically if there are to be more of these delays then timely performance becomes harder to maintain.

Conclusions and Recommendations

30. The situation laid out above is not a new phenomenon. Difficulties treating patients in a timely fashion because of a lack of available beds, has been a feature of the Welsh and other UK health systems for some time.

31. This is referred to as Exit Block and can be clearly seen in the available statistics. From 2010-11 to 2014-15 the number of people waiting more than four hours in A&E has increased by 29,080 or 26.65%. During the same period the number of people waiting more than eight hours in A&E has increased by 20,785 or 79.72%.[20]

32. Exit block is proven to be associated with both significant morbidity and mortality. The latter has been estimated at 3000 patients per year in the UK.[21]

33. Paradoxically exit block is associated with a greater number of patients admitted to 'any bed' rather than an 'appropriate bed'. In turn this leads to greater lengths of stay, reducing the available bed stock and perniciously increasing the frequency and severity of exit block.

34. Faced with these trends, and the demonstrable inability of redirection or re-education strategies to alleviate these pressures, it is more logical to respond positively to the needs and demands of patients rather than seek to resist them. It is our opinion that the way to do this is to put in place the co-location of key out of hours urgent care services.

35. This can be achieved both physically and through the greater use of technology such as virtual consultations. This would improve the quality of care for patients would improve the sustainability of emergency medicine in the Welsh NHS by decongesting emergency departments.

36. Given the prevailing situation in the NHS in Wales it would seem unlikely at this point that performance against the four hour target will improve. For that to be the case Welsh A&E departments – and the wider NHS – would need to be adequately staffed and resourced to meet the demands placed upon it. At present it is not.

37. There are too few senior medical staff in A&E departments to deliver effective and efficient care. The attrition rate from UK training programmes has wasted our most valuable resource. We must ensure the work environment and shift patterns promote rather than discourage staff retention.

38. Planning must especially address the need to cope with rising numbers of attendances by the frail elderly – with complex interactions between health and social care and long term co-morbidities.

39. Provision of co-located services within an A&E hub to decongest emergency departments will deliver a successful strategy that is patient centred, affordable, efficient and effective.

RCEM Wales has been campaigning for some time for the reform of emergency medicine around the elements of our step campaign. If acted upon this would ensure that A&E were properly

[20] Stats Wales Performance against 4 hour waiting times target by major hospital
[21] Royal College of Emergency Medicine Exit Block in Emergency Departments 6 Months Review

staffed and resourced and improve services for patients in need. Details of that campaign can be found here: https://portal.rcem.ac.uk/live/RCEM/Shop/Policy/Campaigns/RCEM/Quality-Policy/Policy/Campaigns.aspx

WP 16
Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016
Inquiry into winter preparedness 2016/17
Ymateb gan: Coleg Brenhinol y Seicatryddion
Response from: Royal College of Psychiatrists

Royal College of Psychiatrists in Wales
Consultation Response

DATE: **12 September 2016**

RESPONSE OF: **THE ROYAL COLLEGE OF PSYCHIATRISTS in WALES**

RESPONSE TO: **The Health, Social Care and Sport Committee Winter Preparedness 2016-17**

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

RCPsych in Wales is an arm of the Central College, representing over 550 Consultant and Trainee Psychiatrists working in Wales.

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Royal College of Psychiatrists in Wales
Consultation Response

Health, Social Care & Sport Committee,
National Assembly for Wales,
Cardiff,
CF99 1NA

9 September 2016

The Health, Social Care and Sport Committee Winter Preparedness 2016-17

1. Thank you for giving us the opportunity to respond to your inquiry into Winter Preparedness 2016-17. Local Health Boards develop annual winter pressure plans to avoid major incidents during this time of year yet services continue to struggle for a number of reasons. It's unlikely that we can eradicate these problems but there are ways to prepare for the inevitable increase in admissions.

2. The LHB winter pressure plans are based on data held by the LHBs. The College does not hold or have access to this information. For this consultation, we offer our views based on anecdotal evidence and we highlight those areas specifically impacting on psychiatry.

Psychiatry and Emergency Care

3. A significant element of unscheduled care involves psychiatric provision. In approximately 5% of all emergency department attendances mental health issues are the presenting feature.[1] Up to 60% of inpatients and outpatients can experience poor mental health.[2] The most common conditions amongst inpatients are self-harm, depression, delirium, dementia, adjustment reactions and alcohol-related disorders.[3] Poor health outcomes and increased health care costs can be due to common co-morbid mental and physical health concerns.

4. Although studies have shown that the numbers of psychiatric admissions in A&E and inpatient wards and the prevalence of self-harm and suicide attempts and completions decreases prior to Christmas; this trend is reversed immediately after Christmas and should be cause for concern for psychiatric services.[4] It would be helpful to have data on this for Wales.

5. There is a large population of elderly patients being treated in hospitals. The average age of patients in acute hospitals in the UK is 80.[5] Over 40% of older people in acute hospitals in England have dementia, depression, or delirium.[6] About a quarter of all inpatients are thought to have dementia. These patients are at greater risk of dehydration and falls. They experience more delays when being

[1] Royal College of Psychiatrists (2013) *Liaison Psychiatry for Every Acute Hospital*, CR183. P10
[2] Ibid.
[3] Ibid. p.11
[4] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3257984/
[5] Cornwell, J. (2012) *The care of frail older people with complex needs: time for a revolution*. Kings Fund. p.2.
[6] Department of Health (2012) *Using the Commissioning for Quality and Innovation (CQUIN) Payment Framework: Guidance on New National Goals for 2012–13*. Department of Health.

discharged (twice as long than patients without dementia), which significantly adds to winter pressures.[7]

6. It is estimated that older people account for 80% of all hospital bed-days occupied by adult patients with co-morbid physical and mental health conditions. The most common psychiatric emergencies in the elderly are depression with suicidality, delirium, dementia with behavioural disturbance, substance abuse, elder abuse, conditions resulting from iatrogenic causes and stupor.[8]

7. Pressures on services (not just psychiatric) would be eased if:

    a. The NHS maximised the first point of contact; providing proper assessment of the person's needs as they present to primary, secondary or emergency care;

    b. there were sufficient beds or appropriate alternatives in the community;

    c. there were a full complementary of staff, including in social care, with appropriate training in dementia, delirium, mental illness including alcohol and substance misuse;

    d. there were better integration of services: between health and social care; primary, secondary and tertiary care; with pooled budgets, shared IT systems, and less paperwork. It can take days to assign a social worker to a patient, which lengthens hospital stays and causes delays in discharge.

Liaison Psychiatry

8. Liaison Psychiatry services provide psychiatric treatment to patients attending general hospitals, in out-patient clinics, emergency departments or in-patient wards. The London School of Economics and the Mental Health Network NHS Confederation published a joint report on the *Economic Evaluation of a Liaison Psychiatry Service*, which looked at the Rapid Assessment, Interface and Discharge (RAID) liaison psychiatric services model in City Hospital, Birmingham.[9] RAID was introduced in the hospital in 2009, and is said to have saved the hospital between £3.4 and £9.5 billion a year, primarily due to the reduced bed use amongst elderly patients. New liaison psychiatry services in Cwm Taf, ABMU and Aneurin Bevan are based on the RAID model. (Components of the RAID model in City Hospital Birmingham can be found at the end of our response.)

9. During the winter months, when there is a marked increase in the number of elderly people admitted to hospitals for common ailments associated with the cold season (flu, respiratory illness, falls etc.), liaison psychiatry services will ease winter pressures.

10. The Psychiatric Liaison Accreditation Network (PLAN) of the Royal College of Psychiatrists has set standards for liaison psychiatry service including Standard

[7] Alzheimer's Society (2013) *Making hospitals more dementia friendly*, London: Alzheimer's Society magazine.
[8] Nazir, Ejax (2015), *Emergencies in older persons psychiatry, Emergency Psychiatry*, RCPsych. P228
[9] Parsonage, M and Matt Fossey, Economic evaluation of a liaison psychiatry service, LSE and the Mental Health Network NHS Confederation, 201X? p.3

21 for people with mental health needs with assessment timelines.[10] Services in Wales are not accredited by PLAN. These services are also not meeting the standards set by PLAN. It is also important that the liaison psychiatry services should serve all age groups.[11]

11. Until recently, liaison psychiatry services were woefully underfunded in the UK but more so in Wales. In 2014, the NHS Delivery Unit (Wales) found that provision was at best patchy and at worst not available or not adequate to meet the needs of those presenting with challenging behaviour, in crisis, intoxicated, or suicidal.[12] The Unit was responding to calls that waiting times in emergency departments (ED) breached time targets largely due to problems accessing liaison psychiatry services.

12. The Welsh Government has provided additional investment to ensure that every District General Hospital has effective liaison psychiatry services and we believe that this should go some way to alleviating existing pressures in terms of identifying psychiatric need and managing patient flow. We understand that recruitment to these post has been successful, although LHBs are at various stages of rolling out the services. We also feel that LHB signing up to the PLAN[13] would enable further improvements to delivery, better data collection and increased learning through peer review.

Bed Closures and Delayed Discharge from Hospital

13. Over the years, there has been a general move to reduce the number of psychiatric hospital beds and wards and provide greater support for people requiring treatment for mental illness in the Community. There appears to be an understanding that that community care negates the need for admission beds, but this is not the case. We are still concerned that costs saved from psychiatric bed closures have not been transferred to community care.

14. We are still facing a crisis in community and care home provision for patients. This means that patients who are fit for discharge remain in hospital because there are no beds available in the community. When a patient is discharged, the responsibility of the patient shifts from the NHS to local authorities. This process is overly bureaucratic and time consuming. IT systems between and two are incompatible.

[10] RCPsych (2014) *Quality standards for liaison standards for liaison psychiatry services* http://www.rcpsych.ac.uk/pdf/Standards%204th%20edition%202014.pdf
[11] An evidence base for liaison psychiatry – Guidance (2014). Strategic Clinical Network for Mental Health, Dementia and Neurological Conditions South West.
[12] NHS Delivery Unit (2014) *National Review of Psychiatric Liaison Services Provided to Emergency Departments - Overarching Final Report*.
[13] http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/liaisonpsychiatry/plan.aspx

Community Care

15. It is crucial that we learn from best practice and develop new models of care proven to meet the specific needs of people needing psychiatric care. In Cardiff and the Vale Health Board, there has been a change to Mental Health Services of Older People (MHSOP) to address the increase in demand from a growing elderly population. The focus of the care is provided in the community to support service users to remain in their homes or community placements for as long as possible. Prior to 2012, there was no service available to meet the urgent mental health needs of older people or that operated outside of 9am to 5pm Monday through Friday. It was common for elderly patients in crisis to contact their local CMHTs, placing great strain on these services and disrupting proactive support for CMHT patients. This resulted in a climate of crisis support.

16. The community Response Enhancement Assessment and Crisis and Treatment (REACT) Serviceis a crisis intervention and home treatment service for older adults with both functional illnesses and dementias. Although REACT is not a liaison psychiatry service it has shown significant impact on unscheduled care through cost savings for its work in the community. This impact is through admission avoidance, facilitating discharge from inpatient dementia and functional wards and also the district general hospital wards. There is a need for joint working between liaison psychiatry across all ages and REACT. The service model was changed to ensure continuity of care by Band 6 and Band 7 Psychiatric nurses and Consultant assessment within 24-48 hours of referral. This has led to significant reduction in length of stay in some months from 21 days to 8 days.

17. Detailed economic analysis of the service was undertaken and the results will be presented in detail in due course. Initial findings showed that £1 invested had saved £2.14 for admission avoidance work alone. After the change in the service model with continuity of care and rapid Consultant assessment every £1 invested had saved £4.64.

Next Steps

18. The current problems are deep rooted and would require a cultural shift in order for any positive changes to be realised. In the ongoing reviews of the health and social care workforce in Wales, an additional focus can be on assessment and then implementation of unified training to enhance a collaborative patient-centred approach. The aim should be to initiate a plan to integrate services and share budgets and responsibilities with patient at the heart of it.

Professor Tayyeb Tahir

Chair of Liaison Psychiatry Faculty, RCPsych in Wales

Components of the RAID model in City Hospital, Birmingham

A comprehensive range of mental health specialities within one multi- disciplinary team, where all patients over the age of 16 can be assessed, treated, signposted or referred appropriately regardless of age, address, presenting complaint, time of presentation or severity	Available 24 hours a day, 7 days week, emphasising rapid response, with a target time of one hour within which to assess referred patients who present to A&E and 24 hours for seeing referred patients on the wards.
Meets the mental health needs of all adult patients in the hospital, including those who self-harm, have substance misuse issues or have mental health difficulties commonly associated with old age, including dementia	(At the time of the internal evaluation) the service ran a number of follow-up clinics for patients discharged from the hospital, including clinics for self-harm, substance misuse, psychological input and a general old age psychiatry clinic and an adjoined memory clinic.
Provides formal teaching and informal training on mental health difficulties to acute staff throughout the hospital	Emphasises diversion and discharge from A&E and on the facilitation of early but effective discharge from general admission wards

WP 17
Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016
Inquiry into winter preparedness 2016/17
Ymateb gan: Cymdeithas Llywodraeth Leol Cymru a Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol
Response from: Welsh Local Government Association and Association of Directors of Social Services

Inquiry into Winter Preparedness 2016/17

1. The Welsh Local Government Association (WLGA) represents the 22 local authorities in Wales, and the three national park authorities and three fire and rescue authorities are associate members.

2. It seeks to provide representation to local authorities within an emerging policy framework that satisfies the key priorities of our members and delivers a broad range of services that add value to Welsh Local Government and the communities they serve.

3. The Association of Directors of Social Services Cymru (ADSS Cymru) is the professional and strategic leadership organisation for social services in Wales and is composed of statutory Directors of Social Services, and the Heads of Service who support them in delivering social services responsibilities and accountabilities; a group of more than 80 social services leaders across the 22 local authorities in Wales.

4. Much like other parts of the UK, urgent and emergency care services in Wales have experienced periods of significant pressure and demand. There has been a sharp rise in the number of people seeking treatment and care at emergency departments and a peak in ambulance arrivals at hospitals throughout Wales. Over recent years the NHS across Wales has seen an increased number of people being admitted with a complex range of medical conditions and consequently greater degrees of frailty. Because of the nature of their conditions, these people take longer to assess, diagnose and treat and may have ended up staying in hospital longer for their treatment; they often need more support arrangements to be put in place to enable them to eventually be discharged.

5. Current plans to cope with higher demand over the winter period are aimed at cutting hospital admissions and discharging patients more quickly. Winter plans include:
   - Identifying how extra hospital beds can be made available to respond to any surge in demand
   - Using minor injury units and working with GPs and out-of-hours services to reduce hospital admissions

- Better support for people at home to help them be discharged from hospital as early as possible
- Better coverage by health services at weekends and evenings

6. A recent Together for Health paper, published by the Welsh Government, demonstrates the pressure being put on services for the critically ill. It has reported that critical care units have been over capacity at periods of high demand. In January 2015, bed occupancy was as high as 107% - significantly above the recommended levels of 65 - 70% set out by the Intensive Care Society. The report also notes that serious staff shortages means "the current workforce is beginning to experience added stresses and uncertainty". The report also warned of too many delays in discharging patients from critical care units, with two thirds (66%) of all critical care patients delayed for more than four hours, affecting almost 4,000 patients.

7. The report also warns that with an ageing population, "demand for critical care services will outstrip current supply levels" and recommends that more is done to make efficient use of critical bed capacity across Wales in order to best meet the demands on services.

8. The pressures on acute hospitals in winter come from many sources and are a symptom of wider issues in the local health and social care system, suggesting that a more sustainable response will be developed by looking at the whole system. In addition, we are now finding that problems that were usually confined to the winter months are now increasingly being experienced at other times of the year as well. Whilst there is a mixed picture across the Welsh authorities and regions there are a number of trends reported by local authorities in relation to unscheduled pressures. These include:
   - The fragility in domiciliary care and reablement services, exacerbated by volatility in demand and short-term problems, associated with sickness or leave at times of public holiday.
   - Responsiveness and complexity of service required are significant issues, with recruitment and retention said to be challenging, particularly, though not exclusively, in rural communities.
   - Capacity in traditional residential care has been relatively resilient, but many areas have reported a scarcity of specialist EMI and nursing care capacity (in part as a result of workforce issues and with a particular challenge with recruitment of nurses)
   - Pressures on the hospital system, in particular increased admissions and people presenting with higher levels of acuity

9. Delayed transfers of Care (DToC) are seen as the main reporting mechanism and are the benchmark used by Welsh Government to determine how well a Health Board and Local Authority are performing. Over the years there has been a great deal of work to both understand the issues and causes of DToC along with tools and resources to address these. A number of actions have been identified that could be taken to improve performance in relation to DToC, these include:
   - Implementation of existing guidance - such as 'Passing the Baton' and the Ten High Impact Changes for Complex Care.
   - Avoiding unnecessary hospital admissions – working with GPs to identify key people at risk to target early intervention, use of specialist staff at the "front door", providing support and advice to care homes, use of third sector organisations in the provision of preventative services and support.
   - Choice – ensure implementation of existing guidance, ensure staff are "on message" i.e. hospital is not accommodation and need early discussions to plan discharge, use of intermediate care beds, step down beds, interim placements etc.

   However, whilst there has been work to help improve performance challenges still remain.

10. The Social Services Improvement Agency (SSIA) will shortly be publishing a report, 'Delayed Transfers of Care: Informal Review to Identify Good Practice', which reviewed existing practice and identified actions aimed at enabling sustainable improvement. Capacity was identified as the major factor impacting upon effective flow and contributing to delayed transfers of care. The research found there has been a conscious move towards rebalancing provision towards primary and community led healthcare service. The move towards a more community driven NHS response has led to significant investments in community services, including the establishment of Community Resource Teams (CRTs). Local authorities in partnership with Health Boards have developed the CRTs and have also provided a shared approach to reablement, in addition to the longer term domiciliary care provision. This reinforces the need for all responses to take a whole system approach.

11. Local authorities have been working closely with local health boards, Welsh Government and other partners to plan for these unscheduled pressures and design services to meet needs. Local authorities have utilised the funding streams available to support much of their work in helping to lessen the impact of winter pressures. For example, previously funding from the Regional Collaborative Fund (RCF) was used to support the development of new services across regions with a focus on priority areas, including winter pressures for social care and health services. The Intermediate Care Fund (ICF) has also provided opportunities to achieve a further step change in the way services work collaboratively at both strategic and operational levels.

12. The ICF was introduced in 2014/15 with a focus to improve outcomes for older people and reduce pressures on the unscheduled care system by supporting people to remain at home, avoiding unnecessary hospital admissions and also preventing delayed discharges. Managed through regional arrangements, the funding has been used for:
    - Additional domiciliary care packages (including high end packages).
    - Residential and nursing home care.
    - Extra care nursing and social work capacity.
    - Community equipment.
    - Fast tracking adaptations.
    - 7 day discharge liaison nursing services.
    - Reablement services.
    - Single point of access.
    - Additional step up/step down beds.
    - Respite placements.

13. We have seen significant progress being made on reducing the levels of DToC in Wales in recent years, whilst at the same time it has been reported that the numbers of delays in England are rising. This demonstrates the importance of protecting funding provided to local authorities and the need to continue to invest in preventative services, through schemes such as the Intermediate Care Fund, to improve outcomes for people and reduce pressures on the unscheduled care system. More recently we have seen this reduction in DToC level off and in response a specific element of the ICF grant for 2015/16 was allocated to regions to support them to reduce the number of people who were delayed due to community care assessments, community care arrangements, selection of care home and waiting for availability of care home. This funding has been used by regions to focus on areas where there are known capacity issues, such as domiciliary and residential care. The funding has enabled regions to secure additional capacity to provide more care and support within the community. It has also demonstrated more effective partnership working and more integrated systems of care and support, as well as a greater emphasis on prevention and early intervention. Whilst the data does not demonstrate a reduction in the number of delayed discharges as a result of this work, there is evidence of additional capacity and an increasing number of people that have been supported, along with better outcomes being delivered for individuals. It is clear that without this investment the DToC position would be higher due to the pressures being placed on the system.

14. Other work local authorities have been involved with include the development of unscheduled care plans and pilot projects, aimed at managing winter pressures. This has included elements such as:
    - An exploration of opportunities to jointly fund interim placements with the aim of improving the discharge process and reducing the number of delayed transfers of care
    - Improving GP access during core hours
    - Closer working with regard to escalation procedures at times of increased demand
    - Development of step up / down beds.
    - Expanding Intermediate Care Service (Social Workers, Therapists, District Nurses and generic workers) available over the weekend in order to increase the number of safe discharges during the Winter pressures period
    - Having social work presence within hospitals to help prevent avoidable hospital admissions and facilitate earlier discharge.

15. There are also examples of innovative approaches that have been developed, for example, Healthy Prestatyn/Healthy Rhuddlan Iach, an integrated model of primary care delivery. This aims to treat patients as full and equal partners in their health journey, applying an integrated Multi-Disciplinary Team (MDT) approach to primary care which makes maximum use of community assets to fully address patient need. The new primary care service is based on four elements - Same Day, for minor ailments and injuries; Elective Centre, for planned care including chronic conditions; Domiciliary and Care Home Support; and an Academy providing training for professionals and patients. This represents a more holistic approach, recognising that the way to avoid delayed discharges is to identify how people end up in hospital and tackling the problem at its source.

16. Whilst there are examples of good practice and much progress has been made, a clear and real challenge in addressing the challenges presented by Winter pressures and unscheduled care is the capacity of the organisations and resources available. Given the ever growing pressure on services and continued cuts, particularly to local authority budgets this will continue to be an issue.

17. The chair of Care Forum Wales recently spoke of the need for urgent action to deal with the "triple whammy" hitting care homes and domiciliary care companies (http://www.bbc.co.uk/news/uk-wales-politics-37157515) – with a lack of funding and resources and a major recruitment problem meaning that the care sector was facing a "crisis". As highlighted earlier, one of the challenges facing local authorities is the fragility of the domiciliary care market and challenges around recruitment and retention. These services are vital to support both the NHS and social services to meet the needs of people, but they are being placed under increasing pressure. We believe there is a need to seriously look at the future funding of social care in Wales

and invest new monies into the sector, to ensure the future sustainability of the social care sector.

18. There is a need to get things right for people and their carers/families, ensuring good communication to enable effective decision making. Partners need to work together across the statutory and third sector to ensure best use of scarce resources in a time of austerity. There is a need to inform and involve the public, manage expectations and plan for increasing demographic pressures to ensure the system is fit for purpose going forward, with the development of preventative services.

19. The Social Services and Well-being (Wales) Act provides opportunities to support integrated working with the creation of Regional Partnership Boards and requirements to undertake joint population assessments. We believe that we need to take a more radical approach to integration, with local government at its heart. This is critical if we are to shift focus and resources towards prevention and early intervention, rather than treatment or resolving crises. The Intermediate Care Fund has provided us with opportunities to develop new models of service delivery that have involved the integration of health, housing and social care, along with the essential contribution of third and private sector agencies. We need to learn from this, as well as from the approaches in other countries, in order to be able to accelerate this agenda in Wales, making better use of all available resources to both health and social services, to drive this forward towards more meaningful integration and improved outcomes.

20. Given the pressures facing the health and social care workforce it will also be important to make links between this inquiry and the inquiry looking into the sustainability of the health and social care workforce.

WP 18
Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016
Inquiry into winter preparedness 2016/17
Ymateb gan: Cymdeithas Fferyllol Frenhinol
Response from: Royal Pharmaceutical Society

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12 September 2016

To: Members of the Health, Social Care and Sport Committee

Inquiry into winter preparedness 2016/17

Introduction

1. The RPS is the professional body for pharmacists in Wales and across Great Britain. We are the only body that represents all sectors of pharmacy. We promote and protect the health and well-being of the public through the professional leadership and development of the pharmacy profession. This includes the advancement of science, practice, education and knowledge in pharmacy. In addition, we promote the profession's policies and views to a range of external stakeholders in a number of different forums.

2. We welcome the opportunity to contribute to the Health, Social Care and Sport Committee inquiry into winter preparedness 2016/17 and we are pleased that the Committee is prioritising this important area as part of its work programme.

3. The winter months are a very busy time for all health professionals including pharmacists working in community, primary care and hospital settings. Pressures are intensified in the winter due to the increased risk of poor health among the population, particularly the frail elderly and those people living with long term conditions such as diabetes and chronic obstructive pulmonary disease.

4. Medicines are an important component of healthcare packages all year round but the need for vulnerable groups to access their medicines and to take them as intended is critical during the winter months, especially for vulnerable cohorts of the population. Prescribed medicines that are taken as intended by the prescriber can make a significant difference to patient care, helping patients to manage their health conditions effectively, stabilising their health and minimising the need for unscheduled and urgent care. Immunising vulnerable groups to help minimise the risks from influenza and advising the public about healthy living are also key issues for effectively managing winter pressures.

5. Working alongside their health professional colleagues, pharmacists have a key role to play in helping patients and the NHS prepare for winter and in contributing to the broad endeavor to reduce pressures on unscheduled, urgent and emergency care.

The current pressures facing unscheduled care services, and how well prepared the Welsh NHS and social services are for winter 2016/17

6. We recognise that unscheduled and emergency care services are currently impacted upon by a wide range of demographic, economic, structural and workforce issues. These are well documented and we are aware that the Welsh NHS Confederation has captured these issues succinctly in their response to the Committee's inquiry.

Progress in alleviating pressures on unscheduled care and actions needed to build resilience to seasonal demand for the future

7. We believe that progress has been made over the past five years to help alleviate pressures on unscheduled care. In terms of the role that the pharmacy team can play in contributing to the tremendous endeavour to tackle winter pressures, we welcome the steps taken to integrate pharmacy services into winter planning arrangements. The opportunity for patients from the pharmacy profession can be found in:

i) Delivering influenza vaccinations

8. Many pharmacies throughout Wales offer private and/or NHS funded influenza vaccinations. Those eligible for free NHS influenza vaccinations include those who are aged 65 years and over, or under 65 but have a long term health condition such as chronic respiratory disease, heart disease or diabetes.

9. We support the approach taken by the Welsh Government to ensure national coordination of influenza vaccinations each winter by utilising the skills and experience of community pharmacists and community nurses alongside their GP colleagues. This has increased opportunities for patients to access a health professional trained to safely administer the flu vaccine on the NHS in a location and at a time convenient for them. This has been particularly helpful in areas where the uptake of flu vaccinations has been traditionally low. We note however that uptake for patients eligible for NHS vaccinations decreased slightly in 2015/16 compared with the previous year and it is concerning that this has reversed the upward trend in flu vaccination uptake that we have seen since 2008/09.

10. We believe the accessibility of community pharmacy offers significant opportunities for targeting at-risk groups and helping to increase uptake of the flu vaccination. Currently however the flu vaccination service is not universally accessible to patients via community pharmacy due to the current eligibility criteria for the service. We believe that permitting all community pharmacies to provide the flu vaccination service would increase opportunities for hitting national flu vaccination targets as well as allowing for a national public campaign, providing clear advice and information to the public on how to access the service in their community.

ii) Delivering the Minor Ailments Service

11. We welcomed the commitment of the Welsh Government to introduce the Choose Pharmacy Scheme in March 2016, following the successful evaluation of two pilot schemes in Cwm Taf University Health Board and the Betsi Cadwaladr University Health Board areas. The Choose Pharmacy Scheme offers opportunities for patients to access

medicines and advice regarding minor ailments via community pharmacy and aims to relieve pressures on GP and unscheduled services. We are aware that around 18% of GP workload and 8% of emergency department consultations relate to minor ailments, such as coughs, colds, and conjunctivitis[1] and that these common conditions do not, in most cases, require access to a GP or emergency services. The scheme offers important opportunities for NHS capacity, potentially removing activity from hospital Emergency Departments, GPs and out of hours services.

12. A review of the Choose Pharmacy Scheme has already indicated positive outcomes for patients accessing services as well as better utilisation of NHS resources. We therefore believe this scheme should be universally available and invested in, ensuring the public can access support for minor ailments via community pharmacy wherever they may live in Wales.

13. The current formulary for the Choose Pharmacy Scheme offers a range of medicines for conditions that are common. We would however support the review of this list to explore whether additional medicines that are commonly prescribed during the winter months could be added to the formulary to offer increased opportunities for reducing pressures on unscheduled care.

iii) Emergency Supply of Medicines

14. Pharmacists can make a supply of prescription only medicines (POMs) to a patient without a prescription in an emergency at the request of a prescriber or a patient. They must consider each request on a case by case basis, using professional judgement to decide which course of action is in the best interest of the patient. This can ensure that patients who run out of important medicines do not go without, can continue their treatment and thereby help to reduce unnecessary and avoidable pressures on unscheduled and urgent care (GP out of hours, Accident and Emergency, hospital admissions, NHS Wales Ambulance Service).

15. The pharmacy team are accustomed to planning ahead for patient's medication needs during holiday periods such as bank holiday's and Christmas. Pharmacists also work regularly with their prescribing colleagues to ensure patient medication needs are met during adverse weather conditions such as snow and ice. During these conditions and through collaboration between pharmacists and their GP colleagues, arrangements can be made for patients to receive medication in advance to ensure they do not run out of crucial medicines and to alleviate their worries. Patients who would usually collect their medicines from their community pharmacy can request delivery of their medicines to avoid anxiety of leaving their homes during adverse conditions. These arrangements are mostly informal but are vitally important to patient care and can have a positive effect in reducing the need for unscheduled and emergency care.

iv) Triage and Treat

16. Community pharmacies can be commissioned to address minor injuries in order to support capacity challenges in the NHS at peak times. This innovative approach was

[1] Pharmacy Research UK (2014) The Minor Ailment Study (MINA): Community Pharmacy Management of Minor Illnesses. Available at: http://www.pharmacyresearchuk.org/our-research/our-projects/the-minor-ailment-study-mina/

successfully introduced by Hywel Dda Health Board during the summer months to help alleviate pressures on GPs and emergency services due to the additional pressures created by tourists in Tenby and Saundersfoot. The service allows pharmacists to consult with patients on minor injuries such as insect stings and sunburn and offers choice to patients in accessing clinical support. We believe that while triage and treat has its origins in the summer months, the concept of commissioning community pharmacies to deal with low level injuries could be applied all year round to help reduce pressures on emergency services, GPs and out of hours services.

v) Unscheduled Care – NHS 111

17. We welcome the steps taken by NHS 111/Out of Hours to include clinical pharmacists in their multidisciplinary team approach in Clinical Support Hubs and we are working closely with NHS 111 to advise on the role of pharmacists in this important approach to unscheduled care.

18. The inclusion of pharmacists in the out of hours service of NHS 111 provides a single access point for expert advice on medicines management issues. It also offer opportunities for pharmacists to provide timely medicines advice to the wider multidisciplinary team of health professionals. We believe that inclusion of pharmacists in this service is important in terms of adding value and quality to multidisciplinary approaches to unscheduled care, improving cost effectiveness in out of hours care and helping to reduce pressures on hospital emergency departments and GP out of hours services.

vi) Alleviating hospital pressures

19. Hospital based pharmacists and technicians can play an important role in supporting their A&E colleagues during times of increased demand. Studies have found between 1.4% and 15.4% of hospital admissions were drug related and preventable[2] and this rises in the frail elderly. As the experts on medicines, pharmacists can work with their A&E and hospital colleagues to address medicines related problems, reduce the potential for errors in prescribing and administration, reduce delays in getting medicines to patients, ensure patients are prescribed all of their regular medication and in some cases address patient needs to avoid admission to a hospital ward.

20. We are aware of examples of practice where pharmacists are supporting A&E nurses, doctors and consultants to optimise the use of medicine, helping improve the flow through A&E and improving the level of care delivered to patients[3]. We recommend that initiatives such as these are explored further in Wales.

21. Delivering 24/7 hospital care has a particular set of challenges for the NHS but we believe it is an issue that must also be addressed to relieve pressures on unscheduled and emergency care in Wales. Delivering high quality integrated and multidisciplinary care is a challenge during the weekends and can be a particular problem during the winter months when pressures on emergency departments are intensified. We believe that

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[2] Howard RL, Avery AJ et al, British Journal of Clinical Pharmacology, Vol 63, Issue 2, Feb 2007, 136-147.

[3] Northampton General Hospital – Pharmacy staff join A&E to help reduce winter pressures: http://www.northamptongeneral.nhs.uk/News/2015/Pharmacy-staff-join-AE-to-help-reduce-winter-pressures.aspx

clinical pharmacy input into hospital care at weekends is vital to ensure medication problems and pharmaceutical care issues are identified and resolved within 24 hours, avoiding the delay of waiting for the clinical service to resume on a Monday and reducing the risks to patients from complications. Pharmacist input to multidisciplinary clinical teams at the weekend would offer medical and nursing staff pharmaceutical advice to assist with complex cases, supporting prescribing decisions and contributing to improvements in patient care.

vii) Smoking cessation services

22. It is well recognised that stopping smoking is good for a person's overall health and is of increased benefit during the winter months, when the cold can exacerbate respiratory problems including COPD, which traditionally is a condition that increases pressures on emergency services and inpatient care.

23. Community pharmacies can offer different levels of support for patients including: Level 1 - the provision of leaflets and opportunistic advice to patients presenting prescriptions at the pharmacy; Level 2 - supplying and supporting patients who are receiving intensive behavioural support and advice from Stop Smoking Wales; Level 3 - providing one to one assessment of patients' needs, initiating supply, monitoring the use of appropriate nicotine replacement therapy (NRT) and providing motivational support each time NRT is supplied to a client. Access to smoking cessation services via community pharmacy is part of an important approach to improving individual and population health. We believe it is an area which should continue to be invested in as part of public health approaches to minimise the impact of smoking in Wales.

viii) Signposting patients to support and advice

24. Pharmacy teams are well placed to offer practical advice and signposting to health, social care and voluntary sector services, ensuring that vulnerable people are prepared for the health challenges posed by the winter months. In 2013 a community pharmacy campaign was undertaken to raise awareness of the increased risk of poor health that the cold weather can have for some people e.g. older people and those with long term conditions. The campaign enabled pharmacies to help people get ready for winter and lower any risk to their health that might arise as a result of cold weather. We continue to support public campaigns such as this.

Conclusion

25. The Royal Pharmaceutical Society in Wales is aware of the progress made in winter planning over the past five years in Wales. We appreciate that effective winter planning is a significant undertaking at national and local levels, requiring input not only from the NHS but also from other key stakeholders such as social care and the voluntary sector. We believe that winter planning in Wales should continue to be recognised as a critical function and services should continue to be invested in and, where necessary, remodelled to ensure that service pressures can be alleviated during the winter months.

26. We have highlighted in this response where we believe the pharmacy team makes a difference to tackling winter pressures and where services could be changed or strengthened to achieve improvements for patient access to care and flow through the healthcare system. Further steps are now needed to strengthen the role of the pharmacy team in undertaking the work necessary to alleviate pressures on unscheduled and emergency care during the winter months (and all year round). One key enabler for

change would be pharmacist access to individual patient records. Currently pharmacists are not able to access critical information about patients which severely restricts the potential for meaningful dialogue with patients and GPs about their medicines. Access to appropriate aspects of individual patient records would allow pharmacists to consult more effectively with patients and empower them to treat or refer them on to another health professional in a safe and effective way.

27. Utilising the skills of pharmacist independent prescribers would also offer increased opportunities for reducing demands on GPs, unscheduled and emergency care, and GP out of hours services. As independent prescribers, pharmacists are well placed to work alongside their GP and hospital colleagues to manage the medication of patients, ensuring medicines are taken as prescribed, coaching patients about their medicines, stabilising their condition and thereby reducing pressures on unscheduled and emergency services. We believe that this a resource in the NHS that should be harnessed to help alleviate pressures during the winter and indeed all year round.

Yours sincerely

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