Agenda - Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Lleoliad:
Ystafell Bwyllgora 2 - y Senedd
Dyddiad: Dydd Iau, 29 Medi 2016
Amser: 09.15

I gael rhagor o wybodaeth cysylltwch a:
Sarah Beasley
Clerc y Pwyllgor
0300 200 6565
SeneddIechyd@cynulliad.cymru

Rhag-gyfarfod anffurfiol (09.15 - 09.30)

1 Cyflwyniad, ymddiheuriadau, dirprwyon a datgan buddiannau

2 Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016/17 - sesiwn dystiolaeth gydag Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru

(09.30 - 10.15) (Tudalennau 1 - 34)

Tracy Myhill, Prif Weithredwr yr Ymddiriedolaeth
Richard Lee, Cyfarwyddwr Gweithrediadau'r Ymddiriedolaeth

Egwyl (10.15 - 10.25)

3 Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016/17 - sesiwn dystiolaeth gyda Coleg Brenhinol yr Ymarferwyr Cyffredinol (RCGP) a'r Gymdeithas Fferyllol Frenhinol (RPS)

(10.25 - 11.25) (Tudalennau 35 - 42)

Dr Isolde Shore-Nye, Coleg Brenhinol yr Ymarferwyr Cyffredinol
Dr Jane Fenton-May, Coleg Brenhinol yr Ymarferwyr Cyffredinol
Suzanne Scott-Thomas, Cadeirydd Bwrdd Fferylliaeth RPS Cymru a Chyfarwyddwr Clinigol a Phennaeth Rheoli Meddyginiaethau Bwrdd Iechyd Prifysgol Cwm Taf
Mair Davies, Cyfarwyddwr RPS ar gyfer Cymru

4 Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016/17 - sesiwn dystiolaeth gyda Coleg Brenhinol y Seiciatryddion (RCPsych) a Coleg Brenhinol Pediatreg ac Iechyd Plant (RCPCH)

(11.25 - 12.25) (Tudalennau 43 - 53)

Yr Athro Tayyeb Tahir, Coleg Brenhinol y Seiciatryddion (RCPsych)
Dr Mair Parry, Coleg Brenhinol Pediatrig ac Iechyd Plant (RCPCH)

Egwyl cinio (12.25 - 13.00)

5 Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016/17 - sesiwn dystiolaeth gyda Chymdeithas y Cyfarwyddwyr Gwasanaethau Cymdeithasol

(13.00 - 14.00) (Tudalennau 54 - 60)

Neil Ayling, Llywydd Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru a Phrif Swyddog Gwasanaethau Cymdeithasol Cyngor Sir y Fflint
Claire Marchant, Cyfarwyddwr Arweiniol Gwasanaethau Newydd a Phrif Swyddog Iechyd a Gofal Cymdeithasol Cyngor Sir Fynwy

6 Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod

Er mwyn ystyried:

- tystiolaeth a roddwyd gan randdeiliaid yn ystod y cyfarfod ar yr ymchwiliad i barodrwydd ar gyfer y gaeaf 2016/17
- Bil Cymru Llywodraeth y DU
- deiseb P-04-682 Sgrinio Rheolaidd ar gyfer Diabetes Math 1 mewn Plant a Phobl Ifanc
- deiseb P-04-532 Gwella Gwasanaethau Niwrogyhyrol Arbenigol yng Nghymru

7 Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016/17 - trafod tystiolaeth a roddwyd yn ystod y cyfarfod heddiw

(14.00 - 14.15)

Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016/17: Ymatebion i'r Ymgynghoriad

8 Ystyried Flaenraglen Gwaith y Pwyllgor

(14.15 - 14.25) (Tudalennau 61 - 67)

9 Trafod Bil Cymru Llywodraeth y DU

(14.25 - 14.50) (Tudalennau 68 - 74)

10 Trafod Deiseb P-04-682 Sgrinio Rheolaidd ar gyfer Diabetes Math 1 mewn Plant a Phobl Ifanc

(14.50 - 14.55) (Tudalennau 75 - 77)

11 Trafod Deiseb P-04-532 Gwella Gwasanaethau Niwrogyhyrol Arbenigol yng Nghymru

(14.55 - 15.00) (Tudalennau 78 - 79)

Mae cyfyngiadau ar y ddogfen hon

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

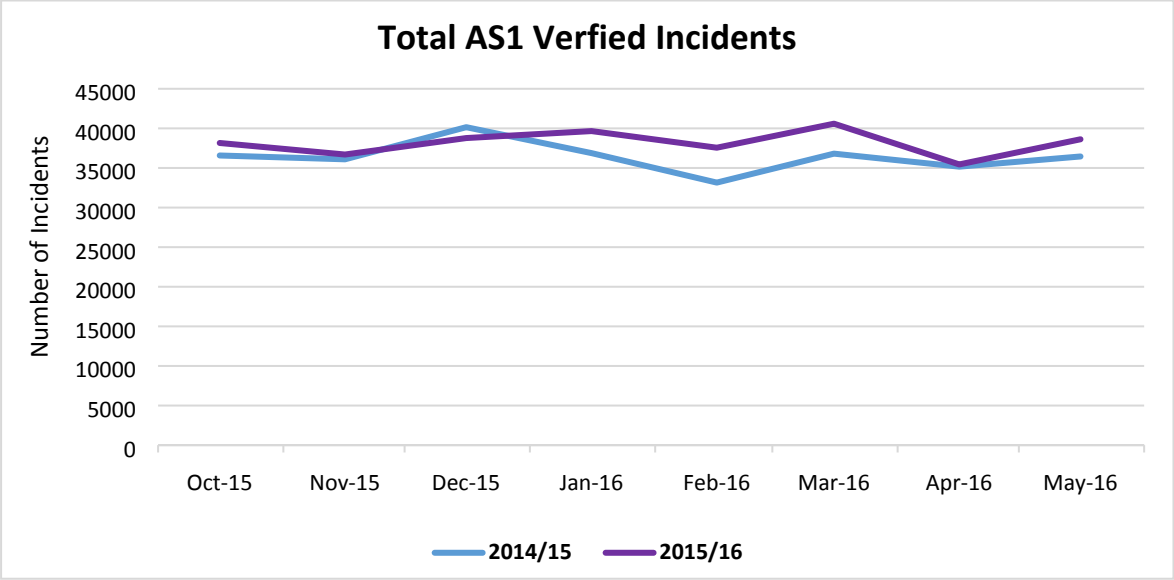
17. In developing a Winter Plan for 2016/17, the experience of winter 2015/16 has been reviewed in detail, looking at four determinants of patient flow and performance, namely:

- 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:

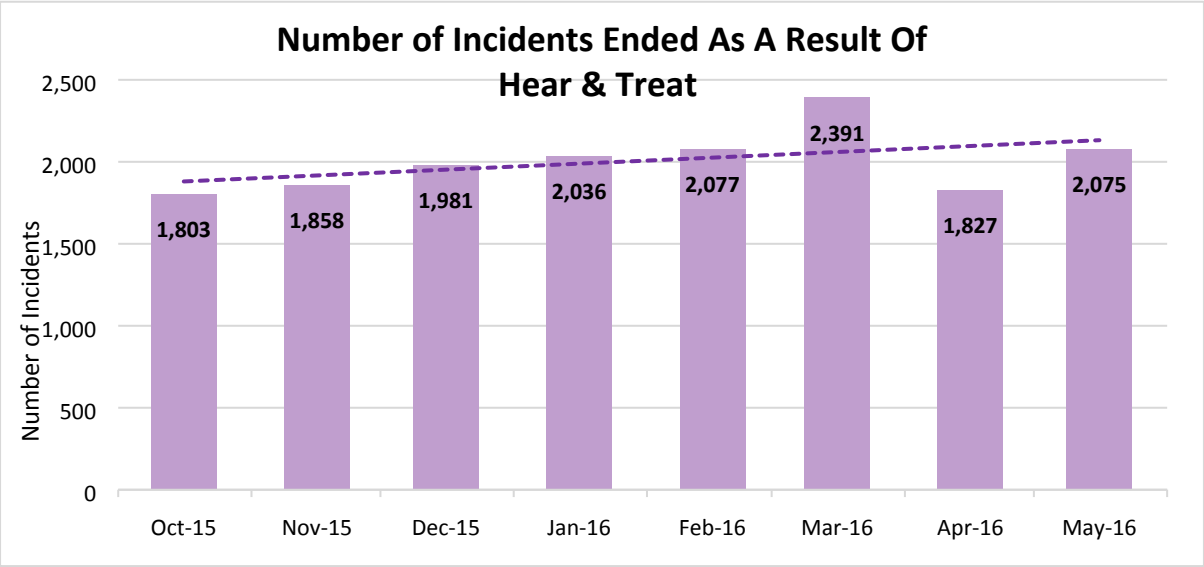
- Demand continued to increase at a rate of 4.89% year-on-year. An increase of approximately 4% is the norm across ambulance services, both in the UK and worldwide and may reflect a variety of factors: 24/7 culture, ageing populations with increasing clinical acuity, access to primary care. Whatever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

Figure 2



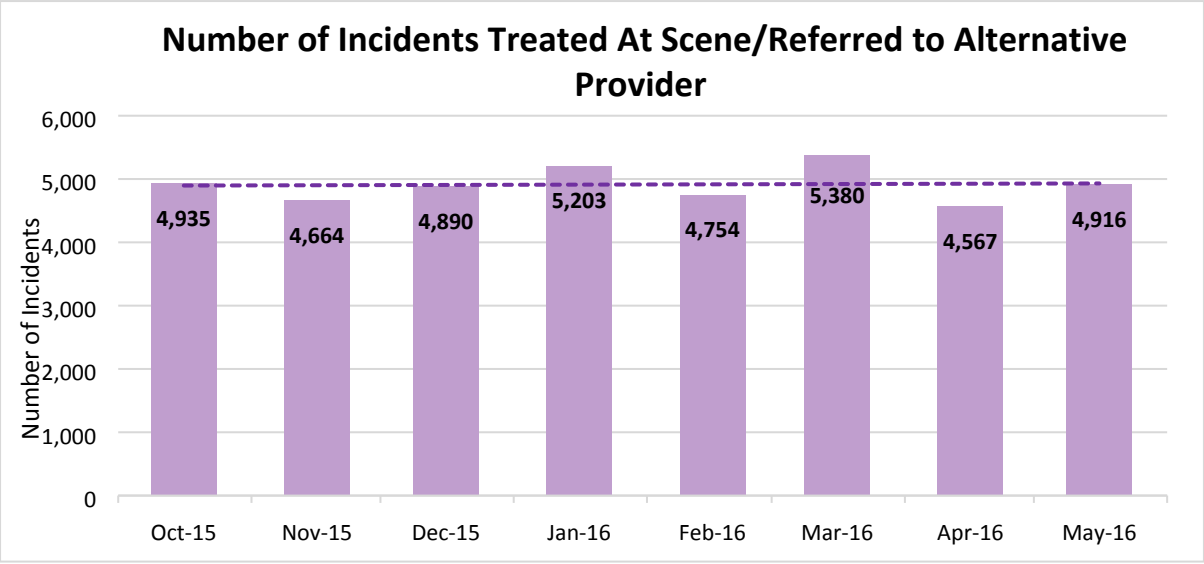
- Incidents ended as a result of "hear and treat" via the Welsh Ambulance Service's Clinical Desk showed an improving trend

Figure 3



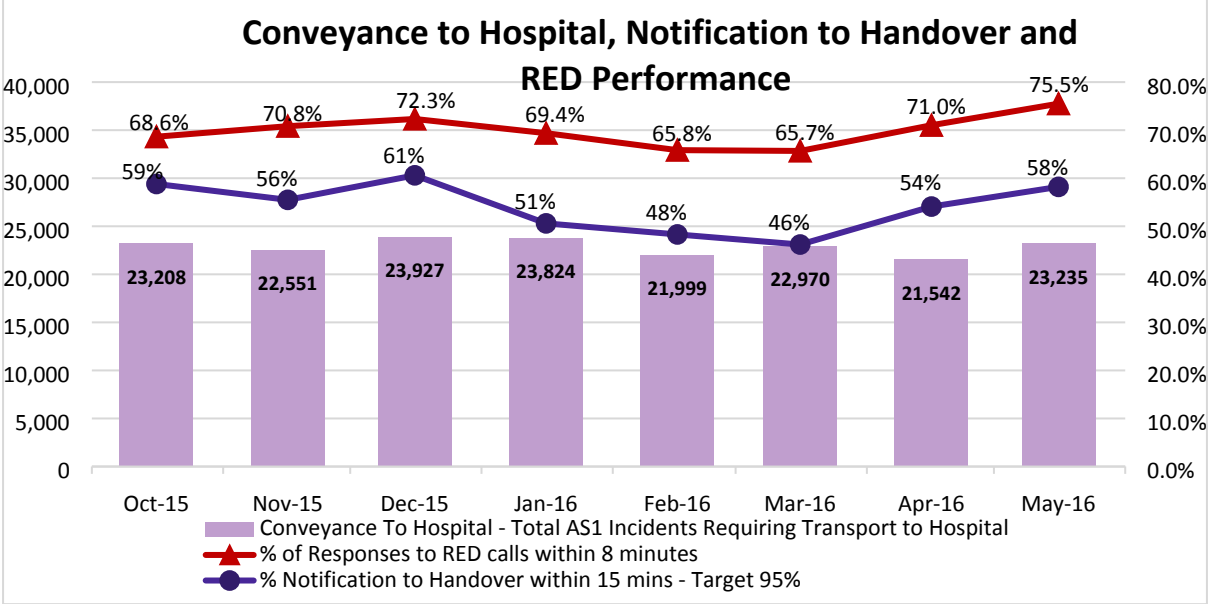
- incidents treated at scene/referred to alternative healthcare providers showed no discernible improvement

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

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.

Royal Pharmaceutical Society
2 Ash Tree Court
Woodsy Close
Cardiff Gate Business Park
Pontprennau
Cardiff
CF23 8RW

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

[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/

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 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.

---

[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

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 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

Mair Davies FFRPS, FRPharmS, FHEA
RPS Director for Wales

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.

[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

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.

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.

[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.

[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

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.

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

[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

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.

[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

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.

For further information please contact:

Ms Manel Tippett
Policy Administrator
RCPsych in Wales
Baltic House
Mount Stuart Square
Cardiff Bay, CF10 5FH

[redacted]

www.rcpsych.ac.uk

@RCPsychWales

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

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-05-16 Papur 6/ Paper 6

WLGA • CLILC

ADSS Cymru
Leading Social Services in Wales
Yn arwain Gwasanaethau Cymdeithasol yng Nghymru

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.

Mae cyfyngiadau ar y ddogfen hon

Mae cyfyngiadau ar y ddogfen hon

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Deisebau

National Assembly for Wales
Petitions Committee

Dai Lloyd AC
Cadeirydd y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Tŷ Hywel
Bae Caerdydd
CF99 1NA

12 Medi 2016

Annwyl Dai

Deiseb P-04-682 Sgrinio Rheolaidd ar gyfer Diabetes Math 1 mewn Plant a Phobl Ifanc

Ystyriodd Pwyllgor Deisebau y Pedwerydd Cynulliad y ddeiseb a ganlyn am y tro cyntaf ar 8 Mawrth 2016:

Rydym yn galw ar Gynulliad Cenedlaethol Cymru i annog Llywodraeth Cymru i gyflwyno sgrinio rheolaidd ar gyfer diabetes math 1 mewn plant a phobl ifanc.
Ym mis Ionawr eleni, yn drychinebus collom ein hannwyl ŵyr 13 oed, Peter Baldwin, a hynny oherwydd diabetes math 1 oedd heb ei ganfod nes ei bod yn rhy hwyr i'w achub. Roedd Peter yn ddisgybl oedd yn annwyl iawn ac yn uchel ei barch gan bawb yn Ysgol Uwchradd yr Eglwys Newydd yng Nghaerdydd. Mae pawb yn ei golli yno, ond mae'r boen i'w deulu yn aruthrol.
Yn ddiweddar, cyflwynwyd gwobr Pride of Britain i'n merch Beth am ei hymdrechion yn codi arian ac ymwybyddiaeth ar gyfer y clefyd ofnadwy hwn, ond gyda'ch cymorth chi a chymorth eich ffrindiau a'ch teulu, gallwn ni wneud gwahaniaeth go iawn
A fyddech cystal â threulio ychydig funudau yn arwyddo'n deiseb i alw ar Lywodraeth Cymru i gyflwyno rhaglen sgrinio a chodi ymwybyddiaeth o'r angen i archwilio unrhyw un sy'n dod at weithiwr gofal iechyd proffesiynol â symptomau anesboniadwy tebyg i ffliw neu deimlad o salwch cyffredinol i weld a ydynt yn dioddef o ddiabetes math 1. Yr unig beth sydd ei angen mewn prawf o'r fath yw pigiad i'r bys neu sampl wrin ac mae'n cymryd llai o amser nag ydych chi wedi'i dreulio yn darllen y paragraff hwn; mae hefyd yn costio

ychydig geiniogau. Ein bwriad yw gwneud y prawf hwn yr un mor arferol mewn meddygfeydd teulu a chlinigau â phrofion tymheredd a phwysau gwaed.
Drwy lofnodi'r ddeiseb hon, gallech helpu i achub bywydau ac atal rhagor o golled erchyll mewn teuluoedd.
Gwybodaeth ychwanegol:
Y safon ddelfrydol fyddai sgrinio pob person ifanc er mwyn canfod y cyflwr llechwraidd hwn yn gynnar. Mae sawl rhan o'r byd yn gweld manteision sgrinio o'r fath ac yn ei gyflwyno – y diweddaraf yw Gogledd Carolina yn UDA. Mae linc isod i benderfyniad Gogledd Carolina.
http://insulinnation.com/living/reegans-rule-passes-north-carolina/ [Yn agor mewn ffenestr porwr newydd]
Mae Senedd yr Alban yn arwain y ffordd yn y DU ac eisoes wedi ymrwymo i drafod y mater, ac mae'n ymddangos yn debygol iawn y bydd yn cychwyn sgrinio. Rydym eisiau hyn ar gyfer ein plant yng Nghymru ac yn galw ar Lywodraeth Cymru i ddechrau sgrinio cyn gynted â phosibl.
LLOFNODWCH Y DDEISEB A'I RHANNU Â CHYNIFER O BOBL Â PHOSIBL
(a chofiwch longyfarch eich hun – mae'n bosibl eich bod wedi achub bywyd plentyn)
Mae deiseb ar Change.org yn casglu llofnodion ar hyn o bryd ar gyfer y newid hwn ar draws y DU:
https://www.change.org/p/craig-williams-mp-screen-children-for-type-1-diabetes [Yn agor mewn ffenestr porwr newydd]

Cyflwynwyd y ddeiseb hon gan Anthony Cook, ar ôl casglu 2,570 o lofnodion. Casglodd deiseb gysylltiedig i Lywodraeth y DU 3,670 o lofnodion.

Yn y cyfarfod ar 8 Mawrth, cytunodd yr Aelodau i ofyn i'r Pwyllgor Iechyd newydd a fyddai'n ystyried cynnwys y mater hwn yn ei flaenraglen waith ar gyfer y Pumed Cynulliad. Fel y Cadeirydd newydd, rwyf bellach yn bwrw ymlaen â'r cais hwn fel y cytunwyd gan y Pwyllgor blaenorol.

Byddwn yn ddiolchgar pe gallech anfon eich ymateb at y Tîm Clercio yn *SeneddDeisebau@cynulliad.cymru*

Yn gywir

Mike Hedges AC
Cadeirydd

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Deisebau
National Assembly for Wales
Petitions Committee

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-05-16 Papur 10 / Paper 10

Dai Lloyd AC
Cadeirydd y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Tŷ Hywel
Bae Caerdydd
CF99 1NA

20 Medi 2016

Annwyl Dai

Deiseb P-04-532 Gwella Gwasanaethau Niwrogyhyrol Arbenigol yng Nghymru

Yn ei gyfarfod olaf ar 8 Mawrth 2016, rhoddodd y Pwyllgor Deisebau ar gyfer y Pedwerydd Cynulliad ystyriaeth i'r ddeiseb a ganlyn a gyflwynwyd gan y Muscular Dystrophy Campaign:

Rydym yn galw ar Gynulliad Cenedlaethol Cymru i annog Llywodraeth Cymru i sicrhau bod Byrddau Iechyd yn gweithredu'r buddsoddiad a gynigir yn Nogfen Weledigaeth Rhwydwaith Niwrogyhyrol Cymru i wella gwasanaethau niwrogyhyrol arbenigol yng Nghymru.

Gwybodaeth ychwanegol:
Mae Rhwydwaith Niwrogyhyrol Cymru'n argymell y dylid blaenoriaethu'r datblygiadau canlynol: 1. Cynyddu nifer y Cynghorwyr Gofal Teulu a lefel y gefnogaeth. 2. Ffisiotherapyddion niwrogyhyrol arbenigol ar gyfer oedolion. 3. Penodi ymgynghorydd anhwylderau niwrogyhyrol ar gyfer oedolion. 4. Cynyddu seicoleg glinigol. 5. Cyllideb offer at bryniannau mân a threfniadau lesio.

Yn y cyfarfod hwnnw, cytunodd yr Aelodau i ofyn i'r Pwyllgor Iechyd newydd a fyddai'n ystyried cynnwys y mater hwn ar ei flaenraglen waith ar gyfer y Pumed

Cynulliad Cenedlaethol Cymru
Bae Caerdydd, Caerdydd, CF99 1NA
SeneddDeisebau@cynulliad.cymru
www.cynulliad.cymru/SeneddDeisebau
0300 200 6565

National Assembly for Wales
Cardiff Bay, Cardiff, CF99 1NA
SeneddPetitions@assembly.wales
www.assembly.wales/SeneddPetitions
0300 200 6565

Cynulliad. Fel y Cadeirydd newydd, rwyf nawr yn bwrw ymlaen â'r cais hwn yn unol â'r hyn a gytunwyd gan y Pwyllgor blaenorol.

Byddwn yn ddiolchgar pe gallech anfon eich ymateb trwy e-bost at dîm clercio'r Pwyllgor yn *SeneddDeisebau@Cynulliad.Cymru*

Yn gywir

Mike Hedges AC
Cadeirydd